



OB Hospital Teams Call

October 27, 2014

12:30 – 1:30 PM

Agenda

- ILPQC Updates
 - Communications
 - Second Annual Conference
 - 2014-2015 Initiatives
- Team Talks
 - PDSA Cycle
 - Hospital Presentations
- Next Steps

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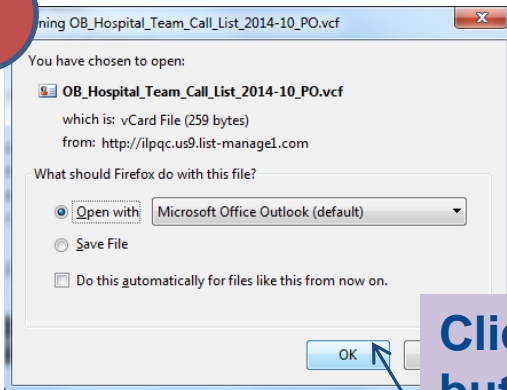
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OB Hospital Team Call List 2014-10 PO: Please Confirm Subscription

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To: Blanca Leon

ILPQC OB Hospital T

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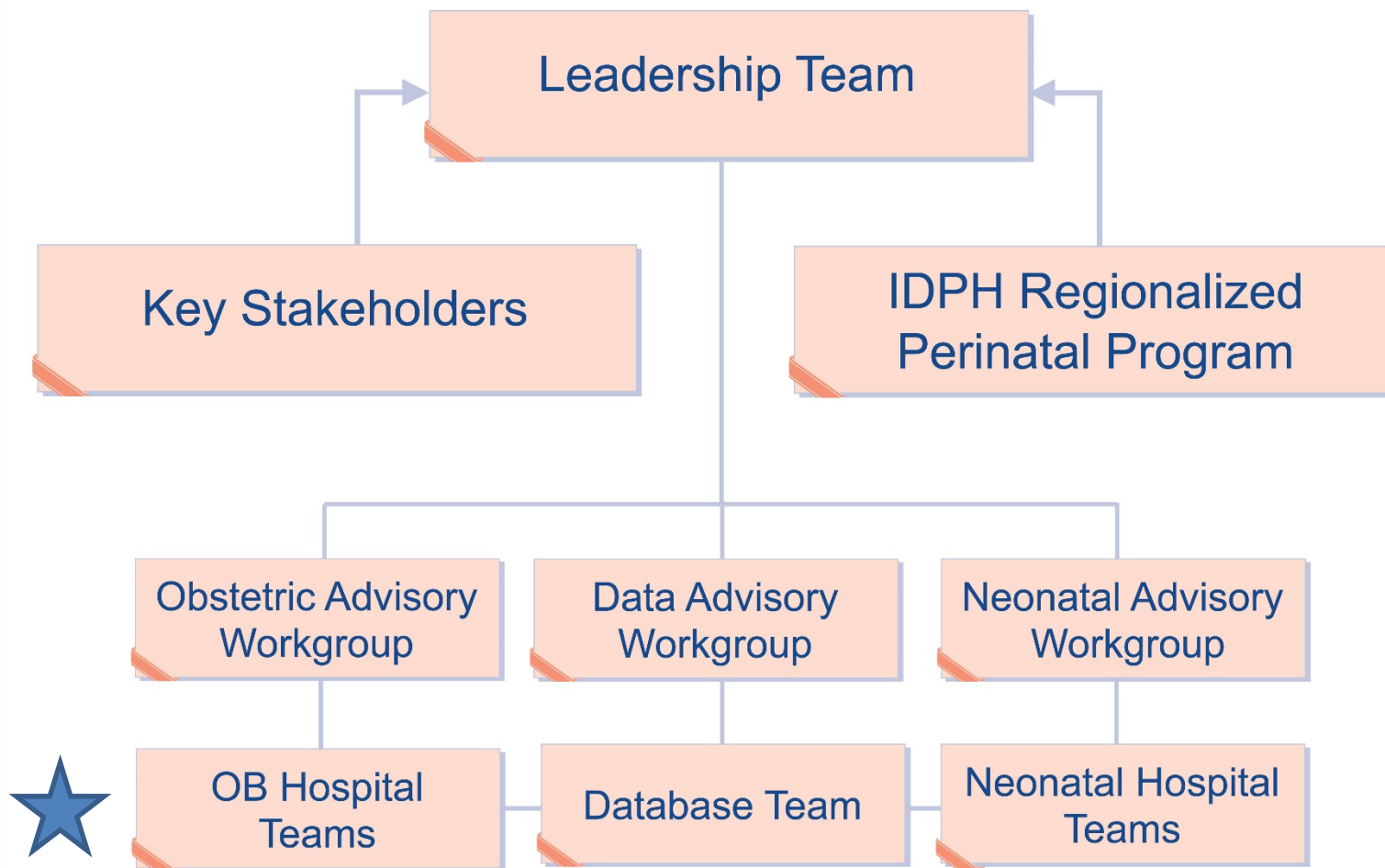
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ILPQC Structure



Conference Overview

- Monday, November 10, 8:00am – 5:00pm
- Northern Illinois University in Naperville
- Speakers include perinatal quality collaborative leaders from across the country
- 231 registrants so far, 19 spots available
- Poster session- 31 poster abstracts accepted
- Offering CMEs and plan to offer CEUs

Conference Agenda



8:00-8:10	Welcome
8:10-8:45	ILPQC: One Year and Counting
8:45-9:45	Keynote: Perinatal Quality Collaboratives: State and National Successes Elliott K. Main, MD, CMQCC
9:45-10:15	Transforming Perinatal Healthcare through Quality Improvement Marty McCaffrey, MD, CAPT USN (Ret), PQCNC
10:15-10:30	Break
10:30-12:00	Panel: Leaders from other Perinatal Quality Collaboratives on Past and Present Initiatives Peter H. Grubb, MD, TIPQC Michael Krew, MD, MS, OPQC Marty McCaffrey, MD, CAPT USN (Ret), PQCNC
12:00-1:30	Networking Lunch and Poster Session
1:30-2:15	Engaging Families in Quality Improvement Tara Bristol, MA, PQCNC

