ILPQC
Illinois Perinatal Quality Collaborative

Birth Certificate Accuracy Initiative Monthly OB Teams Call

June 22, 2015

12:30 pm – 1:30 pm

Overview

- Birth Certificate Accuracy Initiative update
- QI topics of interest - Two methods to improve the accuracy of your birth certificate data:
  - Process Improvement
  - Understanding Definitions
- Variables of the month
  - Previous preterm birth
  - Fetal intolerance of labor
  - Gestational age
- Team Talks
  - Advocate Lutheran General – Debbie Schy
  - Blessing Hospital – Deb Landacre
- Next Steps

BC Accuracy F2F Recap

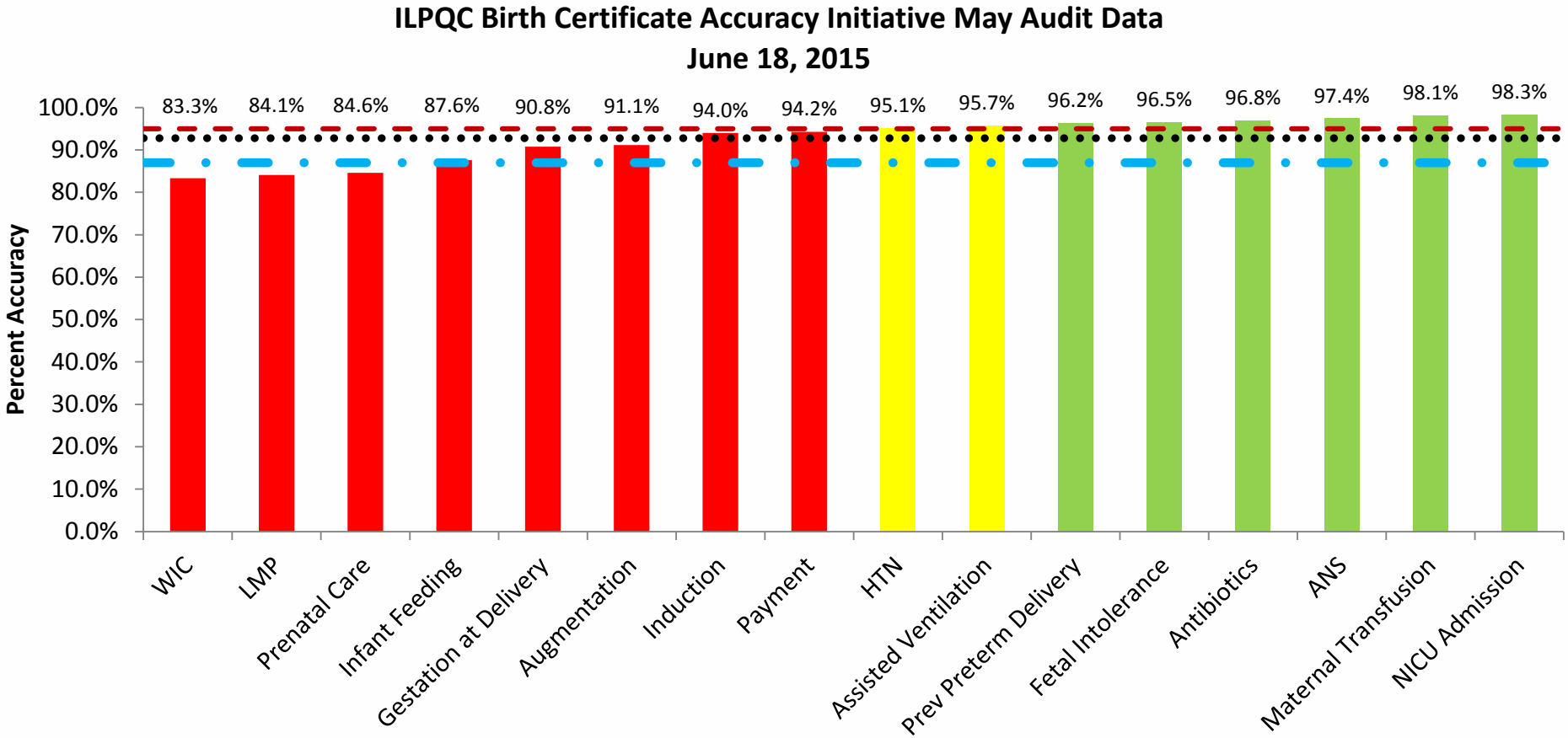
- 230 participants
- 96 hospitals represented at the meeting!
- Guest Speakers
  - Susan Ford, BEACON Quality Improvement Coordinator, OPQC
  - Cindy Mitchell, Birth Certificate Accuracy Initiative Perinatal Network Administrator Lead, South Central IL
  - Vickie Williams, Vital Records, Illinois Department of Public Health

BC Accuracy May Data

- 106 team rosters submitted for initiative (44 wave 1, 62 wave 2)
- May audit data due 6/15 in REDCap
  https://redcap.healthlnk.org/
  - As of 6/18, 86 teams completed (81.1% of teams)!
  - 2 teams with partial data entered
- QI Process Feedback Forms
  - 36 completed as of 6/18
  - Report your QI process monthly:

  https://www.surveymonkey.com/s/MonthlyProcessSurveyMay2015

BC Accuracy May Data: All Variables



Goal = **95.0%** (red dashed line)
Baseline = **87.0%** (blue dash dot line)
Overall accuracy for all 17 variables for May = **92.7%** (black dotted line)
Total Hospitals Reporting May Data = 88

