



OKLAHOMA PERINATAL QUALITY
IMPROVEMENT COLLABORATIVE

THE OKLAHOMA AIM EXPERIENCE

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MAY 1, 2018

OPQIC

Creating a culture of excellence
in perinatal care

The Landscape of Perinatal Care In Oklahoma

50 birthing hospitals

58% rural

42% urban

~52,000 annual births

69% in urban hospitals

31% in rural hospitals

From 80 – 4700 annual births

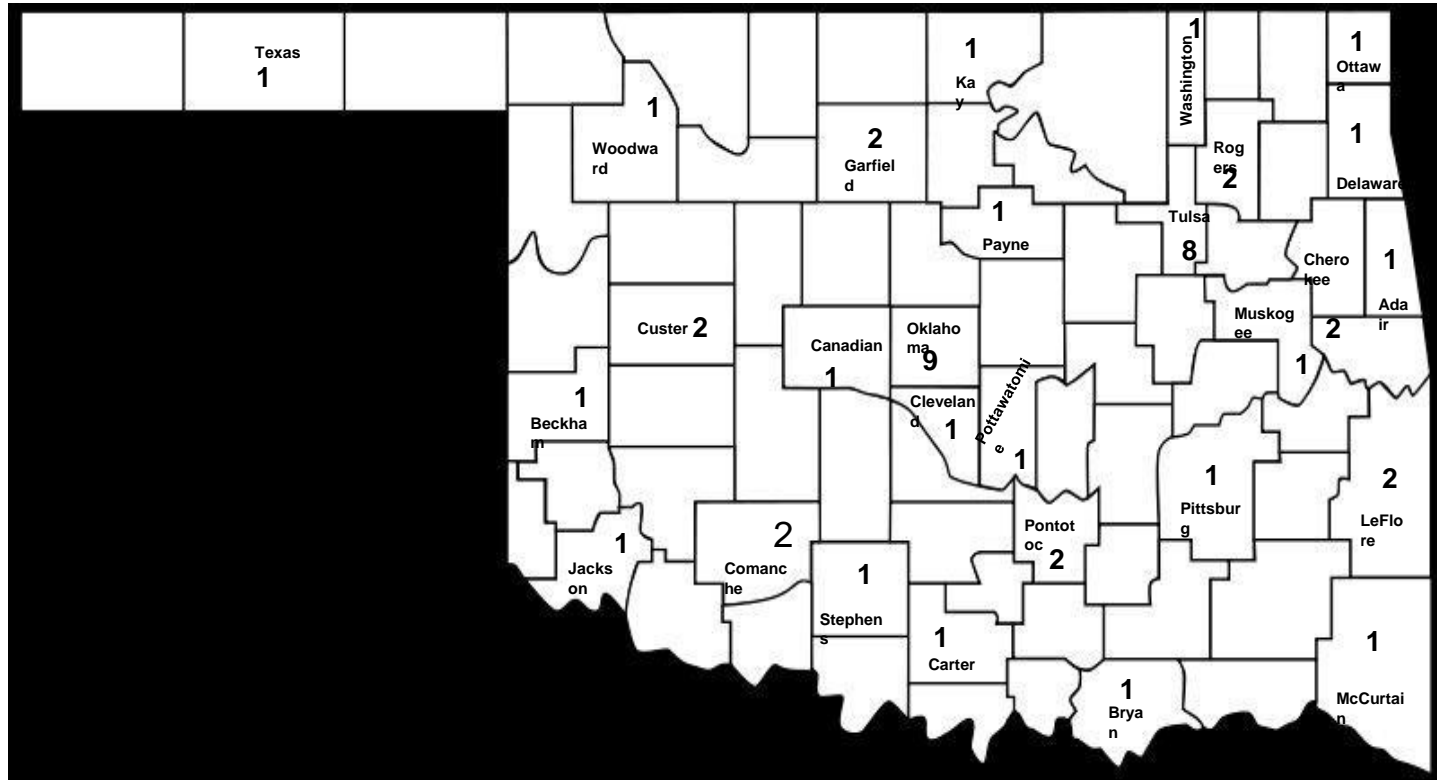
~60% covered by Medicaid

48 hospitals signed on to participate in AIM

Kick-Off in April 2015

42/50 actively participating (90% of births)

OB Hemorrhage Bundle and Severe HTN Bundle



123(5):973-977, May 2014



Current Commentary

The National Partnership for Maternal Safety

Mary E. D’Alton, MD, Elliott K. Main, MD, M. Kathryn Menard, MD, and Barbara S. Levy, MD

