OB Harm Initiative Webinar

August 20, 2014

Sharon Burnett
Vice President of Clinical and Regulatory Affairs
Missouri Hospital Association
Webinar Objectives

- Provide an update on MO HealthNet EED no-payment rule, CMS reporting of PC-01 and COP R/T assessment/monitoring of patients receiving high risk medications
- Provide an update by hospital representatives on their work on the maternal hemorrhage and preeclampsia initiatives
- Discuss ways to reduce maternal and neonate injuries captured by the AHRQ OB patient safety indicators PSI 17, 18 and 19
- Provide information on opportunity to receive scholarships to attend the March of Dimes Perinatal Conference to be held on Nov. 13 and 14 in Columbia
- Provide information on upcoming events, deadlines and available resources
Farewell and Welcome

- Farewell to Cathy Lewis - Part-Time HEN Improvement Advisor and Jeanne Naeger, Vice President of Clinical Quality Improvement
- Welcome to Alyson Williams, Vice President of Clinical Quality Improvement
Homestretch of Reducing EEDs

- HEN Hospital reported EED rate for last 6 months is **1.4%**!
- Early Elective Delivery No Payment Rule Final published July 15, August 15, effective Oct. 1
- PC-01 new measure for VBP FFY 2017
- Must have a Hard Stop policy that is enforced by staff and backed up by your medical director of obstetrics and administration
PC-01 EED Measure Added to VBP Program

- CMS FY 2015 IPPS Final Rule Published August
- Adopted PC-01 for inclusion in the FY 2017 VBP program
  - Performance Period Jan. 1 to Dec. 31, 2015
  - Baseline Period Jan. 1 to Dec. 31, 2013
  - Achievement Threshold – 3.1% (0.03125)
  - Benchmark – 0%
- Also adopted for voluntary reporting under eCQM
Other Regulatory and Legislative Updates

- Umbilical Cord Blood Bank - Beginning **July 1, 2015**, DHSS to transport collected, donated umbilical cord blood samples from approved collection sites to a nonprofit umbilical cord blood bank located in St. Louis City. Signed by the Governor.

- Appendix A Acute Care Hospitals COP – Revisions to tag A-405 under Nursing Services include new requirements
  - Patients are to be assessed by nursing and/or other staff, per hospital policy, for their risk to their prescribed medications
  - Patients who are higher risk and/or receiving high-alert medications should be monitored for adverse effects ([ISMP High Alert Medications](#))
  - Staff must be knowledgeable of intervention protocols when patients experience adverse medication-related events
Other Maternal and Infant Mortality Initiatives

- Legislation to create a Perinatal Advisory Council to define neonatal and maternal care regions and levels was not enacted. The MO House Children’s Services Commission, appointed a Prematurity & Infant Mortality Subcommittee to look at the recommendations in the Missouri Taskforce on Prematurity and Infant Mortality Report.

- DHSS is applying for AMCHP funding to extend their Pregnancy Associated Mortality Review and develop state wide strategies to reduce maternal mortality.

- MFH is funding a multi-year collective impact project to reduce infant mortality in St. Louis City and counties in the boot heel with the Maternal Child and Family Health Coalition.

- SHARE has received a 3-year grant from the MFH to provide training and resources for caregivers from Missouri birthing hospitals and clinic provider networks to care for grieving families.
Pre-Work

- Premier’s HEN Implementing a Maternal Early Warning System Webinar Excellent!
  
  https://premierhealth-ec.webex.com/premierhealth-ec/lsr.php?RCID=614130b774ae77aa0d521b170d2f00bb

- The National Partnership for Maternal Safety commentary by Mary D’ Alton, MD et all
  
Fish Reports
Maternal Hemorrhage/ Preeclampsia Team Update

Mindy Thomure RN
Director of Birth Place
Citizens Memorial Hospital
Bolivar, MO
Maternal Hemorrhage Team Update

Pam Lesser, RNC-AWH, MS
Director, Perinatal Services – LDR and NICU
SSM St. Mary's Health Center