Conference Agenda



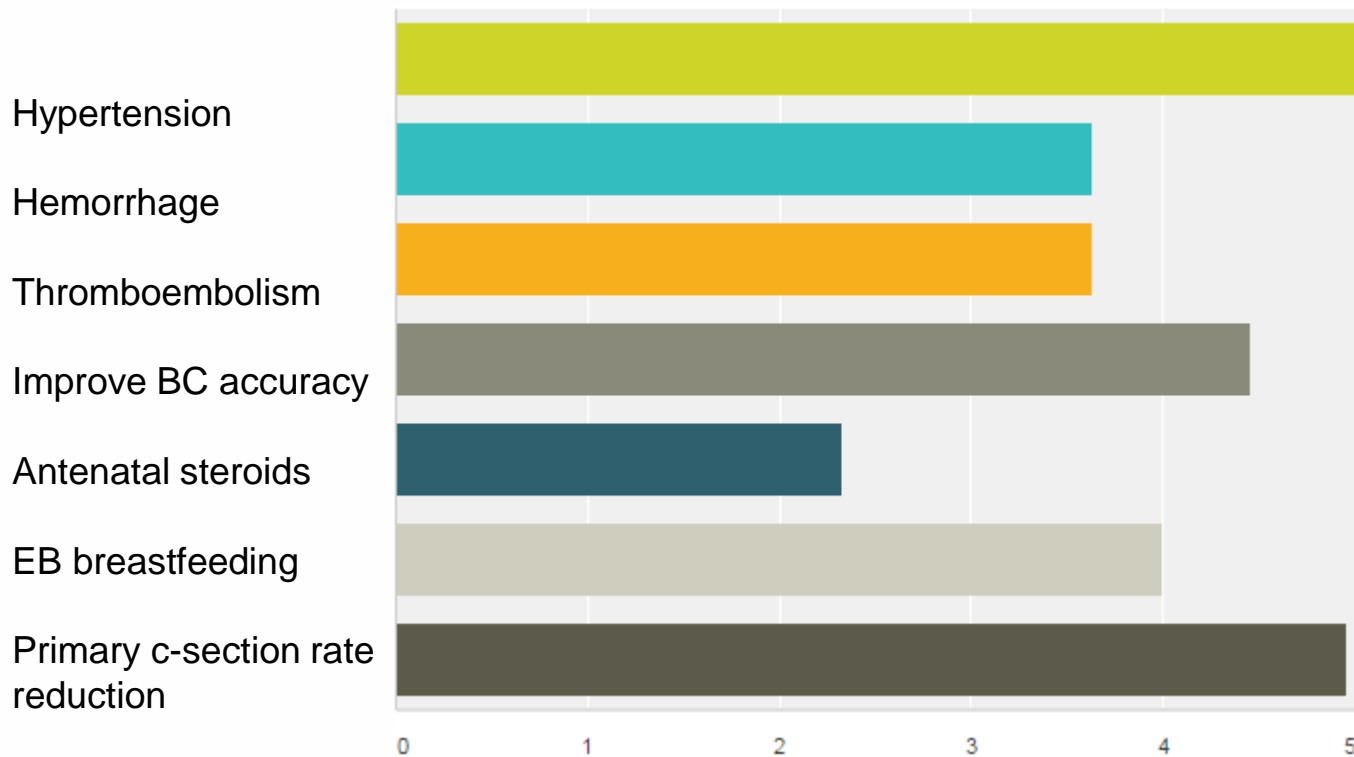
2:15-3:00	Improving Outcomes with Preeclampsia: the Role of a State Collaborative Elliott K. Main, MD, CMQCC
3:00-3:15	Break
3:15-4:45	Hot Topics in Neonatal and OB QI: Discussion of Current and Future Initiatives Neonatal Breakout: Aki Noguchi, MD, ILPQC; Patricia Ittmann, DO, ILPQC; Peter H. Grubb, MD, TIPQC; Marty McCaffrey, MD, CAPT USN (Ret), PQCNC Obstetric Breakout Ann Borders, MD, MSc, MPH, ILPQC; William Grobman, MD, MBA; Michael Krew, MD, MS, OPQC; Cindy Mitchell RN, BSN, MSHL, ILPQC Family Engagement Breakout Tara Bristol, MA, PQCNC
4:45-5:00	Wrap up & Evaluation

2014-2015 Maternal Initiatives



- Birth Certificate accuracy in collaboration with IDPH – kick off November 2014
 - Cindy Mitchell – lead
- Proposal for secondary clinical QI initiative
 - Implementation of new hypertension guidelines with focus on maternal morbidity reduction

Future Initiatives - Survey Responses (24 hospitals)



Average Ranking (higher value = higher interest)