Recognition of the need to reduce maternal mortality and morbidity in the United States has led to the creation of the National Partnership for Maternal Safety. This collaborative, broad-based initiative will begin with three priority bundles for the most common preventable causes of maternal death and severe morbidity: obstetric hemorrhage, severe hypertension in pregnancy, and peripartum venous thromboembolism. In addition, three unit-improvement bundles for obstetric services were identified: a structured approach for the recognition of early warning signs and symptoms, structured internal case reviews to identify systems improvement opportunities, and support tools for patients, families, and staff that experience an adverse outcome. This article details the formation of the National Partnership for Maternal Safety and introduces the initial priorities.

(Obstet Gynecol 2014;123:973–7)

DOI: 10.1097/AOG.0000000000000219

issued a Sentinel Alert entitled “Preventing Maternal Death”² and proposed various initiatives to decrease maternal mortality including case reporting and review, health care provider education, team training and drills, and thromboembolism prophylaxis.

During the past 2 years, several organizations—including the American College of Obstetricians and Gynecologists (the College), the Centers for Disease Control and Prevention, the Society for Maternal-Fetal Medicine, the Health Resources and Services Administration, the Association of Women’s Health, Obstetric, and Neonatal Nurses, and the American College of Nurse-Midwives—have collaborated to identify priorities for maternal safety. Universal recognition of the need for action to reduce U.S. maternal mortality and morbidity led to the creation of the National Partnership for Maternal Safety. This report outlines a national initiative for every birthing facility

National Partnership for Maternal Safety: 3 Maternal Safety Bundles in 3 Years

What every U.S. birthing
facility should have...

- Obstetric Hemorrhage
- Preeclampsia/Hypertension
- Prevention of VTE in
Pregnancy



READINESS

Every unit

- Hemorrhage balloons and co
- Immediate acc
- Establish a respi advanced gynec
- Establish massiv negative/uncros
- Unit education (

RECOGNITION

Every patient

- Assessment of h appropriate tim
- Measurement of
- Active manag

RESPONSE

Every hemorrhage

- Unit-standard, s plan with check
- Support progr

REPORTING

Every unit

- Establish a cultu identify success
- Multidisciplinary
- Monitor outcom committee

Standardization of health c
Safety in Women's Health (c
scientific, and patient safet
course of treatment or pro



READINESS

Every Unit

- Standards for early of severe preeclam
- Unit education on g
- Process for timely t with hypertension i
- Rapid access to me Medications should areas where patien dosage.
- System plan for es transport, as need

RECOGNITION

Every Patient

- Standard protocol all pregnant and po
- Standard response investigating patien AST and ALT)
- Facility-wide stand and symptoms of



READINESS

Every Unit

- Use a standardized thromboembolism 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)

RECOGNITION & PREVENTION

Every Patient

- Apply standardized tool to all patients to assess VTE risk at time points designated under "Readiness"
- Apply standardized tool to identify appropriate patients for thromboprophylaxis
- Provide patient education
- Provide all healthcare providers education regarding risk assessment tools and recommended thromboprophylaxis

RESPONSE

Every Unit

- Use standardized recommendations for mechanical thromboprophylaxis
- Use standardized recommendations for dosing of prophylactic and therapeutic pharmacologic anticoagulation
- Use standardized recommendations for appropriate timing of pharmacologic prophylaxis with neuraxial anesthesia