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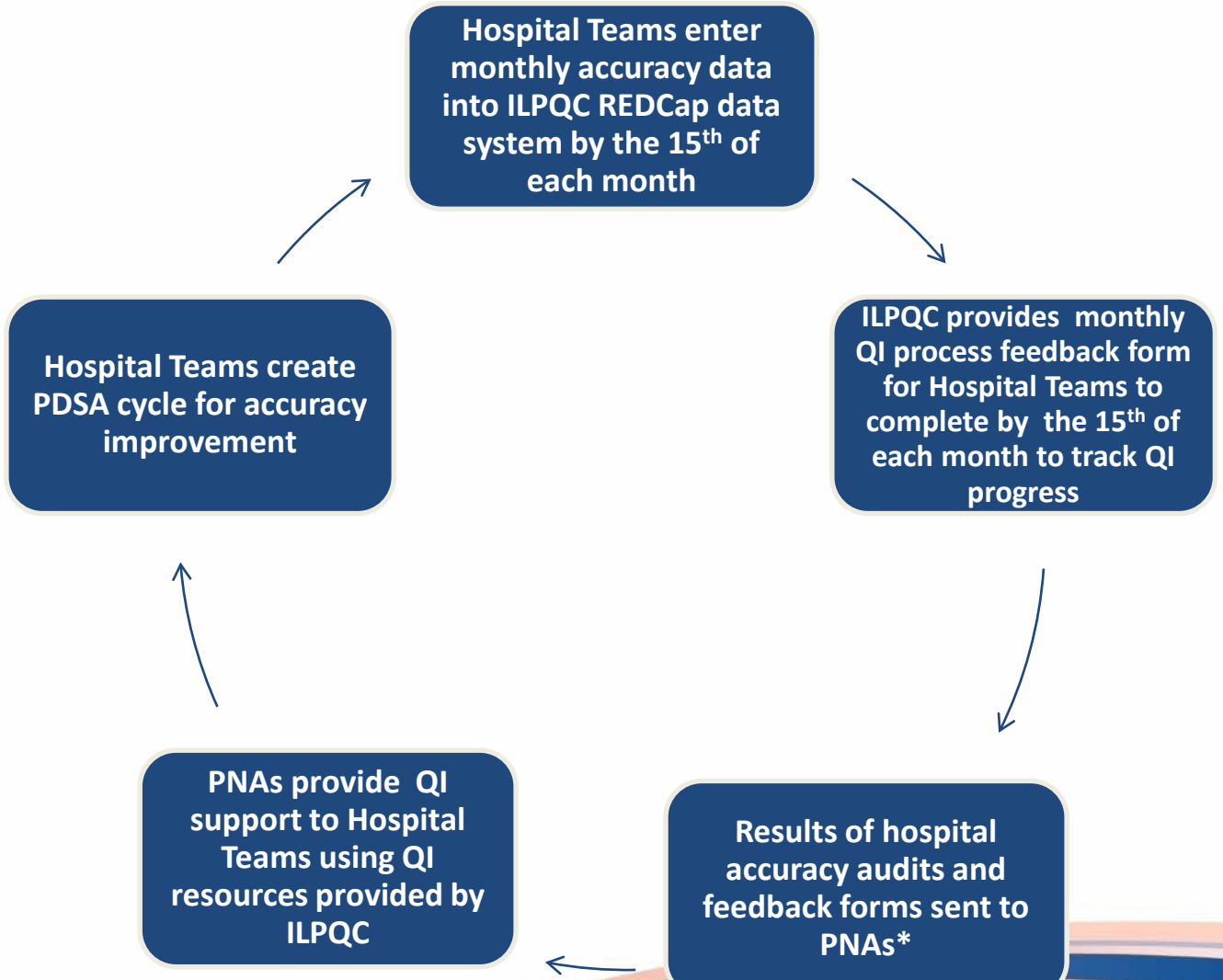
"The focus of healthcare for women and infants over the next century depends on the quality of the data collected by those who fill out the birth certificates."

Bill Callaghan, MD MPH
Centers for Disease Control and Prevention
December 1, 2011

Getting Started Checklist

- Be sure you entered your May audit data into REDCap and your May QI process work via the QI process feedback form link
- Register for the ilpqc.org member's only section
- Check your May accuracy reports online via REDCap