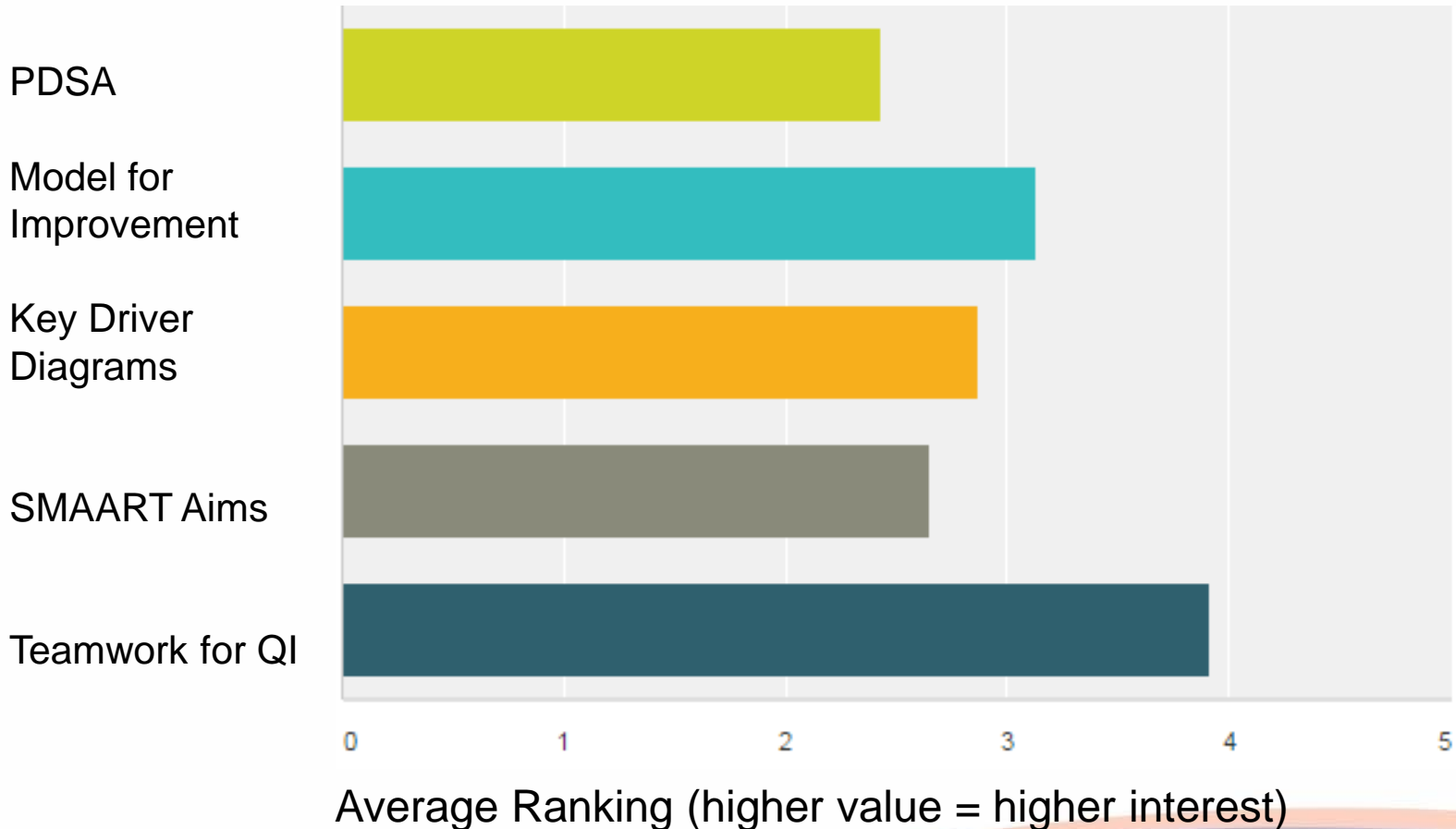
Birth Certificate Accuracy - Pilot

- Audit 10 charts on 18 key variables from July-Sept. 2014 retrospective chart review
- Do IVRS birth certificate and medical record match?
 - Yes/No
- Level II+ and III facilities if 2/10 charts not deliveries < 34 weeks audit 2 more charts on deliveries < 34 weeks