Yvonne D. Smith, R.N.
Director of Nursing
SSM St. Clare Health Center
SSM Health

OB Hemorrhage Response Process

Pam Lesser, RNC-AWH, MS
Yvonne Smith, RN, BSN
Judy Wilson-Griffin, RNC-INP, EFM, PNC NS
Our learning curve

- **Situation awareness and a shared mental model - Team STEPPS**
  - Core team meetings each shift
  - Briefs prior to complex procedures
  - Huddles for unusual and multi-department events
  - Debriefs
<table>
<thead>
<tr>
<th>Stock Qty</th>
<th>Supplies</th>
<th>Stock Qty</th>
<th>Supplies</th>
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<tr>
<td><strong>Drawer One</strong></td>
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<tr>
<td>2</td>
<td>Surgical Consents</td>
<td>1</td>
<td>Pressure Bags</td>
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<tr>
<td>2</td>
<td>Blood Consent and Refusal Forms</td>
<td>1</td>
<td>O2 Regulator, Xmas Trees, O2 Mask</td>
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<tr>
<td>1</td>
<td>Specimen Bags, Hand Sanitizer</td>
<td>1</td>
<td>Stethoscope</td>
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<tr>
<td>1</td>
<td>Flashlight</td>
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<tr>
<td><strong>Drawer Two</strong></td>
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<tr>
<td>3</td>
<td>Intracan each size (16,18,20, g)</td>
<td>3</td>
<td>Vacucontainers Two Types</td>
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<tr>
<td>2</td>
<td>Statlock</td>
<td>3 each</td>
<td>Blood tubes (white, pink, green, purple, blue)</td>
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<tr>
<td>2</td>
<td>Tegaderm Film</td>
<td>4</td>
<td>Chlora Prep Sept</td>
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<tr>
<td>1</td>
<td>Butterfly</td>
<td>3</td>
<td>Safety Needles (18,20,27 g)</td>
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<tr>
<td>2</td>
<td>IV Start Kit</td>
<td>4</td>
<td>0.9 Sodium Chloride flushes</td>
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<tr>
<td>10</td>
<td>Alcohol Prep</td>
<td>2</td>
<td>Syringes (3,6,12,20ml)</td>
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<tr>
<td>6</td>
<td>Bandages</td>
<td>4</td>
<td>Red Cap, Tourniquets, Tape, Green tape</td>
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<td><strong>Drawer Three</strong></td>
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<tr>
<td>2</td>
<td>Y Blood Tubing #9375154</td>
<td>2</td>
<td>Pump IV tubing</td>
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<tr>
<td>2</td>
<td>Anesthesia Tubing (Stopcock)</td>
<td>2</td>
<td>Blood Set Tubing (V2400) Platelets and FFP</td>
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<td><strong>Drawer Four</strong></td>
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<tr>
<td>2</td>
<td>1000ml Normal Saline</td>
<td>2</td>
<td>30 units Oxytocin in 500ml NS</td>
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<tr>
<td>1</td>
<td>500 ml Normal Saline</td>
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<td><strong>Drawer Five</strong></td>
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<tr>
<td>2</td>
<td>Laps Packages 18 x 4</td>
<td>2</td>
<td>OR towels</td>
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<tr>
<td>2</td>
<td>Vaginal packing</td>
<td>2</td>
<td>Q Tips Packages</td>
</tr>
<tr>
<td>2</td>
<td>Rings</td>
<td>2</td>
<td>Suture (3-0 Vicryl, 2-0, 3-0 Chromic)</td>
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<td></td>
<td></td>
<td>10</td>
<td>Sterile Lubricant</td>
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<td><strong>Drawer Six</strong></td>
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<tr>
<td>2</td>
<td>Gowns</td>
<td>1</td>
<td>Pressure Infuser Bags</td>
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<tr>
<td></td>
<td>Mask with shields</td>
<td>1</td>
<td>0.9 Sodium Chloride Irrigation 500 mL</td>
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<tr>
<td><strong>Drawer Seven</strong></td>
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<tr>
<td>1</td>
<td>Under Pads (0.24lb), package</td>
<td>1</td>
<td>Foley Kit &amp; Latex Free Foley</td>
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<tr>
<td>2</td>
<td>Sterile gloves (6.5,7,7.5,8)</td>
<td>2</td>
<td>Speculum</td>
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<tr>
<td>4</td>
<td>Long gloves (large)</td>
<td>1</td>
<td>Bed pan</td>
</tr>
<tr>
<td>5</td>
<td>Single use gloves</td>
<td>1</td>
<td>Inder Ballon</td>
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<tr>
<td>1</td>
<td>Hemabate 500 mL</td>
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<tr>
<td>10</td>
<td>100 mcg mifepristone (Mecten)</td>
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<tr>
<td>2</td>
<td>0.2 mg/ml methylergonovine maleate (Methergyl)</td>
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<tr>
<td>1</td>
<td>250 mcg/ml carboprost tromethamine (Hemabate)</td>
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</tbody>
</table>