QI Cycle Support Recap



*PNA: Perinatal Network Administrator

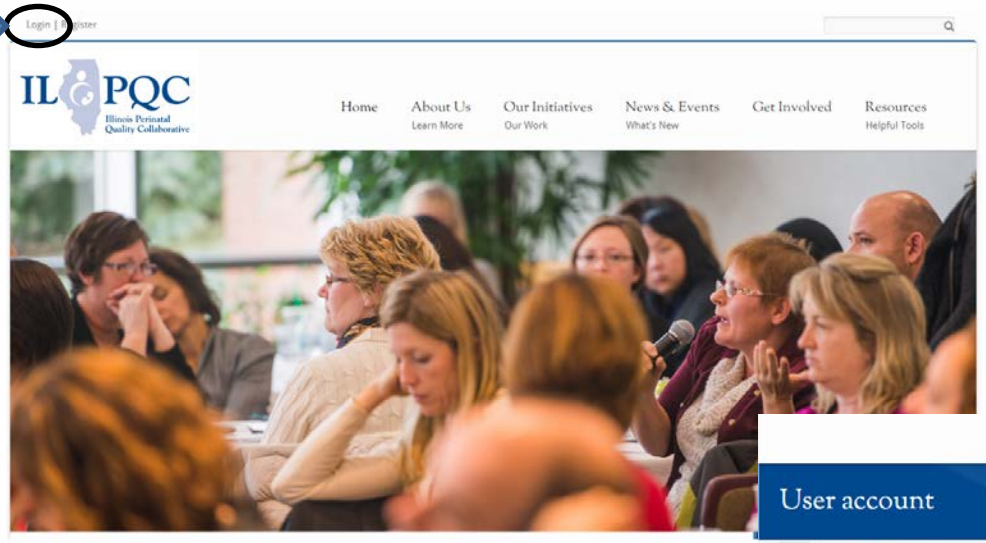
QI Cycle Support Recap

- **Monthly** QI cycle process implemented in partnership with the Perinatal Network Administrators
  - OB Teams webinar on the 4th Monday of each month, 12:30-1:30
    - Team Talks, education, support
  - Data reporting via REDCap and QI process feedback reporting via SurveyMonkey
  - QI coaching calls with Perinatal Network Administrators

Sign Up for Member's Only Area on *ilpqc.org*

Illinois Perinatal Quality Collaborative

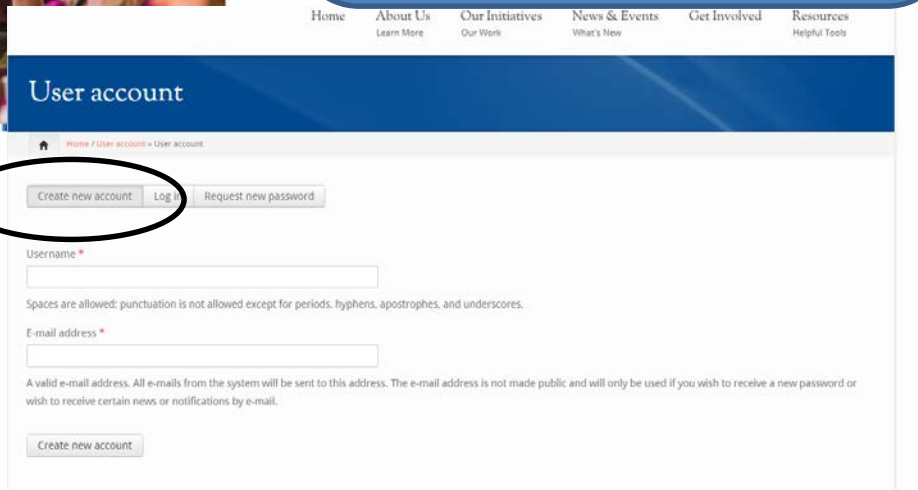
Click



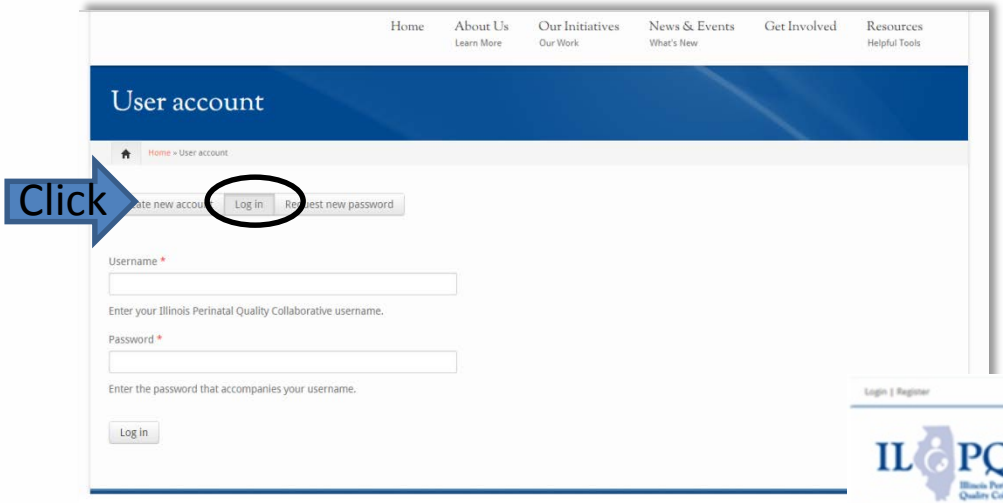
Create your user account today to have access to everything you need online!