REPORTING/SYSTEMS LEARNING

Every Unit

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

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical

PATIENT SAFETY BUNDLE

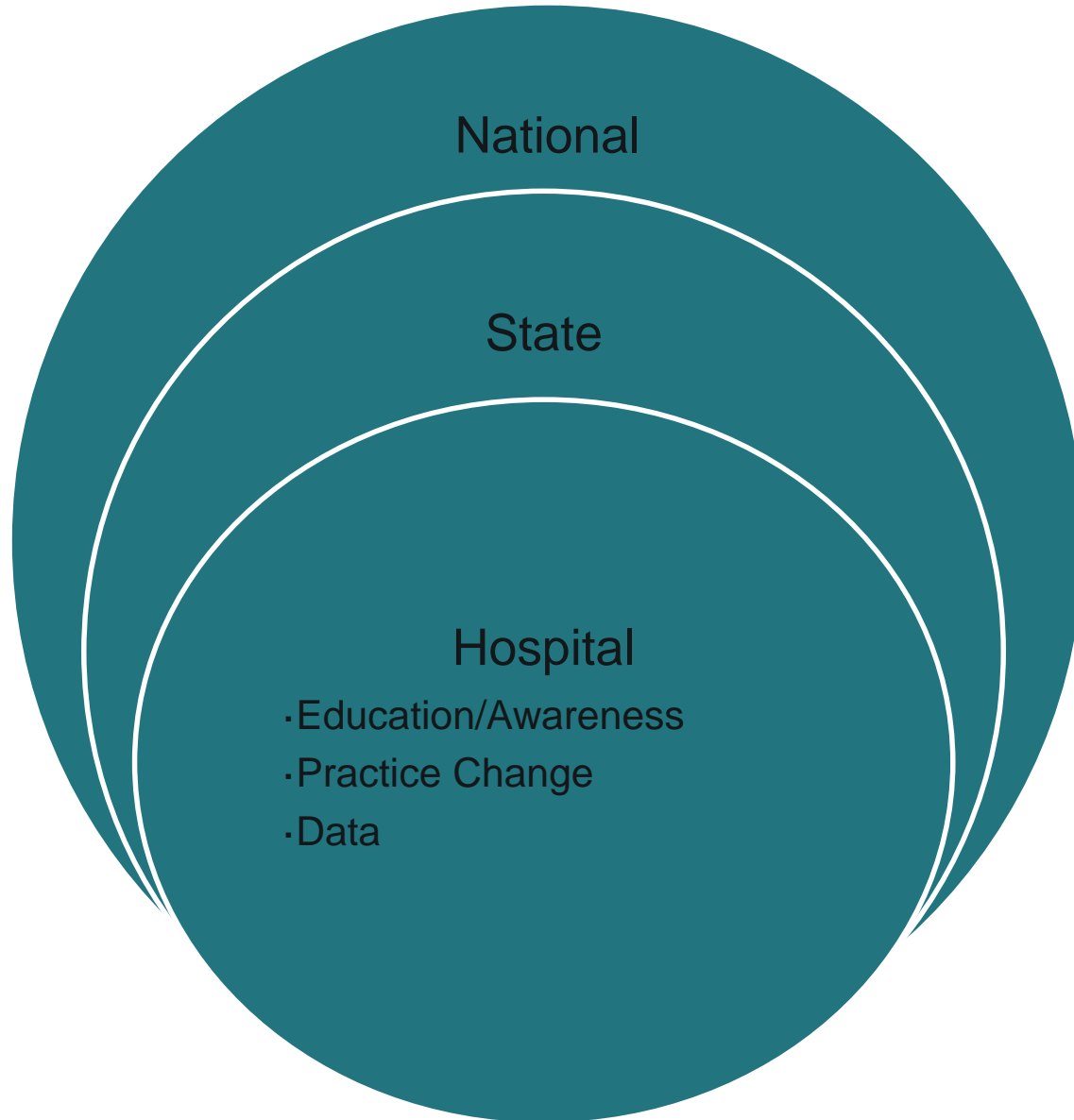
Maternal Venous Thromboembolism Prevention

Launch of AIM in Oklahoma

- 2015
 - Every Mother Counts launched in response to National Partnership for Maternal Safety call to action and Oklahoma Maternal Mortality Review/CDC data
 - Hospitals recruited via email and telephone
 - Kick-Off April 2015

Launch of AIM in Oklahoma

- 2015
 - Alliance for Innovation in Maternal Health (AIM) getting started simultaneously
 - Oklahoma first state to join
 - Resources and data portal would assist in bundle implementation
 - Oklahoma implementing OB Hemorrhage and Severe HTN/Preeclampsia bundle
 - Individual hospital calls for data portal began in Q4 2015 – data portal operational