Pyxis Refrigeration Items (call pharmacy to replace kit 88341)

<table>
<thead>
<tr>
<th>Administration Route: IP</th>
<th>Contraindications: allergy to progesterone</th>
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</thead>
<tbody>
<tr>
<td>IM preferred, or IV</td>
<td>Hypertension, Hypersensitivity, Pregnancy</td>
</tr>
<tr>
<td>IM only</td>
<td>Hypersensitivity, acute active cardiac, pulmonary, renal, hepatic disease or acute pelvic inflammatory disease</td>
</tr>
</tbody>
</table>

Judy Wilson-Griffin, RNC, APRN
Perinatal Clinical Nurse Specialist
judy_wilson-griffin@ssmhc.com

Pam Lesser, RNC, MS
Director, Women’s Services
pam_loesser@ssmhc.com
Hemorrhage Education and Simulations

- Staff lecture
- Visual cues
- Annual competency
- Blood estimate stations

Simulation
- Multidisciplinary
- Videotaped
- Debriefed

Estimated Blood Loss Recognition Using Familiar Objects
weighing object is best 1 gm = 1 ml

1 cup = 250ml
  = 5 cm clot (orange)
  = 1 unit PRBCs

12 oz soda can = 355 ml

2 cups = ~ 500 ml
  = 10 cm clot (softball)
  = 2 unit PRBCs
Keeping Normal *Normal!*

- Reduce All OB Harm to 5 or less per 100 live births
- Keeping Normal *Normal* for 665 families (700 births)
- CUSP – Ask staff two questions
  - How will the next patient be harmed?
  - What can we do to prevent this harm?

*IHI Perinatal Improvement Community Goals*
Making The Business Case

• Childbirth is the most common cause of hospitalization, one-fourth of all discharges
• Cesarean delivery is the most common cause operating procedure
• 13% of all births have obstetrical complications (hemorrhage, infection, PE/VTE, cardio and cerebrovascular conditions, laceration and trauma, etc.)
• Rates of major OB complications vary almost fivefold among US Hospitals*
• Birth-associated adverse outcomes: 2-10% (80,000-400,000 annually), half of which are preventable (Forster et al., 2006, Leape, 2008)

*Health Affairs 33, No. 8 (2014): 1330-1336
Making The Business Case

• Approximately 50 percent of hospital risk management budgets are allocated for obstetric events, and birth-related events account for more than 75 percent of claims paid in amounts over $1 million. (Pettker, 2001)

• Prevention or minimization of harm through adherence to evidence-based practice guidelines is the best defense against patient harm and malpractice claims. (Cherouny et al., 2005)
OB Harm Initiatives

- Early Elective Deliveries
- Obstetric Hemorrhage
- Hypertension in Pregnancy
- Venous Thromboembolism – Future
- Induction, Augmentation, Oxytocin and Vacuum Bundles

**Reduction in Birth and Obstetric Trauma**

- PSI 17 Birth Trauma Injury to Neonate
- PSI 18 OB Trauma Vaginal with Instrument
- PSI 19 OB Trauma Vaginal without Instrument
Where Can I Get My OB Trauma/Laceration Rates - ARHQ PSI data?

