Today’s Moderator

Bernie Rosof, MD
Co-Chair, National Priorities Partnership

Today’s Featured Speakers

- Maureen Corry, MPH, Executive Director, Childbirth Connection
- Kathleen Simpson, PhD, RN, Perinatal Clinical Nurse Specialist, St. John’s Mercy Medical Center
Today's Reactor Panel

- Peter Cherouny, MD, OB/GYN, Emeritus Professor of Obstetrics, Gynecology and Reproductive Services, University of Vermont
- Alan Fleischman, MD, Senior Vice President and Medical Director, March of Dimes

Welcome to the Patient Safety Webinar Series
The objectives of the series are to:

- Share strategies for “getting started” to accelerate improvements in national patient safety efforts
- Highlight the role of public-private partnership in achieving Partnership for Patients goals
- Describe NPP’s role in catalyzing action and enabling change

Objectives for Today’s Webinar

- Provide an opportunity for leaders in the field of maternal health to share best practices, success stories, and strategies for getting started
- Generate action in organizations and communities nationwide
- Provide examples of public-private partnerships working collaboratively to achieve results
About the Audience

<table>
<thead>
<tr>
<th>Audience Type</th>
<th>%</th>
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<tbody>
<tr>
<td>Quality Improvement Organization</td>
<td>9%</td>
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<tr>
<td>Supplier Industry</td>
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<tr>
<td>University/Academia</td>
<td>2%</td>
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<tr>
<td>Consumer organization</td>
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<tr>
<td>Citizens (non-hospital)</td>
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<tr>
<td>Healthcare provider (non-hospital)</td>
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<tr>
<td>Hospital</td>
<td>40%</td>
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<tr>
<td>Other</td>
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Audience Regional Location

- No Response: 12%
- West: 15%
- Northeast: 20%
- South: 20%
- Midwest: 20%

Affordable Care Act: Establishing a Framework & Resources for Measurement-Based Improvement

- HHS required to develop a National Quality Strategy (NQS) to make care safe, effective and affordable
- NQS to be shaped – and specified – with input from diverse healthcare leaders who can “hit and then skate to the puck”
- Coordination and alignment within the Federal government and across the public and private sectors is key to the ultimate success of the NQS in transforming the U.S. healthcare system
NPP Input into the National Quality Strategy

- **October 2010:** NPP provides input to HHS to inform the development of the NQS
- **March 2011:** HHS issues NQS based on the triple aim
- **September 2011:** NPP input to HHS helps to make NQS more actionable:
  - Identification of goals and measures
  - Recommendation of strategic opportunities
  - Consensus across key leaders about where they should drive their organizations
  - Full report is available from the Links tab in the upper left corner of your screen

HHS’s National Quality Strategy Aims and Priorities

**Better Care**

**Patient Safety**

Goals:

- Reduce preventable hospital admissions and readmissions
- Reduce the occurrence of adverse healthcare associated conditions
- Reduce harm from inappropriate or unnecessary care

Measure Concepts:

- Hospital admissions for ambulatory-sensitive conditions
- All-cause hospital readmission index
- All-cause healthcare-associated conditions
- Inappropriate medication use and polypharmacy
- Inappropriate maternity care
- Unnecessary imaging

*CMS’s Partnership for Patients identifies adverse drug events, catheter-associated urinary tract infections, central line bloodstream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.*
Partnership for Patients Goals

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.

- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010.

Partnership for Patients Nine Areas of Focus

- Catheter-associated urinary tract infections (CAUTI)
- Central line associated blood stream infections (CLABSI)
- Injuries from falls and immobility
- Adverse drug events
- Obstetrical adverse events
- Pressure ulcers
- Surgical site infections (SSI)
- Venous thromboembolism
- Ventilator-associated pneumonia (VAP)

Partnership for Patients: Goal for Obstetrics

Cut the number of preventable obstetrical adverse events in half by 2013. Over three years this would prevent nearly 100,000 obstetrical adverse events.
How Will Change Actually Happen?

And how will it happen at scale?