National

State

Hospital

- Education/Awareness
- Practice Change
- Data

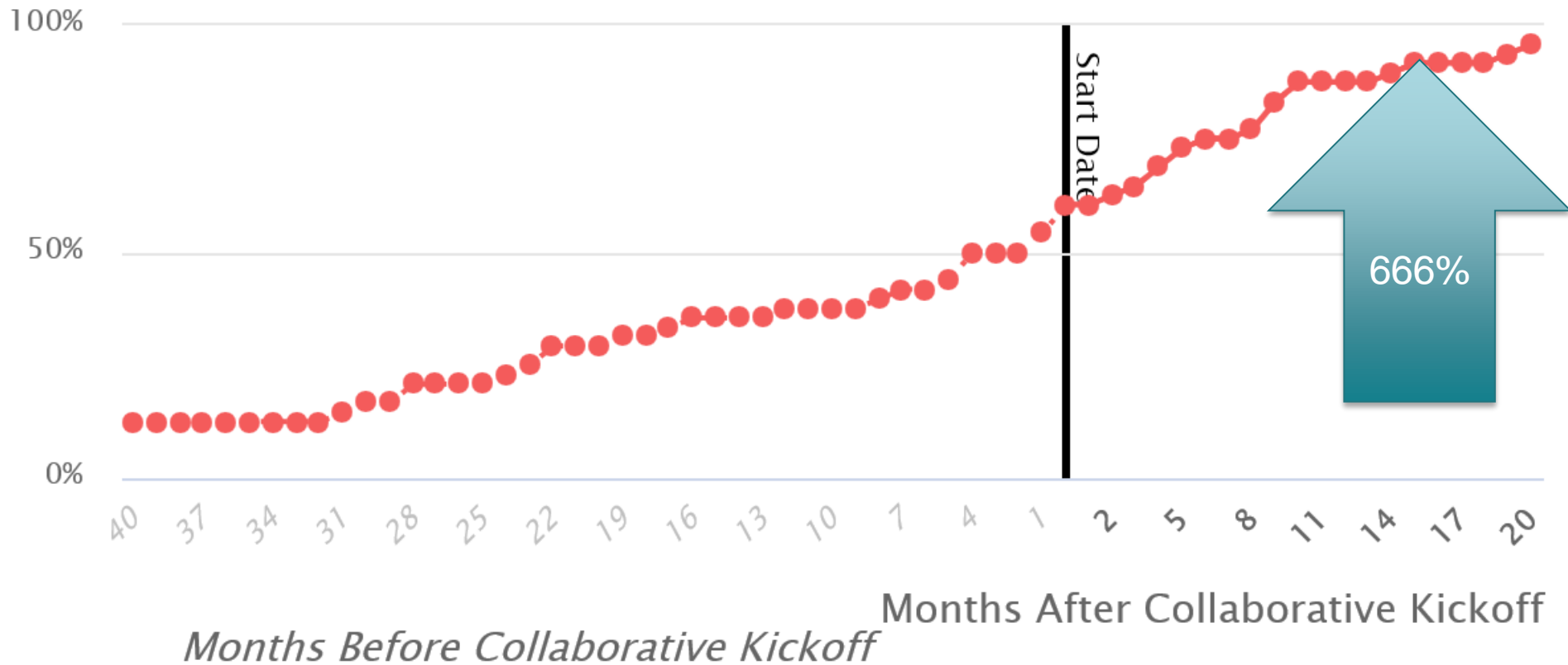
HEMORRHAGE BUNDLE PRIORITIES

Data Informed Priorities

- Hemorrhage Cart
- Management Plan for Obstetric Hemorrhage
- Risk Assessment for Obstetric Hemorrhage
- Quantification of Blood Loss

