Improving Quality at Your Facility

Presented by Debra Bingham, DrPH, RN, FAAN
Founder and Executive Director of the Institute for Perinatal Quality Improvement

Associate Professor, University of Maryland School of Nursing
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Disclosures

Debra Bingham is the Executive Director of the Institute for Perinatal Quality Improvement and is a perinatal consultant.

I will not discuss any off-label use/or investigational use in my presentation.
17 Year Research to Action Gap

“It now takes an average of 17 years for new knowledge generated by randomized controlled trials to be incorporated into practice, and even then application is highly uneven.”

The mission of the Institute for Perinatal Quality Improvement (PQI) is to **expand the use of improvement science** in order to eliminate preventable perinatal morbidity and mortality and end perinatal racial and ethnic disparities.
# Executive Advisory Board

<table>
<thead>
<tr>
<th>Mary Ellen Boisvert</th>
<th>Robyn D’Oria</th>
<th>Barbara O’Brien</th>
<th>Zola Golub</th>
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<tbody>
<tr>
<td>MSN, RN, CLC, CCE</td>
<td>MA, RNC, APN</td>
<td>BSN, MSN</td>
<td>M.Ed., RN, IBCLC</td>
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<tr>
<th>Peter Bernstein</th>
<th>Brian T. Bateman</th>
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<tr>
<td>MD, MPH</td>
<td>MD, MSc</td>
<td>BS, Biology</td>
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Launched July 2017
# Editorial Advisory Board

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<tr>
<th>Sarah J. Rhoads</th>
<th>Catherine Ivory</th>
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<tr>
<td>DNP, PhD</td>
<td>BSN, MSN, PhD</td>
<td>BSN, MSN, NNP</td>
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<tr>
<td>BSN, M.Ed., MSN</td>
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<td>BSN, MSN, PhD</td>
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Objectives

- Describe the key elements of a quality and safety program that is designed to improve the outcomes of perinatal patients.

- Describe methods of evaluating the outcomes of high-risk and critically ill pregnant women based on the national recommendations for performing maternal morbidity and mortality reviews.

- Discuss how to set priorities for action based on the maternal morbidity and mortality reviews and develop a tailored safety and quality action plan.
Don’t be afraid to look at your data.

Data helps us know what improvements are needed.
Trends in Maternal Morbidity and Mortality

*Note: Number of pregnancy-related deaths per 100,000 live births per year.

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.htm
Recent Increases in the U.S. Maternal Mortality Rate
Disentangling Trends From Measurement Issues

“Simply totaling the raw, unadjusted data from all states results in a reported U.S. maternal mortality rate that more than doubled from 9.8 maternal deaths per 100,000 live births in 2000 to 21.5 maternal deaths per 100,000 live births in 2014.”

The Leading Causes of Pregnancy-Related Mortality

Causes of deaths has shifted over time. Currently in the United States the leading causes of the 2011-2013 deaths are:

- Cardiovascular diseases, 15.5%.
- Non-cardiovascular diseases, 14.5%.
- Infection or sepsis, 12.7%.
- Hemorrhage, 11.4%.
- Cardiomyopathy, 11.0%.
- Thrombotic pulmonary embolism, 9.2%.
- Hypertensive disorders of pregnancy, 7.4%.
- Cerebrovascular accidents, 6.6%.
- Amniotic fluid embolism, 5.5%.
- Anesthesia complications, 0.2%.

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.htm
Maternal Mortality is the Tip of the Iceberg
1998-1999 compared to 2008-2009

- 75% increase in severe maternal complications
- 183% increase in blood transfusions

Women die or suffer injuries because they do not receive early, effective and aggressive lifesaving treatments.

Timing of Pregnancy-Related Deaths (2011-2013)

- 30.5% died before giving birth
- 16.8% died on the day they gave birth
- 18.2% died 1-6 days after giving birth
- 21.3% died 7-41 days post-birth
- 13.2% died on or after 42 days

1998-1999 compared to 2008-2009

• 75% increase in severe maternal complications

• 183% increase in blood transfusions

In the United States Racial Disparities Persist

- 12.7 deaths per 100,000 live births for white women.
- 43.5 deaths per 100,000 live births for black women.
- 14.4 deaths per 100,000 live births for women of other races.