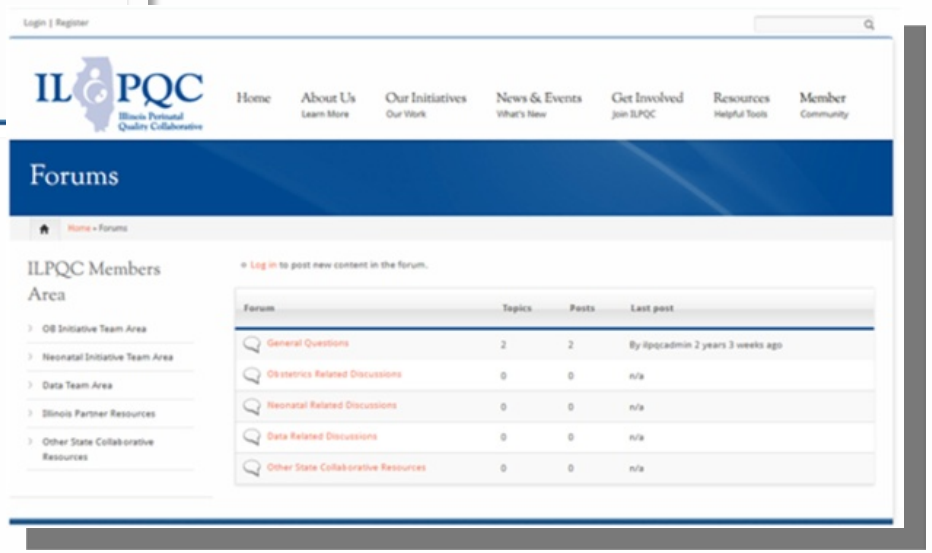
Click

Fill in info



Sign Up for Member's Only Area on ilpqc.org



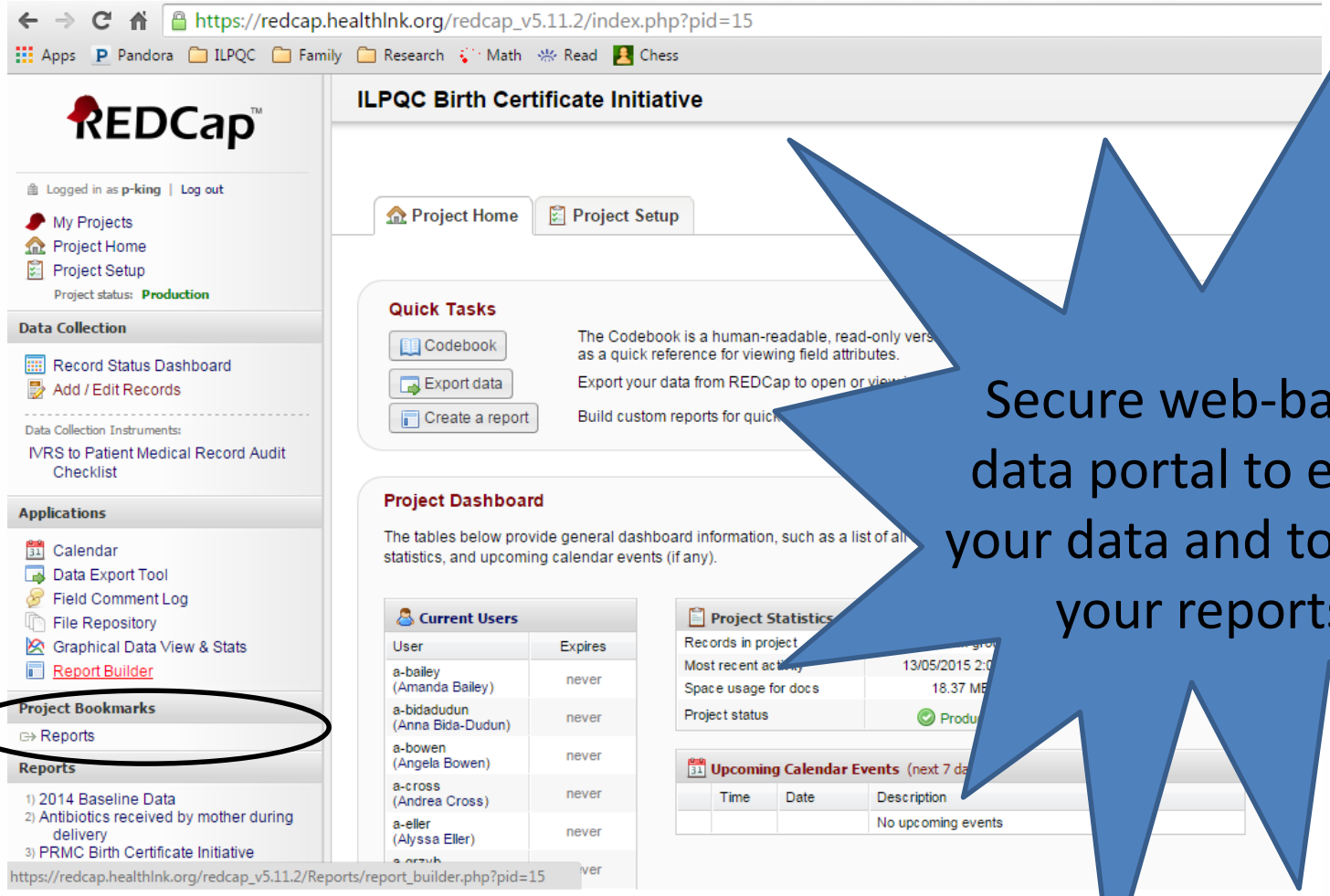


- Share initiative specific resources
- Collaborate and communicate via online ILPQC initiative forums/discussion boards

How to Access Reports

- https://redcap.healthlnk.org/
- Login to REDCap with user name and password
- Click “My Projects” Tab
- Click “ILPQC Birth Certificates” Link
- Click “Reports” Link Under “Project Bookmarks” in left sidebar
- A new window will launch, Enter your three digit hospital id, “009”, “055” or “101”
- Select 2015 from the year drop down menu to see your monthly progress since baseline

REDCap Data System



Secure web-based data portal to enter your data and to view your reports

Understanding Your REDCap Reports

- Focus on **your hospital's line graph** to see improvement in your data
- Look for upward trends in accuracy in your May through Nov. audits

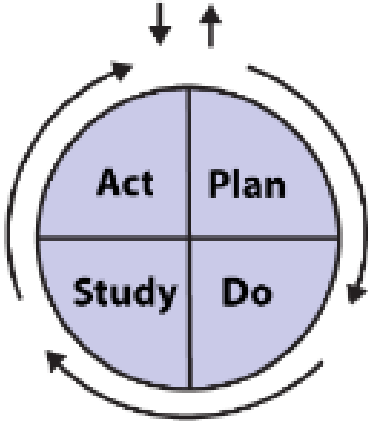
IDENTIFYING OPPORTUNITIES FOR CHANGE: BEYOND ACCURACY AUDITS

The Model for Improvement

AIM
What are we trying to accomplish?