HEM S4: Hemorrhage Cart

Structure Measure Objective Completion Percentage

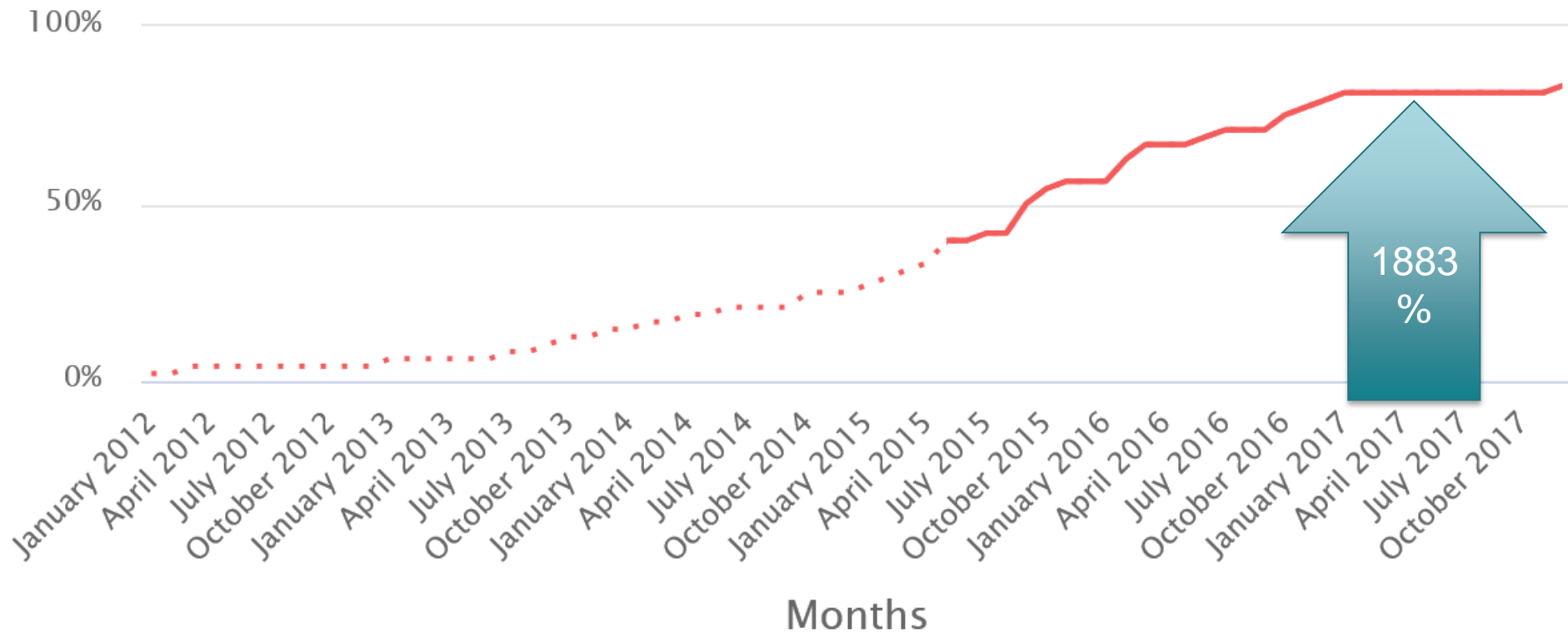


Dotted lines show data prior to collaborative kickoff date
 Click to hide a collaborative