Many of these disparities are due to structural racism

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.htm
It is unacceptable that Black and African American women are three to four times more likely to die during childbirth than women in all other racial and ethnic groups. The Institute for Perinatal Quality Improvement is working to change this fact.

**Race Isn’t a Risk Factor in Maternal Health. Racism Is.**

Apr 11, 2018, 11:50am  Dr. Joia Crear-Perry

The language of the moment suggests that it's Blackness that's the problem, not bias.

https://screenshots.firefox.com/Xq1uThfvQra8vqSZ/rewire.news
EQUALITY

EQUITY
Conversation is where change begins and we have the power to change the conversation.

#SpeakUp for African American and Black Women!

#SpeakUp for all women!

www.perinataQI.org
Women die or suffer injuries because they do not receive early, effective and aggressive lifesaving treatments.

Maternal Mortality Rate, California and United States; 1999-2013

QI Saves Lives!

www.perinatalQI.org
Definition of Quality Improvement (QI)

“When we use the term “QI” in this report, we mean systematic, data-guided activities designed to bring about immediate, positive changes in the delivery of health care in particular settings.”

Who has the responsibility for improving the quality of care?
“We conclude that engaging in quality improvement is NOT purely Discretionary; health professionals, managers, delivery organizations, patients, and government all have an ethical responsibility to cooperate with one another to improve the quality of care.”

Have you received education on QI concepts, methods, and tools?
Clinicians need
QI Education & QI Support

• QI Methods and Concepts
  – Implementation Theories
  – Implementation Frameworks
  – QI Process Models
  – QI Ethics

• QI Tools
  – QI Process Maps or Flowcharts
  – Cause and Effect (Fishbone) Diagrams
  – Logic Models
  – Driver Diagrams
What is the relationship among?

- Evidence-based practice
- Research
- Implementation Science
- Improvement Science
- Quality Improvement
Bingham’s Evidence-Based Practice, Research, Implementation Science, and Quality Improvement Flow Chart

1. Evaluate & Grade the Research or Evidence for the Practice (EBP), Review Population Health Data & Clinical Outcomes
   - Review surveillance & utilization data to track and review population health and outcomes.
   - Review the research literature to determine which current practices need to change & how.
   - Determine the level of evidence and Evidence-Based Practice (EBP) Gaps

2. Design and Implement a Quality Improvement Initiatives
   - Implement evidence-based care using QI implementation and improvement science.
   - Utilize process models, determinant frameworks, classic theories, & implementation theories
   - Small tests of change

3. Evaluate & Determine Next Steps
   * Program evaluation:
     - Structures, Processes, Outcomes (Healthcare & Population Health)
   * Identify practice & policy implications
   * Track un-intended consequences
   * Recommend modifications
   * Sustain
   * Spread

Human Subjects Research to Generate New Clinical Knowledge

Implementation Science Research
   - Develop and test theories, frameworks, models

Improvement Science (Translation)
   - Study Implementation Methods (Strategies & Tactics, Validated Measures, Organizational Readiness, Barriers & Facilitators, Fidelity, etc.)

dbingham@perinatalQI.org • @debra_bingham • ©Institute for Perinatal Quality Improvement
Why is it important for clinicians to know about implementation science?
A knowledge of maternal and fetal physiology helps clinicians tailor care decisions to individual patients.

Similarly, an understanding of the “physiology” or science behind QI makes it possible for clinicians to more thoughtfully select the QI strategies and tactics they employ to ensure QI success.
Why Study Implementation Science?

• Simply acknowledging that change is hard and messy does not go far enough to ensure that a QI leader is effective.

• Teaching QI leaders about QI tips and tools also does not adequately prepare them to decide which tools to use, and when.

• A foundation in implementation science will help QI leaders know how to select and use the QI implementation tools effectively and what to do when barriers to successful implementation are identified.
IMPLEMENTATION SCIENCE IS THE PHYSIOLOGY OF QUALITY IMPROVEMENT

Posted By Institute for Perinatal Quality Improvement, Thursday, December 21, 2017

Author: Debra Bingham, DrPH, RN, FAAN

*Have you ever been a part of a quality improvement (QI) effort that felt like a waste of time?*

*Have you gone to meeting after meeting or collected a lot of data but no changes were ever made?*

*Or have you made changes that did not improve outcomes?*

*Have you wondered what you could do to make QI efforts more effective?*

While thinking about how to reduce QI-related frustration, I was reminded of when I first became a labor and delivery nurse. Initially I did not understand the physiology behind the patterns I was seeing. I knew how to recognize some fetal heart monitoring patterns, but I was like the proverbial blind man

Subscribe to the blog.
Implementing Perinatal Quality Improvement Conference
Implementation Theories

Used for predicting and explaining

- Outline a fact or a set of facts and ideas that either explain or predict implementation effectiveness. Research, as outlined in theories is the solid foundation for all QI efforts.