MEASURES
How will we know that a change is an improvement?

CHANGES
What changes can we make that will result in improvement?



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Our Initiative Aim

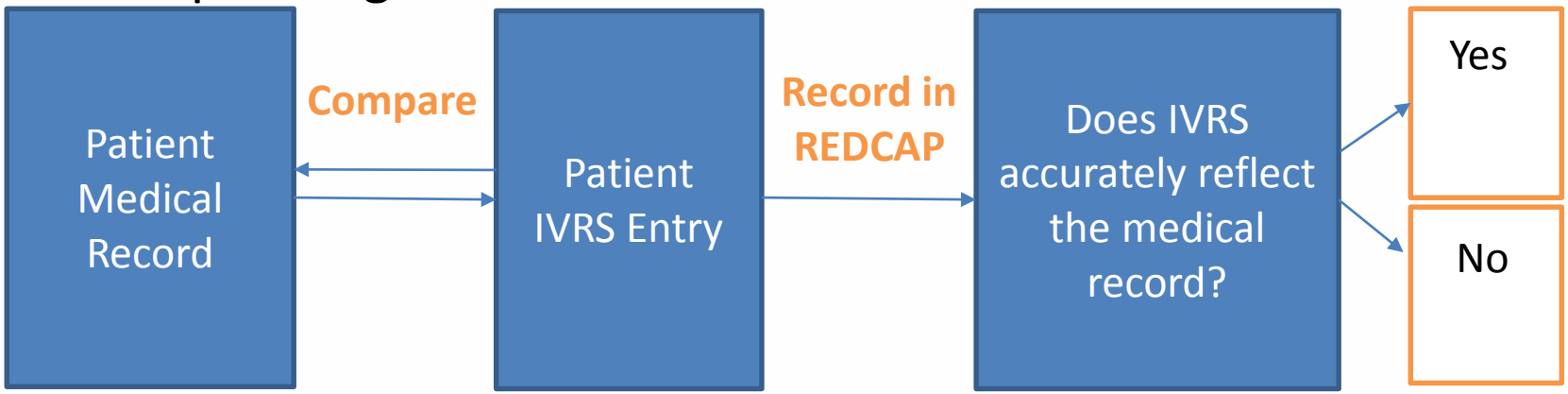
Obtain 95% accuracy on 17 key birth certificate variables by December 2015

- Maternal hypertension
- Maternal transfusion
- Previous preterm birth
- Augmentation of labor
- Induction of labor
- Antenatal Corticosteroids
- Fetal intolerance of labor
- Antibiotics received during labor
- Gestational age
- Assisted ventilation
- NICU admission
- Infant Feeding
- Mother's social security number
- Date of first prenatal care visit
- WIC participation
- Source of payment
- Date of last menstrual period

Your QI work: What changes can you make to your process or systematic understanding of the variable definitions to reach 95% accuracy

Our Initiative Measures

- Audits - You will measure your progress in increasing accuracy by comparing 10-12 patient medical records with their corresponding IVRS entries each month



- You will compare your monthly data (May-Nov., 2015) to your baseline data (avg. of Aug., Sep., Oct., 2014) using reports accessed via REDCap
- You do not need to use audits for your PDSA DO step

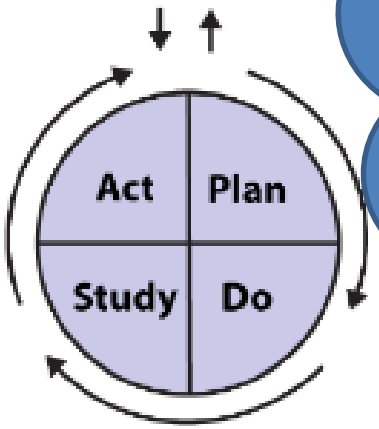
The Model for Improvement

AIM
What are we trying to accomplish?

MEASURES
How will we know that a change is an improvement?

CHANGES
What changes can we make that will result in improvement?

Question 3



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P–D–S–A Sequential small tests of change

Your QI Work: What small changes can you make to your process or systematic understanding of the variable definitions and test using a PDSA?

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What changes can you make and test at your hospital to reach 95% accuracy?

- Two target areas for change for this initiative
  - Your hospital's process of birth certificate data abstraction and entry
    - Resource: process flow diagram
  - Your hospitals' understanding and systematic use of key birth certificate variable definitions
    - Resources: Key Variables Guide, Guidebook

Opportunities to change Process from Teams at Face-to-Face (1/2)

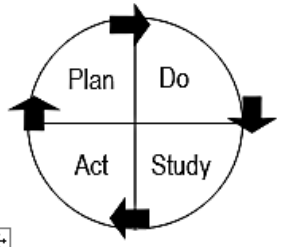
- Identifying most accurate source for variables
  - Identifying one or best location for information
  - Improving tools used to collect birth certificate information
- Accessing prenatal records
  - Linking prenatal and hospital records
  - Obtaining accurate and complete prenatal records

Opportunities to change Process from Teams at Face-to-Face (2/2)

- Linking definitions with EMR
  - Engaging EMR
  - Staff access to EMR
- Ensuring staff availability and accountability
  - Small group of dedicated staff
  - Education on the value of the BC
  - Limit staff distractions other duties
  - Increasing involvement of staff with clinical expertise
  - Providing real time feedback from clinical staff