—●— Oklahoma

HEM S5: Unit Policy & Procedure

Structure Measure Objective Completion Percentage

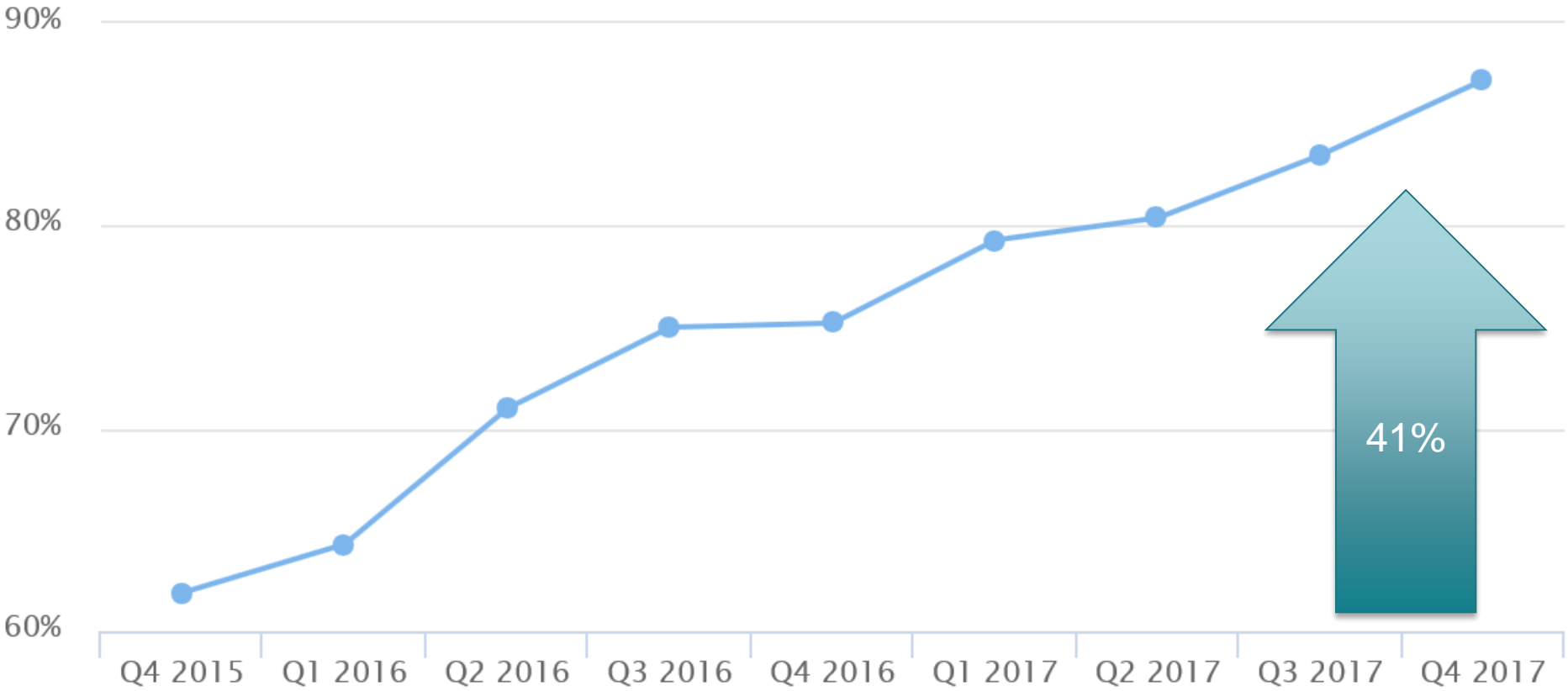


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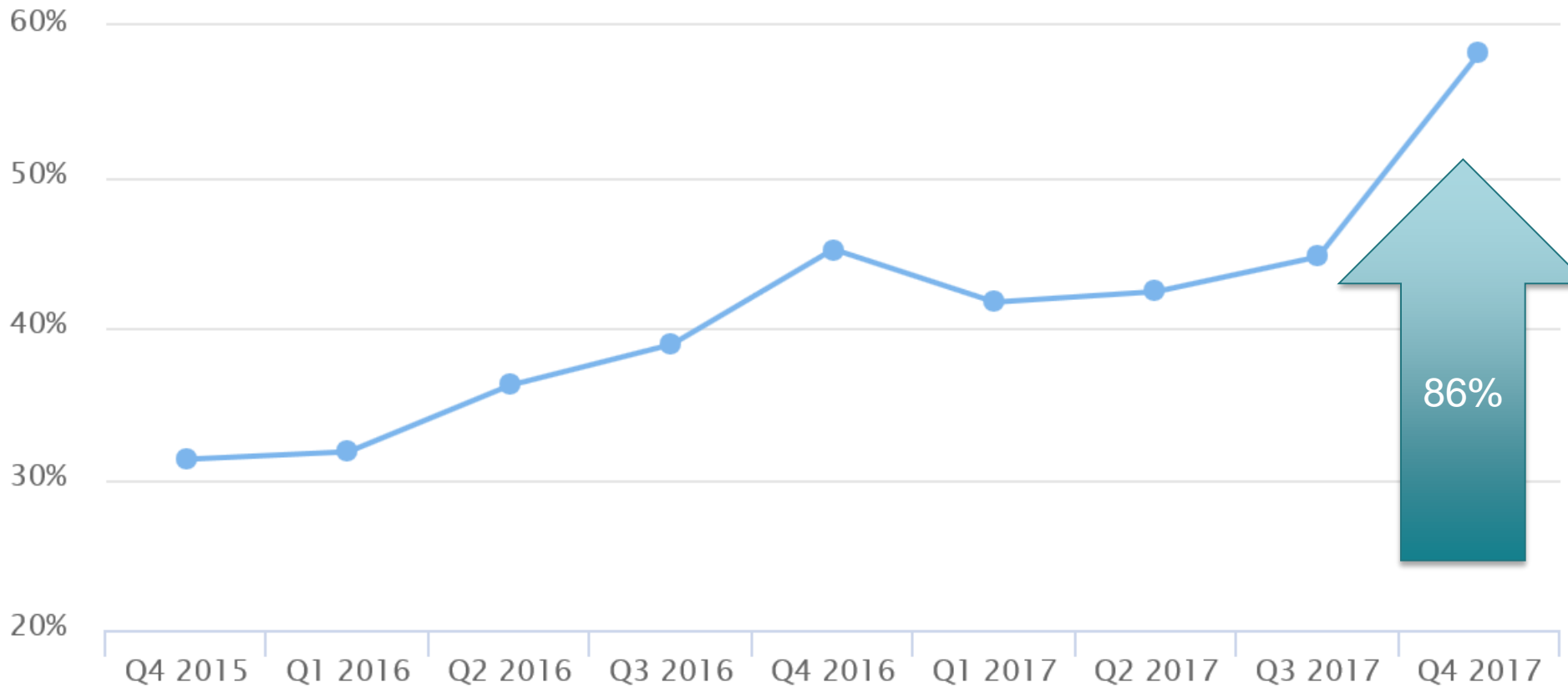
 Oklahoma