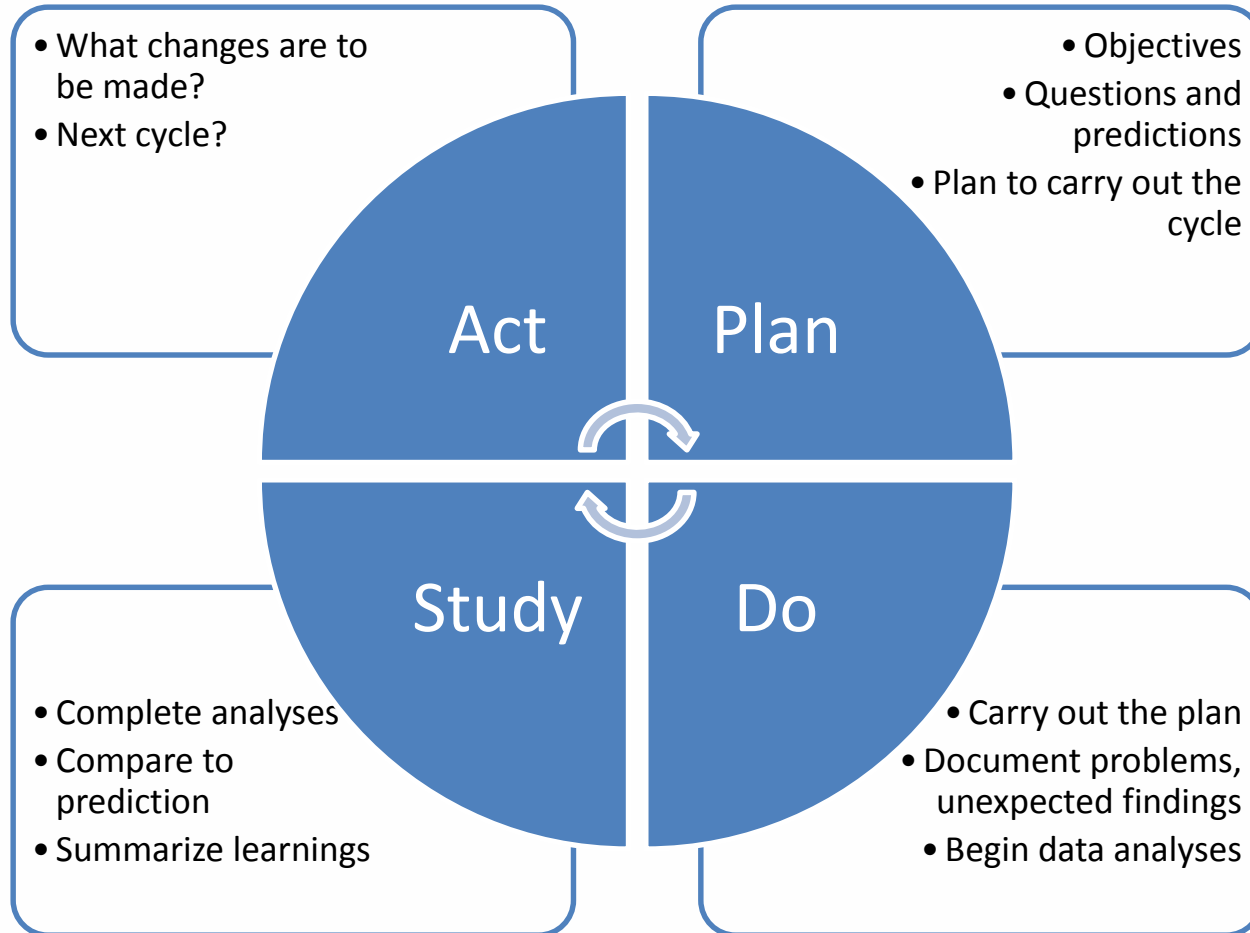
Team Talks

- Teams present 5-10 min on current QI work
 - What was the test of change (i.e., your QI process)?
 - What did you predict your change would improve?
 - What did you learn?
- Generate discussion and learning through sharing
- Begin with conference poster presentations, other QI, then will move to birth certificate initiative QI work
- Sign up form for volunteers on website
 - Would like all teams to present within next year

QI Topics of Interest – Survey Responses (23 hospitals)



PDSA Cycle



Team Talks

1. **Melinda Murray Panzarella, RNC, MSN, MBA**

OB Quality Coordinator/OB Data Registrar

Edward Hospital

2. **Lori M. Andriakos RNC-OB**

Perinatal Quality Coordinator

Alexian Brothers Women's and Children's Hospital

3. **Stephen Locher, M.D.**

Chairman, Department of Obstetrics and Gynecology

Advocate Illinois Masonic Medical Center

Team Talk 2

Melinda Murray Panzarella, RNC, MSN, MBA

OB Quality Coordinator/OB Data Registrar

Edward Hospital

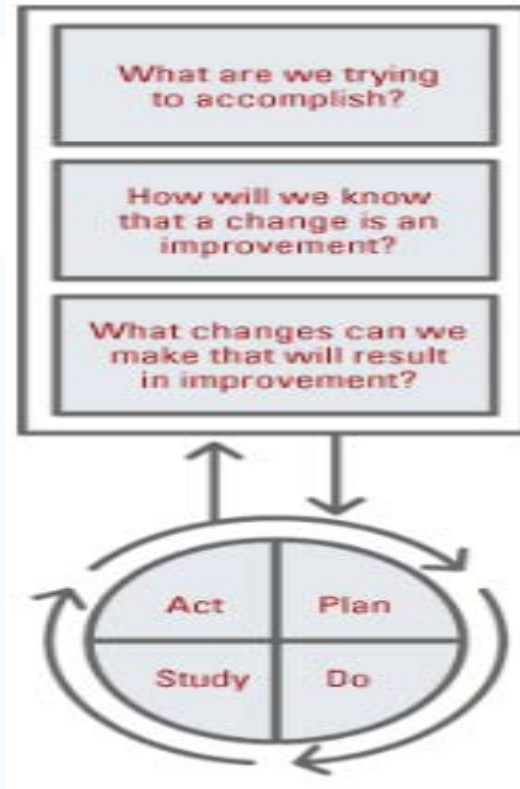
Quality Improvement Obstetrics

VTE Prophylaxis in OB

ILPQC Teams Call 10/27/14 Melinda Panzarella, MBA, MSN, RNC



Focus PDSA is the Test of Change we use When Implementing Performance Improvement



Find a Process to Improve

- ◆ In Reviewing VTEP Practices We Realized that there is No Assessment/Order Protocol for All Hospitalized Obstetric Patients
- ◆ Planning, Developing and Implementing An Assessment/Order Set for VTE Prophylaxis of the OB Patient is the Project We are Currently Working On



Organize a Team

- ◆ Dr. Donald Taylor – Medical Director of Maternal Fetal Medicine
- ◆ Jean Dwyer, L&D Educator
- ◆ Melinda Panzarella, OB Data Registrar/OB Quality Coordinator
- ◆ Pat Bradley, Director of Obstetrics
- ◆ Nancy Armstrong, Performance Improvement Coordinator
- ◆ Vickie Chirico, Application Analyst





Clarify Understanding of the Problem/Opportunity

- ◆ VTE Accounts for 9% of Maternal Death in US
- ◆ Pregnant Women have a Fivefold Increased Risk Compared to Non-Pregnant Women
- ◆ Prevalence of VTE Among Pregnant Women 0.5-2 per 1000 Deliveries
- ◆ Half of VTE Occurs During Pregnancy and Half Postpartum

ACOG Bulletin # 123



Clarify Understanding of the Problem/Opportunity Maternal Etiology

- ◆ Mechanical Causes: Venous Compression, Vascular Injury? (May Thurner)
- ◆ Increased Levels of Factor VII, VIII, X & VWF, Fibrinogen; Relative Reduction In Protein S
- ◆ Many VTE Related to Inherited Thrombophilia, History of VTE or Operative Risk

James AH. Arterioscler, Thromb, Vasc Bio 2009;29: 326-31. Bates SM. Chest 2012; 141(2_suppl):e691s-3736S.