Opportunities to Change Understanding and Systematic Use of Variable Definitions from Teams at Face-to-Face

- Tools for educating all physician, nursing, hospital and practice staff on variable definitions
- Tools for systematic use of variable definitions
  - Developing hospital specific guides
  - Minimizing need to interpret definitions
  - Clarifying medical terminology



PDSA WORKSHEET

Team Name: Hospital ABC	**Date of test:** 5/4/2015	**Test Compl**
Overall team/project aim: Improve birth registry accuracy so that focused 17 focuse audit sheet will be transmitted accurately in 95% of records		
What is the objective of the test? To better understand the process of abstracting the		

Don't forget to use the PDSA Worksheet! Send them to info@ilpqc.org to share with other Teams.

PLAN:

Briefly describe the test:

- The team lead will meet with the birth abstractor to identify how many places in the patient chart GA is documented and if the documentation is all the same.

How will you know that the change is an improvement?

- The birth abstractor will have an identified source of information for accurate Gestational Age in the chart.

What driver does the change impact?

- Identification and spread of best practices for data entry and verification.

What do you predict will happen?

- While there are probably numerous places GA is documented, the abstractor will know where to obtain the correct information.

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1. Patti will schedule a meeting with Kate to review 3 patient charts with her for abstraction of GA.	Patti	5/4/2015	L&D
2. Patti and Kate will choose 3 recently submitted births to IVRS.EMR and paper charting for mom and infants will be accessed.	Patti & Kate		L&D back desk computers via EMR and paper chart
3. Kate will point out to Patti the numerous areas GA is documented in each of the 3 charts.(Patti will document findings)	Kate Patti		L&D back desk
4. Kate will select the GA variable from the chart to be submitted.	Kate		L&D back desk
5. Patti & Kate will check if this was the variable submitted to IVRS.	Patti & Kate		L&D back desk

Plan for collection of data: Patti will use the GA Check Sheet to keep track of number of times GA is documented as well as the result.

DO: Test the changes

Was the cycle ca

Record data and observa

- Patti recorded the numbe chart on the Check Sheet (22). Kate s ect for the submission (37.4). They bo submitted. (38).

What did you observe that was not p plan?

- The GA chosen by Kate did not match the GA that was submitted into IVRS.

STUDY:

Did the results match your predictions? ☐ Yes ☒ No

Compare the result of your test to your previous performance:

- This was the initial PDSA

What did you learn?

- There are numerous places the GA is documented; they are not always consistent. Different abstractors have different methods of abstracting the data.

ACT: Decide to Adopt, Adapt, or Abandon.

☒ Adapt: Improve the change and continue testing plan.

Plans/changes for next test:

- Patti will work with the other 2 abstractors on 5/5, completing the same GA Check List as was used with Kate.

☐ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

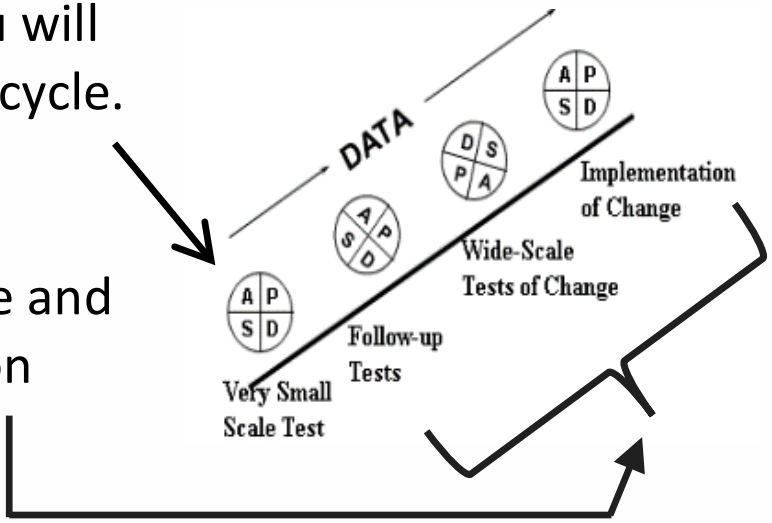
☐ Abandon: Discard this change idea and try a different one

Decide to Abandon, Adapt, or Adopt.

Abandon: Discard change idea and try a new one.

Adapt: Improve the change and continue testing. Describe what you will change in your next PDSA cycle.

Adopt: Select changes to implement on a large scale and develop an implementation plan for sustainability.



If you plan to adopt, what plans do you have for your next 2-3 PDSA cycles for follow-up tests and implementation:

Key Variable of the Month

Team Talks

- Advocate Lutheran General
  - Debbie Schy, RN Perinatal Outreach Educator
- Blessing Hospital
  - Deb Landacre

Advocate Lutheran General Hospital Birth Certificate Accuracy Team

Sherri Moormann, BC Registrar, Debbie Schy, RN Perinatal Outreach Educator, Cynthia Hartwig, RN, Executive Director Women's Health, Thomas Iannucci, MD, Interim OB Chair