Hemorrhage Risk Assessment



- Oklahoma Hospital 50th Percentile
- ◆ Oklahoma Hospital Average
- Oklahoma Collaborative-wide Rate
- Oklahoma 50th to 75th Percentile
- Oklahoma 25th to 50th Percentile

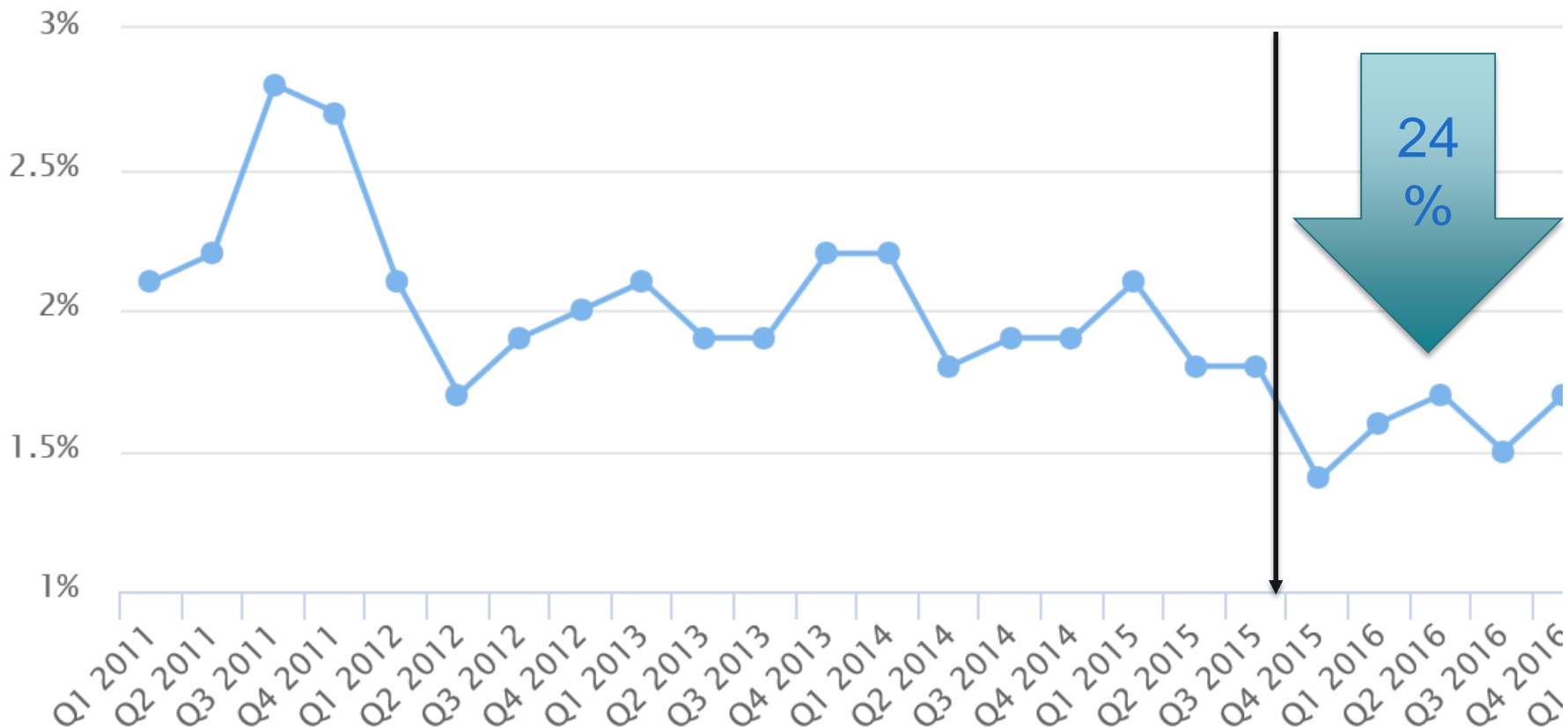
Blood Loss Measurement



- Oklahoma Hospital 50th Percentile
- Oklahoma Collaborative-wide Rate
- Oklahoma 25th to 50th Percentile