Clarify Understanding of the Problem/Opportunity

- ◆ We Have a Lack of a Standardized Risk Assessment / Order Set in an Already Risky Setting

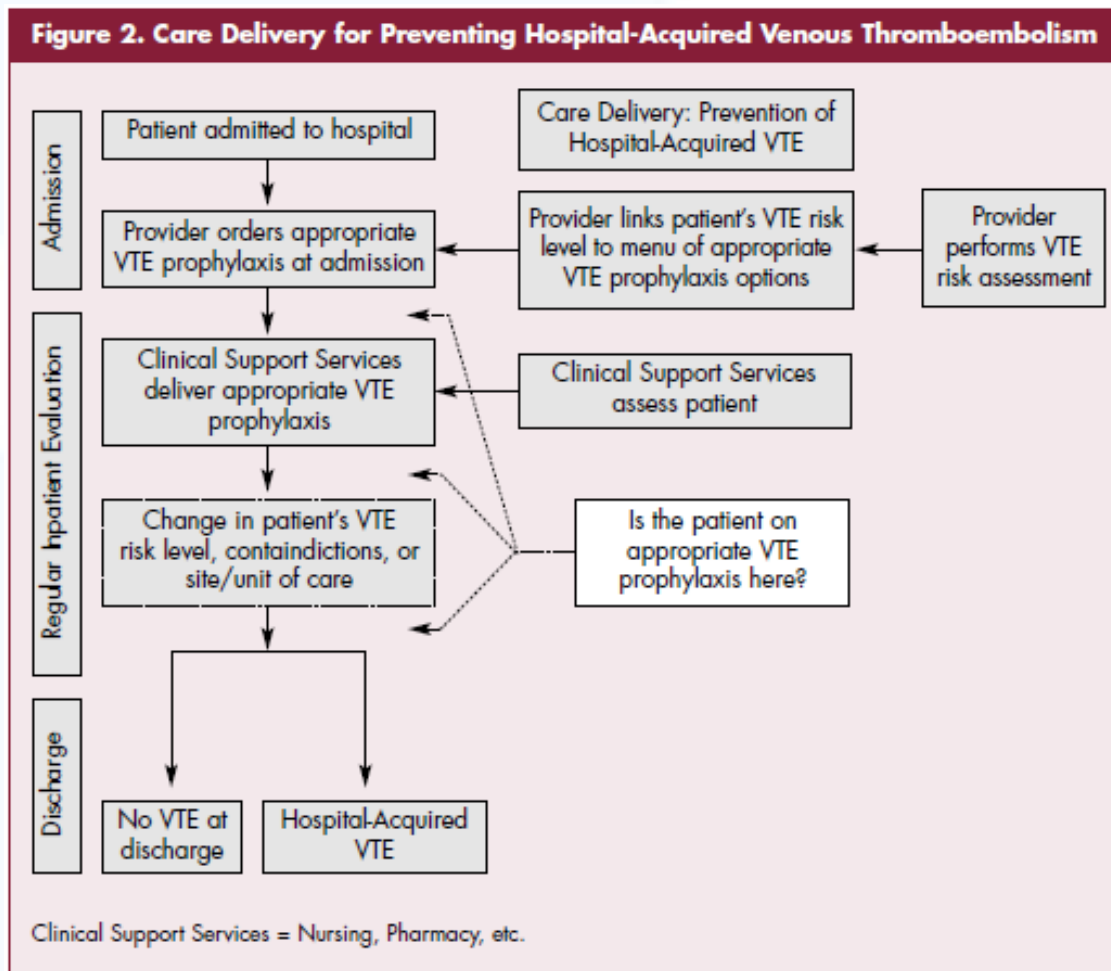
Understand the Data

In the process of gathering

- ◆ Incidence of Hospital Acquired PE/DVT in OB
- ◆ Readmission Rates for PE/DVT in OB Population
- ◆ Length of Stay for Patients with PE/DVT in OB Population



Plan-AHRQ Preventing Hospital-Acquired VTE



Conceptual Flow Diagram of Care Delivery for Providing VTE Prophylaxis: A number of interrelated steps combine to determine whether a patient, at any given moment, is receiving appropriate VTE prophylaxis.



DVT/VTE Prophylaxis Timeline of Implementation

- ◆ Educate Staff Regarding VTE Etiology, Prevalence, Signs and Symptoms, Prophylaxis-Done at October 2013 Staff Skills/Marathon Days
- ◆ VTE A Sticky Situation Evidence Based Practice Conference-OB Cases Highlighted-Done November 6th 2013
- ◆ Obtain More SCD Machines and Foot Pumps-In Process
- ◆ Develop OB Physicians Guide to Thrombosis Prevention-Done Presented to P&T 3/19/14



DVT/VTE Prophylaxis Timeline of Implementation

- ◆ Present to OB Quality Committee on December 16th-Committee in Agreement with presenting to OB Department on 1/13/14 for Approval.
- ◆ OB Department Approval January 13th
- ◆ ISS Build of Order Set & Intranet Hyperlink-In Process-Approved by P&T will have some minor changes Awaiting those changes
- ◆ Present to P&T – March 19th-Approved by P&T will have some minor changes. Awaiting those changes to present back to OB Department for Approval





DVT/VTE Prophylaxis Timeline of Implementation

- ◆ Patient Education-Working with Marketing for materials and PR
- ◆ Home Mechanical Prophylaxis-Started 3/7/14
- ◆ Please put in Case Management Notification for Home Prophylaxis
- ◆ Work Collaboratively with House-wide Efforts to Develop and Implement a Medical Assessment Smart Form that Automatically Populates High Risk, Medium Risk or Low Risk Order Sets-OB
Representation at DVT Prophylaxis Focus Group 3/11/14





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Do

▼ DVT/VTE — **Required**

Physician Guide to Obstetrical Patient Thrombosis Prevention Tool

▼ DVT: Non-pharmacological — **Required**

- Place TED hose
Routine, Continuous
- Place sequential compression device
Routine, Continuous
- Early Ambulation if no contraindications
Routine, Continuous

▼ DVT: Pharmacological — **Required**

- heparin (porcine) injection
5,000 Units, Subcutaneous, Every 8 hours
- heparin (porcine) injection
5,000 Units, Subcutaneous, Every 12 hours
- heparin (porcine) injection
10,000 Units, Subcutaneous, Every 12 hours
- enoxaparin (LOVENOX) injection
40 mg, Subcutaneous, Daily
- Reason for no VTE prophylaxis

▶ Pharmacological if HIT positive

0 of 1 selected

▼ Additional SmartSet Orders

Add Order

Click the Add Order button to add an order in this section.