There is no “silver bullet," but we know we must:

- Work together
- Provide thoughtful incentives
- Engage patients and families, authentically
- Engage leadership
- Assist in the painstaking work of improvement

Addressing Obstetrical Adverse Events

Maureen Corry, MPH
Executive Director
Childbirth Connection

Partnership for Patients/National Priorities Partnership
Patient Safety Webinar Series
September 28, 2011
Childbirth Connection

Mission

To improve the quality and value of maternity care through consumer engagement and health system transformation

Evidence-Practice Gaps in Maternity Care

Milbank Report, Evidence-Based Maternity Care (2008):

Much of the care women and newborns receive is not consistent with the best evidence despite unprecedented body of comparative effectiveness research to guide practice and quality improvement

Maternity Care is Procedure-Intensive and Costly

Deficiencies include:

• **Overuse** of many practices that entail harm and waste for mothers, babies, and the system at large (e.g., elective induction, cesarean section)
• **Underuse** of effective, high-value practices that would improve outcomes (e.g., exclusive breastfeeding, vaginal birth after cesarean)
• **Broad variation** in care, outcomes, and costs across geographic regions, facilities, and providers unwarranted by health status or women’s preferences

www.childbirthconnection.org/ebmc
Maternity Care Patient Safety

Must include high-reliability practice that delivers the right care at the right time to avoid:

- Unneeded care and duplication
- Omission
- Haste and delay
- Waste
- Unnecessary harm

Overused Maternity Interventions: Elective Delivery

Hospital Corporation of America: 3 Approaches to Reducing Elective Births < 39 Weeks

- “Hard stop” policy, not allowed; staff empowered to refuse schedule or perform;
- “Soft stop” policy, compliance left up to individual doctors
- Education only approach for providers re: current evidence, ACOG guidelines, facility policies

Elective delivery may be reduced to level of <2% using “hard stop” policy; cost savings of $1 billion annually. Correct patient misconceptions re harms to women and babies

Source: Clark et al., AJOG, November 2010
Overused Maternity Interventions: Cesarean Section

- Effective strategies targeted to health professionals use multi-faceted components based on audit and feedback and addressing barriers
- Effective interventions targeted to health professionals used guidelines that required a mandatory second opinion, guidelines with support of local opinion leaders, and internal peer review and mandatory second opinion


Overused Maternity Interventions: Cesarean Section

  - Of 28 participating organizations, 15% achieved cesarean delivery reductions of 30% or more during 12 month period of active collaborative work.
  - Additional 50% achieved reductions between 10-30%
- Reducing cesarean birth rates with data-driven quality improvement activities, Main EK, Pediatrics, 1999
  - Physician practice patterns and cesarean birth rates can be altered w. intensive use of comparative outcome data & strong physician leadership

Underused Maternity Practice: Vaginal Birth After Cesarean

- “How to Stop the Relentless Rise in Cesarean Section,” Dr. John Queenan calls for concerted action by his profession to confront the problem and commit to action to “curtail the runaway increase in cesarean deliveries.”
- He offers two “complex” solutions: “make VBAC more accessible and more desirable” and “prevent primary deliveries in the first place.”

Source: Queenan J. Obstet Gynecol 2011
Underused Maternity Practice: Exclusive Breastfeeding

- CDC national hospital mPINC surveys identify need for improved hospital practice; “Baby-Friendly” hospitals achieved improved BF rates
- Increased implementation of the Ten Steps of the Baby-Friendly Hospital Initiative is associated with increased breastfeeding. Hospitals with comprehensive breastfeeding policies likely to have better BF support services and better BF outcomes
- Baby-Friendly designated hospitals have elevated rates of BF initiation & exclusivity regardless of demographic factors linked with low BF rates


Listening to Mothers II: Selected Survey Results

- Mothers wanted to know every or most complications before consenting to induction (97%) and cesarean (98%), but majority of women did not identify correct response on adverse effects of either intervention
- 45% of mothers with previous cesarean were interested in option of VBAC, but 57% of those denied option due to caregiver (45%) or hospital unwillingness (22%)
- Mothers felt pressure from a health professional to have induction (17% with induction) and cesarean (25% with cesarean)
Transforming Maternity Care Project

- Multi-year collaboration with more than 100 health care leaders from across health system
- Resulted in publication of two direction-setting papers in 2010: “2020 Vision for A High-Quality, High-Value Maternity Care System” and “Blueprint for Action”

11 Critical Blueprint for Action Focal Areas

- Liability
- Payment Reform
- Disparities
- Health Professions Education
- Development and Use of HIT
- Workforce Composition and Distribution
- Coordination of Care
- Clinical Controversies
- Decision Making and Consumer Choice
- Performance Measurement
- Scope of Covered Services

Resources

- [2020 Vision for A High-Quality, High-Value Maternity Care System]
- [Blueprint for Action]
Separate web pages to help women and health professionals make informed maternity care decisions, featuring:

- Childbirth Connection’s Blueprint for Action
- Childbirth Connection’s 2020 Vision
- Milbank Report: Evidence-Based Maternity Care
- Listening to Mothers surveys and reports
- Information written specifically for women and maternity health professionals

Access these resources through the Links tab in the upper left corner of your screen.