- ◆ Oklahoma Hospital Average
- Oklahoma 50th to 75th Percentile

Severe Maternal Morbidity among All Delivering Women



- Oklahoma Hospital 50th Percentile
- Oklahoma Collaborative-wide Rate
- Oklahoma 25th to 50th Percentile
- ◆ Oklahoma Hospital Average
- Oklahoma 50th to 75th Percentile



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Communications Office

Washington, DC

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National Initiative Aimed at Reducing Maternal Deaths Shows Early Signs of Improvement in Severe Maternal Morbidity

January 2, 2018

Washington, D.C.—Four states that were the first to join a national initiative aimed at reducing U.S. maternal mortality and morbidity have made promising improvements in maternal morbidity rates evident in the first round of outcomes data released by the American College of Obstetricians and Gynecologists (ACOG) today.

The [Alliance for Innovation in Maternal Health \(AIM\)](#) is a national data-driven maternal safety and quality improvement initiative that relies on a partnership between state health departments, health associations and perinatal collaboratives and hospitals, to implement and report progress on consistent maternity care practices, or “bundles,” for common pregnancy-related conditions.

What are challenges and barriers?

- RN responses:
 - 100% stated biggest barrier is lack of provider compliance with protocols
 - “Physicians are not aware of protocol and bundles. We can’t mandate education”
 - “They don’t buy-in. What do we do when a physician states they don’t believe our QBL amount and they’re going to give a different EBL amount? This creates conflict and a dilemma.”
 - “We hear a lot of, “Those are just recommendations, not hard, fast rules.”
 - “There must be a physician champion aware of evidence supporting change and willing to speak up and promote change – not often a popular or sought after role.”

What are challenges and barriers?

- RN responses:
 - “Time; especially with multiple priorities.”
 - “Need for bundles to be physician driven instead of nursing driven.”
 - “Real life situations don’t always fit in a bundle.”
 - “Staff turnover.”

What are challenges and barriers?

- MD responses:
 - Biggest barrier is lack of awareness of bundles/protocols
 - “Don’t assume they know about the bundles.”
 - Time constraints
 - Need evidence to support change
 - “In my opinion, we’re skeptics by nature. So, if someone can’t give me a really good reason for why I’m going to change the “way I’ve always done things”, it’s hard for me to change.”

Addressing Challenges

- Provider resistance
 - Recruit champions from the beginning
 - Use old-fashioned methods for creating awareness
 - Copies in restrooms, call-rooms, on units
 - Accountability
 - Monitoring individual compliance
 - Including as MOC Part IV, Clinical ladder
 - Empower champions
 - Include state professional organizations

Addressing Challenges

- Time
 - Recruit and delegate
 - Know that this will improve performance in long-term
 - Regular QI meetings to create deadlines
- Physician driven vs. Nursing driven
 - Involve all on improvement team
- Real-life situations don't fit in a bundle
 - Clinical judgment
- Staff turnover
 - Create a healthy work environment

Addressing Challenges

- Evidence to Support Change
 - Bundle
 - Resources within bundle

Keys to Success

- National AIM Leadership and Resources
 - National infrastructure
- National and State Partnerships
- **AIM Data Portal**
 - Data driven change
- National and local champions
- Simulation drives improvement and sustainment!

Lessons Learned

- Hemorrhage cart is easy win
 - Good first step
- Begin early on stage-based management protocol
 - Need it to support clinical practice
- Incorporate into EMR
- QBL is most complex
 - Need to purchase equipment
 - Start with pilot group
- Use quality improvement process!

WHAT CAN YOU DO?

- ***Passionately Engage*** at local, state and national level

“Passionate people collapse timeframes.”

- Deyonka Geeter, Oklahoma City



WHAT'S THE LATEST?

INITIATIVES

COURSES

CALENDAR

RESOURCES

ABOUT US

ABOUT US

Our mission is to provide leadership and engage interested stakeholders in a collaborative effort to improve the health outcomes for Oklahoma women and infants using evidence-based practice guidelines and quality improvement processes.



WELCOME

to the Oklahoma Perinatal Quality Improvement Collaborative



Check out our **Featured Resource** of the month

CONTACT US TODAY



INITIATIVES

See initiatives facilitated by the Oklahoma Perinatal Quality Improvement



COURSES

View a list of courses offered by the Office of Perinatal Quality Improvement.



RESOURCES

Find resources for perinatal health care providers.

www.opqic.org

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