▼ **DVT/TE — Required**

Physician Guide to Obstetrical Patient Thrombosis Prevention Tool

Physician Guide to Obstetrical Patient Thrombosis Prevention Tool

Risk Factor Score 1		Risk Factor Score 2		Risk Factor Score 3	
<input type="checkbox"/> Age > 35	1	<input type="checkbox"/> Obesity: BMI >30	2	<input type="checkbox"/> Factor V Leiden Mutation (Homozygous)	3
<input type="checkbox"/> Bed Confinement more than 24 hours	1	<input type="checkbox"/> Malignancy	2	<input type="checkbox"/> Antithrombin Deficiency	3
<input type="checkbox"/> Protein C or S Deficiency	1	<input type="checkbox"/> Paralysis lower Extremities	2	<input type="checkbox"/> Prothrombin Gene Mutation (Homozygous)	3
<input type="checkbox"/> Smoking	1	<input type="checkbox"/> Central Venous Catheter	2	<input type="checkbox"/> Lupus Anticoagulant (Combine with Anticardiolipin Antibodies into Antiphospholipid Syndrome)	3
<input type="checkbox"/> Preeclampsia	1			<input type="checkbox"/> Hyper-Homocysteinemia	3
<input type="checkbox"/> Cesarean Delivery	1			<input type="checkbox"/> Anticardiolipin Antibodies	3
<input type="checkbox"/> Multiple Gestation	1			<input type="checkbox"/> Plasminogen Activator Deficiency	3
<input type="checkbox"/> Labor > 24hours	1			<input type="checkbox"/> Previous VTE or PE related to Pregnancy or Contraceptive Pills	3
<input type="checkbox"/> Unexplained 2 nd or 3 rd Trimester Spontaneous Abortion	1			<input type="checkbox"/> Family History of Unprovoked Thrombosis	3
<input type="checkbox"/> Three 1 st Trimester Losses	1			<input type="checkbox"/> Mechanical Heart Valve	3
<input type="checkbox"/> Multiparity (>4)	1				
<input type="checkbox"/> Previous VTE Associated with Transient Risk Factors no Longer Present	1				
<input type="checkbox"/> Long Distance Air Travel (>6 hours)	1				
<input type="checkbox"/> Significant Varicosities	1				
<input type="checkbox"/> Trauma	1				
<input type="checkbox"/> Nephrotic Syndrome Over 3g/24 Hour	1				
<input type="checkbox"/> Sickle Cell Disease	1				
<input type="checkbox"/> Lupus	1				
<input type="checkbox"/> Inflammatory Bowel Disease	1				
<input type="checkbox"/> Heart Failure	1				
<input type="checkbox"/> Current Infection	1				
<input type="checkbox"/> Pneumonia	1				

PRE-Delivery VTE Risk Score _____ POST-Delivery VTE Risk Score _____

Discharge VTE Risk Score _____

Prophylaxis Orders for the Obstetric Patient per Risk Factor Score

Low Risk (Score of 2 or Less) Check all that Apply	Moderate Risk (Score of 3) Check all that Apply	High Risk (Score of ≥4) Check all that Apply
<input type="checkbox"/> Early Ambulation AND/OR <input type="checkbox"/> SCD's	<input type="checkbox"/> Early Ambulation <input type="checkbox"/> SCD's AND/OR Select 1 Pharmacologic Option: <input type="checkbox"/> Enoxaparin (Lovenox) 40 mg subcutaneous every 24 hours <input type="checkbox"/> Heparin 5,000 Units Subcutaneous every 8 hours <input type="checkbox"/> Heparin 5,000 Units Subcutaneous every 12 hours <input type="checkbox"/> Anesthesia Service Consult <input type="checkbox"/> Other <input type="checkbox"/> Pharmacologic Prophylaxis Contraindicated Due to:	<input type="checkbox"/> Early Ambulation <input type="checkbox"/> SCD's AND Select 1 Pharmacologic Option: <input type="checkbox"/> Enoxaparin (Lovenox) 40mg Subcutaneous every 12 hours <input type="checkbox"/> Enoxaparin (Lovenox) 40mg Subcutaneous every 24 hours <input type="checkbox"/> Heparin 5,000 Units Subcutaneous every 8 hours <input type="checkbox"/> Heparin 5,000 Units Subcutaneous every 12 hours <input type="checkbox"/> Heparin 10,000 Units Subcutaneous every 12 hours <input type="checkbox"/> Fondaparinux 2.5 mg Subcutaneous Daily (may be used when patient allergic to Heparin) <input type="checkbox"/> Anesthesia Service Consult <input type="checkbox"/> Other <input type="checkbox"/> Pharmacologic Prophylaxis Contraindicated Due to:
Postoperative and Postpartum Patients Receiving Heparin, Enoxaparin (Lovenox), or Fondaparinux Start Dose at (time) _____		
Labs: For patients receiving Heparin, Enoxaparin (Lovenox), or Fondaparinux: Obtain a baseline CBC and CBC on day 5 of therapy and every 3 days thereafter. Notify provider if platelet count is less than 100,000.		
Relative or Absolute Contraindications to pharmacologic prophylaxis: Active bleeding, thrombocytopenia (platelet count less than or equal to 60,000) hypertensive urgency/emergency/crisis, immune mediated Heparin induced thrombocytopenia, recent intraocular or intracranial surgery. Do NOT give Enoxaparin or Fondaparinux if spinal/epidural anesthesia or surgery is planned in the next 24 hours, or NOT until 12 hours after removal of epidural catheter. Use of Enoxaparin and Fondaparinux is contraindicated in hemodialysis patients.		
Contraindication to SCD's: Acute DVT, Acute Heart Failure, Recent Skin Graft, Immediate Postoperative Vein Ligation, or Gangrene		