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Childbirth Connection and Foundation for Informed Medical Decision Making are collaborating to:

- expand opportunities for shared decision making in maternity care and develop electronic tools and resources to facilitate women’s informed choice
- publish and make relevant tools available to the public via diverse stakeholder channels (health plans, employers, providers, government agencies, etc.)

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### Opportunities to Improve Quality and Reduce Costs

**Average Facility Labor and Birth Charge By Site and Method of Birth, United States, 2007-2009**

<table>
<thead>
<tr>
<th>Method of Birth</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
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<tbody>
<tr>
<td>Birth center vaginal</td>
<td>$10,151</td>
<td>$10,311</td>
<td>$11,275</td>
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<tr>
<td>Hospital vaginal</td>
<td>$15,812</td>
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<td>Hospital cesarean no</td>
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<tr>
<td>Hospital cesarean</td>
<td>$20,074</td>
<td>$20,712</td>
<td>$21,495</td>
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<tr>
<td>Cesarean complications</td>
<td>$21,495</td>
<td>$22,074</td>
<td>$23,507</td>
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</table>

Sources:
Best available evidence and high performing facilities and providers show that rapid gains in maternity care quality, value and outcomes are within reach.

Thank You!
Maureen Corry, Executive Director
Childbirth Connection
corry@childbirthconnection.org

References


Leapfrog Group. "Hospital rates of early scheduled deliveries." Available at: http://www.leapfroggroup.org/hospitaldeliveries


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Obstetric Adverse Events

Kathleen R. Simpson, PhD, RNC, FAAN

Challenges

- Definitions / Consensus
- Timely identification / Treatment
- Measurement issues
- Thorough analysis of adverse events
- Woman and family partnership in care
- Convenience over safety
- Autonomy vs standardization
- Real-time feedback to front line clinicians
- Effective preventive strategies

OB Never Events Adapted from NQF 2002

- Infant abduction
- Infant discharged to the wrong person
- Infant death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia
- Maternal or infant death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- Maternal death or serious disability associated with labor and birth in a low-risk pregnancy while being cared for in a healthcare facility
OB Never Events Adapted from NQF 2002

- Maternal or infant death or serious disability associated with a medication error, e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration (includes overdose of oxytocin, misoprostol, magnesium sulfate)
- Wrong surgical procedure performed on a mother or infant (e.g. circumcision, tubal ligation)
- Retention of a foreign object in a mother or infant after surgery or other procedure

OB Never Events Adapted from NQF 2002

- Maternal death after pulmonary embolism in untreated woman with known high risk factors for DVT
- Infant breastfed by wrong mother or breast milk to wrong infant
- Death or serious disability of a fetus/infant with a normal FHR pattern on mother’s admission for labor barring any acute unpredictable event
- Prolapsed umbilical cord after elective rupture of membranes with the fetus at high station

OB Never Events Adapted from NQF 2002

- Prolonged periods of untreated uterine tachysystole during oxytocin or misoprostol administration
- Prolonged periods of an indeterminate/abnormal FHR pattern during labor unrecognized and/or untreated with the usual intrauterine resuscitation techniques or birth
- Ruptured uterus following prostaglandin administration for cervical ripening/labor induction to a woman with a known uterine surgical scar
- Missed administration of RhoGam to a mother who is an appropriate candidate
- Circumcision without pain relief measures
OB Never Events Adapted from NQF 2002

- Artificial insemination with the wrong donor sperm or wrong egg
- Neonatal group B streptococcus or HIV infection after missed intrapartum chemoprophylaxis
- Infant death or disability after multiple attempts with instruments to effect an operative vaginal birth
- Infant death or disability after prolonged periods of coached second stage labor pushing efforts during an indeterminate/abnormal FHR pattern

Types of Measurement

- Manual medical record review
- Electronic medical record review
- Reporting systems
- Adverse outcomes index
- “Ideal” delivery rate
- Trigger tools
- Administrative data
- Claims data

Measurement Challenges

- Costs
- Time / Personnel
- Inaccurate data
- Late notification
- Real-time surveillance
- Clinical relevance
- Timely and effective prevention strategies
Prevention Strategies

- Standardization of key clinical practices and unit operations
- Evidence based clinical practice
- Professional standards and guidelines
- Administrative and clinical leadership
- Willingness to change
- Teamwork
- Courage in speaking up
- Elimination of hierarchical relationships
- Ongoing surveillance
- Robust sustained changes in clinical practices

Polling Question

What systems are in place in your organization to prevent obstetrical never events?