June 2015

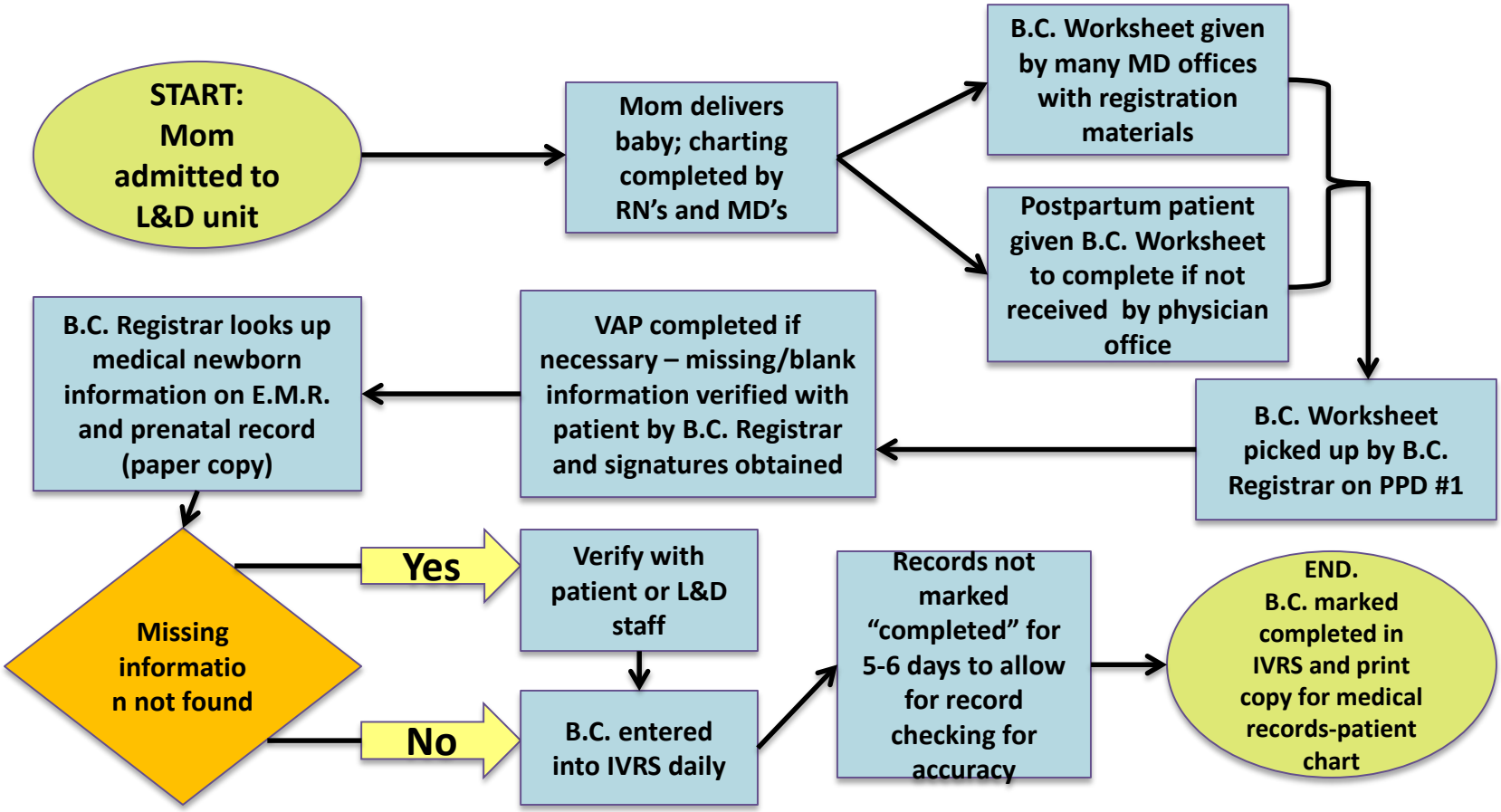
Advocate Lutheran General Hospital

Inspiring medicine. Changing lives.

- 638 Bed Hospital – 6th largest hospital in Chicagoland area
- Level I Trauma Center
- Level III Perinatal Center
  - 2014
    - 4260 live births, 4151 women delivered
    - 628 NICU admissions
- Center for Fetal Care
  - 1st Hospital in Illinois to perform laser ablation for twin to twin transfusion
- Teaching Hospital with residents and fellows
- Magnet Designation
- ILPEX Gold Award

Advocate Lutheran General Hospital
Inspiring medicine. Changing lives.

Process Flow Diagram



Advocate Lutheran General Hospital

Inspiring medicine. Changing lives.

PDSA Worksheet

- Team Name: Advocate Lutheran General Hospital
- Date of test: 6/3/15 Test completion:6/3/15
- Overall team /project aim:
  - To use accurate induction definition with 100% accuracy of induction reported to IVRS
- What is the objective of the test
  - To evaluate correct use of induction in IVRS.

Plan

- **Briefly describe the test**
  - We would pick 10 cases of scheduled inductions and compare those with the chart and IVRS
- **How will you know the change is an improvement?**
  - Every record picked would be accurately reported in IVRS. Our goal is 100% accuracy
- **What driver does the change impact?**
  - Identification and spread of best practices for data entry and best practices.
- **What do you predict will happen?**
  - We anticipate that some patients will have inaccurate recording of induction in IVRS.