Do

Clinical Referen... Nursing

Early Ambulation if no contraindications Accept Cancel

Priority:

Frequency:

For: Hours Days Weeks

Starting: At:

Starting: **Today 1548** **Until Specified**

Scheduled Times: [Hide Schedule](#)

Comments (F6):

Accept Cancel

More Activities



Do

Reason for no VTE prophylaxis ✓ Accept ✗ Cancel

Questions:

Prompt	Answer	Comments
1. Reason for no VTE prophylaxis	1. Low risk for VTE	
	2. Experiencing, or has a recent history of active bleeding	
	3. History of heparin induced thrombocytopenia	
	4. Epidural or spinal analgesia administered	
	5. Platelet count < 100,000	
	6. Has brain/spinal cord mets	
	7. Already on full anticoagulation therapy	
	8. Hypersensitivity to drug/class/HIPA Ab	
	9. Other (see comments)	

Comments (F6): [Click to add text](#)





Study

- ◆ Patient Education Effectiveness-Compliance with Mechanical Prophylaxis
- ◆ Patient Satisfaction with VTE Prophylaxis
- ◆ Physician Satisfaction with Thrombosis Prevention Assessment and Order Set

Study

- ◆ Incidence of Hospital Acquired PE/DVT in OB
- ◆ Readmission Rates for PE/DVT in OB Population
- ◆ Length of Stay for Patients with PE/DVT in OB Population



Act

- ◆ Based Upon Evaluation of Data
- ◆ Work Collaboratively with House-wide Efforts to Develop and Implement a Long Term-Medical Assessment Smart Form that Automatically Populates High Risk, Medium Risk or Low Risk Order Sets

What Have we Accomplished?

- ◆ Generated Knowledge, Interest and Momentum in Prevention of VTE in the Edward OB Patient Population



Team Talk 2

Lori M. Andriakos RNC-OB

Perinatal Quality Coordinator

Alexian Brothers Women's and Children's Hospital

Early Elective Delivery

Print Date & Time: 10/24/2014 15:45

TEST, Christine

MR#: **Test12345** DOB :.
Account#: Age :.
Unit: Train Bed: Train6
Attending:

OBSTETRIC PROGRESS NOTE

ALLERGIES: _____ HEIGHT: . . . WEIGHT: . . .

Induction or Augmentation of Labor

Date: _____ Time: _____

Gravida: 5 Para: 3 Weeks gestation: 40.5 Estimated Date of confinement (EDC): 10/10/14

Little or no prenatal care: Yes No

Oxytocin Pitocin Foley Bulb Cervidil Cytotec

Indication: . . .

Prior uterine scar? Yes No

Estimated fetal weight (Check appropriate category):

- Small for gestational age
 - Appropriate for gestational age
 - Large for gestational age
- _____ grams (if available)

Dilatation _____ cm Effacement _____ % Station _____

Membranes:

Scoring Criteria	0	1	2	3	Total: possible 13
Cervical consistency	Firm	Medium	Soft		Soft
Cervical position	Posterior	Midposition	Anterior		Anterior
Cervical effacement	0-30%	40-50%	60-80%	> 80%	60-70_ effaced
Cervical dilatation	Closed/FT	1-2 cm	3-4 cm	> 5 cm	1-2 cm
Station of fetal head	-3	-2	-1	> +1	minus 2
				Grand Total	8

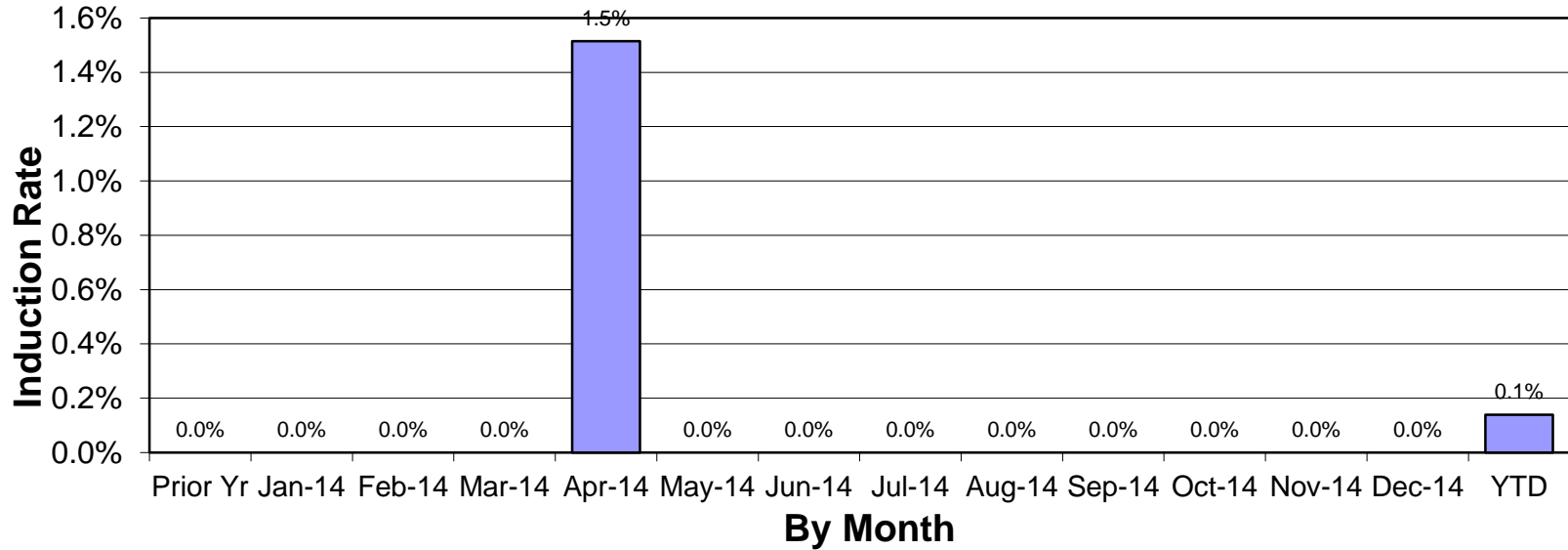
Fetal heart rate tracing (Check appropriate category):