Examples:

- Classic theories (theories that originate outside of implementation science research and implementation theories)
  - E.M. Roger's Theory of Diffusion of Innovations

- Implementation theories
  - B.J. Weiner’s Theory of Organization Readiness for Change
  - Klein and Sorra’s Determinants and Consequences of Implementation Effectiveness
Klein & Sorra’s Determinants and Consequences of Implementation Effectiveness merged with E.M. Rogers

Climate for Implementation
 Implementation policies & practices (the types of rewards & support there are for the innovation) and broader organizational features

Skills
 Incentives & Disincentives
 Absence of obstacles
 Knowledge or Behaviors

Innovation Effectiveness
 Quality & consistency in the use of a specific innovation

Implementation Effectiveness
 The benefits realized by the organization(s) that implemented the innovation.

Commitment & Enthusiasm
 Compliance to get rewards or avoid punishments versus internalization where the change is congruent with a worker’s values.

Strategic Accuracy of Innovation Adoption

Innovation-Values Fit
 The shared values of the organization’s targeted users as a whole or distinct groups of targeted users within an organization.

Definitions, clarification, and merging with Donabedian added by the Institute for Perinatal Quality Improvement
Implementation Frameworks

Used for planning and adjusting the QI implementation strategies and tactics

- They help describe and identify potential QI implementation barriers and facilitators.
- Implementation frameworks are useful for identifying the implementation and improvement science research study results that are most relevant to the QI effort.

Examples of Implementation Frameworks are:

- G. Harvey and A. Kitson’s Integrated Promoting Action on Research Implementation in Health Sciences (i-PARIHS)
- L. Damschroder, et al.’s Consolidated Framework for Implementation Research (CFIR; www.CFIRguide.org)
- Graham, et al.’s Knowledge to Action Framework
Implementation Process Models

Used as checklists and as a guide for writing up the QI Plan or Protocol (similar to having a research protocol)

- They guide the planning and evaluation process that will be used to improve outcomes and translate research into practice.
- Process models do not predict implementation effectiveness or describe the causal mechanisms of various implementation activities.

Examples of process models are:
- Mobilize-Assess-Plan-Implement-Track (MAP-IT)
- Plan-Do-Study-Act (PDSA)
- Six Sigma
MAP-IT is a QI Process Model
Mobilize – Assess – Plan – Implement – Track (MAP-IT)

Perform Small Tests of Change
Learn then Adjust (as often as needed)

MAP-IT Cycle 1

MAP-IT Cycle 2

MAP-IT Cycle 3

QI Saves Lives!
www.perinatalQI.org
Quality Improvement is like climbing a spiral staircase.

Each cycle gets you closer to your goal.
Components of A Project Charter

- Opportunity Summary
- Goals & Objectives (measures of success)
- Scope – In-Scope, Out-of-Scope
- Team Membership
- Key Milestones
- Constraints and Barriers
- Dependencies
• Physicians, RNs, & Midwives have critical insights that will help improve quality and safety

• The more clinicians understand about QI methods, concepts, and tools the faster care can be improved!
Objectives

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- Discuss how to set priorities for action based on the maternal morbidity and mortality reviews and develop a tailored safety and quality action plan.
AWHONN PPH Project Wrap-Up Video

www.pphproject.org
Joint Commission
Sentinel Events

“Careful investigation and analysis of patient safety events, as well as strong corrective action that provide effective and sustained system improvement is essential to reduce risk and prevent patient harm.”

http://www.jointcommission.org/assets/1/6/CAMH_24_SE_all_CURREN.pdf
Definition of Sentinel Event

A patient safety event (*not primarily related to the natural course of the patient’s illness or underlying condition*) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

http://www.jointcommission.org/assets/1/6/CAMH_24_SE_all_CURRENT.pdf
ACOG, CDC, SMFM Definition of Severe Maternal Morbidity

A patient safety event that occurs intrapartum through the immediate postpartum period (24 hrs), that requires the

- Transfusion of 4 or more units of packed red blood cells
- and/or admission to the intensive care unit (ICU)
  - Admission to the ICU is defined as admission to a unit that provides 24-hour medical supervision and is able to provide mechanical ventilation or continuous vasoactive drug support.

http://www.jointcommission.org/assets/1/6/CAMH_24_SE_all_CURRENT.pdf
Severe Maternal Morbidity: Clarification of the New Joint Commission Sentinel Event Policy

Facilities are strongly encouraged to review all cases of severe maternal morbidity for learning and improvement.