Plan

List the tasks necessary to complete the test	Person responsible (who)	When	Where
Pull up log and list 10 scheduled inductions.	BC clerk and L&D secretary	6/2/15	L&D
Cross reference chart	BC clerk & RN	6/3/15	BC office
Cross reference IVRS	BC clerk	6/3/15	BC office
Document outcomes & report	RN	6/3/15	BC office

Plan for collection of data: Lead RN noted accuracy of 10 charts

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Do: Test the changes

- Was the cycle carried out as planned? Yes
- Record data and observations:
  - 7 inductions listed correctly
  - 2 scheduled inductions presented in labor correct on IVRS
  - 1 Discrepant data: admission note listed as induction and delivery record listed as augmentation – IVRS correct
- What did you observe that was not part of our plan?
  - Expected errors, identified problem with charting system

Study

- Did the results match your predictions? No
- Compare the results of your test to your previous performance:
  - No previous test
- What did you learn?
  - More accurate than we thought. 1 Case inconsistent documentation. Multiple places to document augmentation or induction.
    - Nurses, physicians, multiple chart forms

Act: Decide to Adopt, Adapt or Abandon

- X Adapt: Improve the change and continue testing plan. Plans/changes for next test:
  - Test overview of induction vs augmentation with residents and nursing staff. Continue to Monitor.
- X Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability:
  - White board announcement So you think you know OB….
- Abandon: Discard this change idea and try a different one

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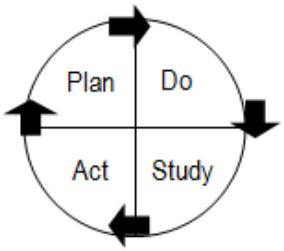
Team Talks

- Blessing Hospital
  - Deb Landacre

Team Talks – Blessing Hospital

C Sections

	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5
Check charts for IM or IV antibiotics	yes	yes	yes	yes	yes
Why was given	pre-op	pre-op	pre-op	pre-op	pre-op
When was given(at what point of labor)	Scheduled c/s	Second stage	Scheduled c/s	First stage/rep c/s	Scheduled c/s
		fetal intolerance			
Where was documentation	emar	emar	emar/clinical sum	emar/clinical sum	emar/clinical sum
Would you mark on BC antibiotic	yes	yes	yes	yes	yes
given during labor					
Time taken to find info	1 min	2 min	1 min	2 min	1 min
	Vaginal				
	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5
Check charts for IM or IV antibiotics	NO	NO	NO	Yes	NO
Why was Given				GBS +	
When was given(at what point of labor)				1st Stage, Ind	
Where was documentation	Clinical Sum/Emar	Clinical Sum/Emar	Clinical Sum/Emar	Clinical Sum/Emar	Clinical Sum/Emar
Would you mark on BC antibiotics				yes	
given during labor					
Time taken to find info	2 min	2 min	1 min	2 min	1 min
Antibiotics received by the mother during deliveries					



PDSA WORKSHEET

Team Name: Blessing Hospital	Date of test: 5/21/15	Test Completion Date:5/21/15
Overall team/project aim: To improve percentage of accuracy of antibiotic administration by following definitions and guidelines		
What is the objective of the test? To see if antibiotics were being recorded incorrectly with cesareans.		

PLAN:

Briefly describe the test:
One nurse audits 10 random charts (5 c/section & 5 vaginal) for IM or IV antibiotics given.

How will you know that the change is an improvement?
When we continue to see improvement in monthly audits.

What driver does the change impact?
Identification and spread of best practices for data entry and verification. Strong communication between clinical team and birth data staff.

What do you predict will happen?
That antibiotic use for cesarean deliveries would be reported inaccurately.

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1. 10 charts pulled for review	Nancy	5/21/15	OB Unit
2. Nurse checked the charts	Lauren	5/21/15	OB Unit
3. Why are antibiotics given?	Lauren	5/21/15	OB Unit
4. What point of labor was it given?	Lauren	5/21/15	OB Unit
5. Where is it documented:	Lauren	5/21/15	OB Unit
6.Would you mark birth certificate as antibiotics given	Lauren	5/21/15	OB Unit
7. Reviewed results with nurse	Nancy	5/21/15	OB Unit

Plan for collection of data: Nancy developed a table for collection of data, with C/section and Vaginal Deliveries separate. Medical record number provided to nurse for each patient.

DO: Test the changes.

Was the cycle carried out as planned? X- Yes No

Record data and observations
Audited 10 charts (5 Vaginal/5 C-Sections)
See attached data form:

What did you observe that was not part of our plan?
Nothing

STUDY:

Did the results match your predictions? X- Yes No

Compare the result of your test to your previous performance:
N/A

What did you learn?
Results were as expected related to incorrect definition.
-5 c-section charts all documented 5 pre-op antibiotics (incorrect)
-1 vaginal chart indicated antibiotic for +GBS (correct)

ACT: Decide to Adopt, Adapt, or Abandon.

Adopt:
Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability.
Educate at 5 June Staff Meetings with slide presentation and time for questions.
Continue to audit with monthly audit with special focus on the outcome.

Next Steps

- Conduct monthly audit and enter data into REDCap by July 15
- Submit monthly QI process feedback form via SurveyMonkey by July 15
  - Monthly data and QI feedback forms are due by the 15th of the next month
- Review your reports immediately in REDCap
  - Data team will review data for errors within 48 hrs
- Contact ILPQC or your PNA with any questions

Next OB Teams Meeting

- July 27, 12:30-1:30pm
- Need 3 teams to sign up for “Team Talks” for July – December meetings
- Remember to register for the www.ilpqc.org

  ILPQC website member’s only section
- Send your Process Flow Diagram and PDSA worksheets to info@ilpqc.org to share with other teams.

ILPQC Administrative Team

Ann Borders
ILPQC Executive Director, OB Lead

Aki Noguchi and Pat Ittmann
Neonatal Leads

Patricia Lee King
State Project Director

Kate Finnegan
Project Coordinator

Email us at info@ilpqc.org
Website: www.ilpqc.org

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