- Analytic Advantage Plus called “AHRQ Provider-Level Measures*” and “AHRQ Provider-Level Measures by Stratification
- MO HEN hospitals in the HRET CDS under reports, raw data and graphs with benchmarks and trend lines.
  - **PSI 17 Birth Trauma Injury to Neonate** – AHRQ 0.0021 (2.10 per 1000), MO 2.66/1000
  - **PSI 18 OB Trauma Vaginal with Instrument** – AHRQ 0.13911 (139.11 per 1000), MO 139.41/1000
  - **PSI 19 OB Trauma Vaginal without Instrument** – Benchmark 0.02246 (22.46 per 1000), MO 23.94/1000

AHRQ Benchmark (May 2013)
OB Trauma - Vaginal Delivery with Instrument (AHRQ PSI-18)
How To Reduce Trauma/ Lacerations PSI 17, 18, 19 Rates

- Chart review of cases – HIDI can provide record numbers
- Ensure correct documentation and coding
- Reduce EEDs
- Induction Bundles
- Vacuum Bundle
- ?????
IHI Resources

• **How-to Guide: Prevent Obstetrical Adverse Events**

• IHI Perinatal Safety Change Package 2013 – 2014 (Advanced)

• [http://www.ihi.org/engage/collaboratives/PerinatalImprovementCommunity/Pages/default.aspx](http://www.ihi.org/engage/collaboratives/PerinatalImprovementCommunity/Pages/default.aspx)
# Education and Training


<table>
<thead>
<tr>
<th>TOPIC</th>
<th>DATE</th>
<th>SPONSOR</th>
<th>REGISTRATION</th>
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<tbody>
<tr>
<td>“R” is for Readiness: Developing and Improving Your Hospital’s OB Emergency simulation Program</td>
<td>Thursday, Sept. 11 2 p.m.</td>
<td>Premier</td>
<td>[<a href="https://premierhealth">https://premierhealth</a> EC.webex.com/premierhealth EC/onstage/g.php?t=a&amp;d=74 4768217](<a href="https://premierhealth">https://premierhealth</a> EC.webex.com/premierhealth EC/onstage/g.php?t=a&amp;d=74 4768217)</td>
</tr>
<tr>
<td>Quantifying Blood Loss</td>
<td>Thursday, Aug. 28 10 a.m.</td>
<td>The Council on Patient Safety in Women’s Health Care</td>
<td>[Click here to register](<a href="http://www.nationalshare.org">http://www.nationalshare.org</a> /sharing-caring.html)</td>
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<tr>
<td>Sharing and Caring: A Perinatal Loss Seminar, St. Charles, MO</td>
<td>Sept. 5 - 7</td>
<td>Share, Inc.</td>
<td>[<a href="http://www.nationalshare.org">http://www.nationalshare.org</a> /sharing-caring.html](<a href="http://www.nationalshare.org">http://www.nationalshare.org</a> /sharing-caring.html)</td>
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<tr>
<td>March of Dimes Perinatal Conference, Columbia, MO</td>
<td>Nov. 13 - 14</td>
<td>March of Dimes</td>
<td>Registration not available yet.</td>
</tr>
</tbody>
</table>
Next Steps

- Enter EED data and OB hemorrhage data (massive and total OB blood transfusions) into CDS by Friday, Aug. 22
- Review your PSI 17, 18 and 19 rates
- Do a deep dive into identified harms including chart reviews
- Set your next team meeting date and invite physicians to discuss data and actions
- Share with staff and physicians resources and archived webinars at http://web.mhanet.com/mha-constituency-groups
- Share and celebrate your work and success