Audience Discussion

Tell us about your experience in reducing obstetrical adverse events

To provide questions or comments, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 1-888-259-8387 confirmation code 5869934 and press *1 to ask a question.

Your questions will be addressed during the audience discussion later on in the webinar.
Addressing Obstetrical Adverse Events

Peter Cherouny, M.D.
September 28, 2011
Partnership for Patients - NPP
Patient Safety Webinars

• Prevent the preventable

• Defend the unpreventable

• What do we know about our system of care
  – Up to one-third of elective deliveries occur prior to documented fetal maturity
  – 53% of the disparity in cesarean section is related to labor induction and early admission
  – Patient centered care is talked about but rarely practiced
  – Communication errors are the leading primary cause of perinatal sentinel events
  – Up to 90% of birth trauma is preventable
  – Maternal Mortality in the US has increased at an annual rate of 2.1% for the last 20 years
Addressing Obstetrical Adverse Events

• What do we need to do?
  • System Change
    – Engage leadership/administration
    – Develop reliable systems of evidence-based care
    – Perinatal Bundles
    – Multidisciplinary training
    – Communication skills training
    – Measurement

Addressing Obstetrical Adverse Events

• Why should we measure?
  – Measuring obstetric quality is the first step in improving obstetric quality
• What should we measure?
  – Outcome measures
    ➢ Assume all adverse events are preventable
    ➢ Perinatal Trigger Tool
  – Structure and process measures
    ➢ Oxytocin deep-dive, Labor deep-dive
Preventing Obstetrical Adverse Events

• Educate Physicians and Nurses to Guidelines and Best Practices—Necessary, but never sufficient
• Develop and enforce hospital policies and procedures to reinforce quality standards
• Engage patients as empowered and knowledgeable partners

Eliminate Non-Medically Indicated Deliveries Before 39 Weeks

Table of Contents
• Making the case
• Implementation Strategy
• Data Collection/QI Measurement
• Clinician Education
• Patient Education

Key Components
• Identify Physician Champion
• Create (Rewrite) Hospital Policies
• Establish Professional consensus on: “Indications for Early Delivery”

Available at: marchofdimes.com

Engaging Women – Babies aren’t fully developed until at least 39 weeks in the womb......If your pregnancy is healthy, wait for labor to begin on its own
Questions for the Panelists

1. In your work, how are you actively engaging patients and families to prevent obstetrical adverse events?

2. What policy or environmental supports are needed to accomplish your goals?

Audience Discussion

Tell us about your experience

To provide questions or comments, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 1-888-259-8387, confirmation code 5869934.

Polling Question

Does your organization have a system in place for educating patients and their families about their role in their care?
Audience Discussion

Talking About Your Experience

What tools and resources do you need to accelerate change in your organization?

To provide questions or comments, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 1-888-259-8387, confirmation code 5869934, and press *1 to ask a question.

Conclusion

Next Steps, Further Resources, and Concluding Remarks

Polling Question

When do you plan to act on the information provided in this webinar?
Polling Question

Did you find tangible actions and practices you can put to use in your organization or community in this webinar?

Further Resources

Resources, links and PDF documents are available now in the top left corner of your screen in the Links tab, including:

- Partnership for Patients website
- National Priorities Partnership (NPP) website
- National Quality Forum patient safety webpage
- IHI's Perinatal Improvement Community website
- John M. Eisenberg Patient Safety and Quality Award – (application period open from Aug. 1 – Oct. 3)

Patient Safety Webinar Series

Upcoming webinar in this series:

Venous Thromboembolism and Catheter-Associated Urinary Tract Infections
Wednesday, October 5 at 1pm ET

To register: eo2.commpartners.com/users/pfp/
Concluding Remarks

Bernie Rosof, NPP Co-Chair

Thank You

A recording of this webinar will be available on the National Quality Forum website within 48 hours. When you exit, you will automatically be directed to an evaluation about this webinar.

For further questions, please contact priorities@qualityforum.org