- Reassuring
- Non-Reassuring

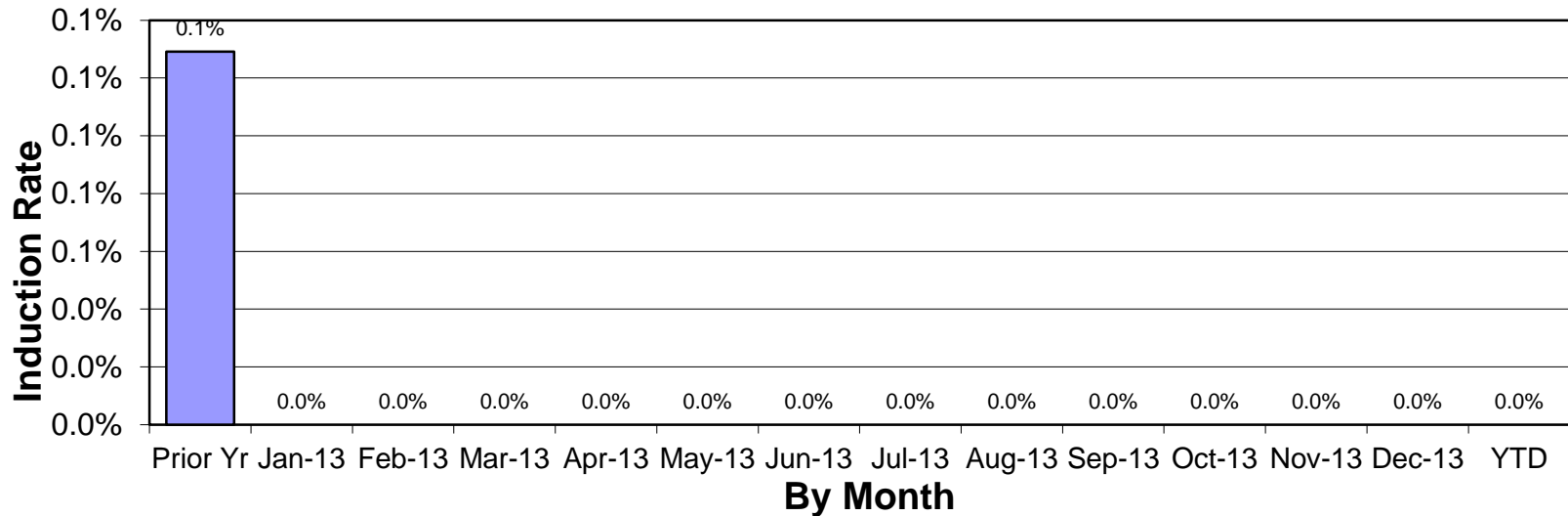
Attending Physician Signature _____ Date _____ Time _____



Delivery Rate - Prior to 39 Weeks without Medical Indication



Delivery Rate - Prior to 39 Weeks without Medical Indication



Team Talk 3

Stephen Locher, M.D.

Chairman

Department of Obstetrics and Gynecology

Advocate Illinois Masonic Medical Center

Decreasing Episiotomy Rates: A Culture Change

Problem: The American Congress of Obstetricians and Gynecologists does not support the routine use of episiotomy during parturition. Despite this recommendation for selective episiotomies, the procedure is still a widely done intervention.

Purpose: To decrease routine use of episiotomies.

Decreasing Episiotomy Rates: A Culture Change

Development of Program: The successful interpretation of evidence into clinical practice can be a challenge. One intervention to aid in the implementation of evidence-based guidelines is to implement a quality improvement curriculum. By offering providers education regarding episiotomy rates at our institution and the recommendation for selective use of episiotomies, the theory was that a culture change could occur thus improving patient care.

Decreasing Episiotomy Rates: A Culture Change

Implementation: Following our baseline data collection, education regarding selective use of episiotomies was presented in an informal didactic session to our 29 Obstetric providers. Written information was provided upon request. At the conclusion of the session, providers were given a hand out with the department's total episiotomy rate and their individual rates for the first quarter of 2014. Our standard delivery form was updated to include an indication for episiotomy if one was done to further discourage routine use.

Decreasing Episiotomy Rates: A Culture Change



Evaluation: Upon close of the second quarter of 2014, our institution's episiotomy rate was calculated. Each provider again received information regarding the department's total episiotomy rate and his own rate. Any outliers were re-educated regarding the selective use of episiotomies.

Results: Our episiotomy rate was calculated as follows :
number of episiotomies/total number of vaginal deliveries.
Our baseline rate, before education, for the first quarter of 2014 was 11%. Our second quarter data demonstrated a rate of 7.2%. Our third quarter showed a further reduction to 5.3%. We found that in review expectations, discussing the evidence behind our recommendations, and reinforcing our patient safety goals on a routine basis, we were able to affect change on our unit.

Next Steps

- If not already completed, enter 2013 PC-01 data quarter 1-4 and 2014 quarter 1-2
- Register for and attend the ILPQC Second Annual Conference
- Contact us to pilot the birth certificate data collection
- Look forward to the Birth Certificate Accuracy Initiative roll out

Thank You

For continuing to move obstetric and neonatal QI forward in Illinois to help make Illinois an even better place to be born!