Not all cases of severe maternal morbidity are sentinel events.

Some severe maternal morbidity events are related to the natural course of the patient’s illness or underlying condition.
The Purpose of Reviewing Adverse Outcomes

• To learn and ultimately improve outcomes.
• Promote a culture of learning from adverse events – not a culture of blame, shame, or punishment

Co-Convened Expert Panel: Tracking Nurses’ Effect on Maternal Mortality and Morbidity

Debra Bingham, DrPH, RN, FAAN – Co-Chair
Andria Cornell, MSPH – Co-Chair
Council on Patient Safety in Women’s Health Care Bundles

www.safehealthcareforeverywoman.org

Dr. Bingham helped form the Council and was the Vice Chair and Chair of the Council
Multi-Disciplinary Consensus Recommendations

Standardized Severe Maternal Morbidity Review: Rationale and Process

Sarah J. Kilpatrick, Cynthia Berg, Peter Bernstein, Debra Bingham, Ana Delgado, William M. Callaghan, Karen Harris, Susan Lanni, Jeanne Mahoney, Elliot Main, Amy Nacht, Michael Schellpfeffer, Thomas Westover, and Margaret Harper

Also published in the Green Journal.
Who Should Review the Event?

- Multidisciplinary standing committee at birth facility representing:
  - Obstetrical providers (obstetricians, family physicians and/or advanced practice nurses)
  - Anesthesia providers
  - Obstetric care nurses
  - Birth Facility quality improvement team
  - Birth Facility administration
  - Patient advocate
  - Scribe
- Small birth facilities should consider partnering with regional perinatal center or outsourcing the review
When to Review?

- As close as possible to the time of the event
- The more severe the event, the closer the timing to review
- If large birthing facility with a number of events, consider scheduling regular meeting to do reviews.
How to Review?

- Reviews should be sanctioned by the facility and protected from discovery.
- Confidentiality statements should be gathered from each committee member.
- Gather all pertinent patient medical records and facility records regarding this patient and event.
- Engage a trained reviewer/abstractor to complete the Abstraction Section of the SMM Review Form, including a pertinent synopsis of the event and objective information found in the records.
- Primary review is then presented to the review committee.
- Multidisciplinary Reviews follow a standard format (i.e. Assessment section of SMM Review Form).
- Multidisciplinary Review conclude with recommendations.

What were the QI opportunities?
Not BLAME or SHAME
### Basic Data

Forms available at: safehealthcareforeverywoman.org

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<thead>
<tr>
<th>SMM (recorded cause)</th>
<th>SMM Date</th>
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<tr>
<td>MR # or PATIENT ID</td>
<td>Zip code of patient residence</td>
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<tr>
<td>Abstraction Date</td>
<td>Abtractor</td>
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<td>Birth Facility</td>
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<th>Hospital Level</th>
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<th></th>
<th></th>
<th>Birth center</th>
<th>Other (Specify)</th>
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<tr>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
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<th>Obstetric History</th>
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<td>Gravida _____</td>
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<tr>
<td>Para _____ Term ____ Premature ____ Aborted ____ Living ____</td>
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<tr>
<td># Previous fetal deaths ____</td>
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<td># Previous infant deaths ____</td>
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<th>Prenatal Care (PNC)</th>
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<td>Yes ☐ Week PNC began _____ Week unknown</td>
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<tr>
<td>No ☐ Unknown PNC status ☐</td>
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<th>Discipline of Primary PNC Provider (choose one)</th>
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<td>Choose an item.</td>
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<th>Prenatal care source/location</th>
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<td>Choose an item.</td>
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<th>Planned/intended place of delivery</th>
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<th>Timing of maternal morbidity</th>
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<th>Maternal Transport (during peripartum period)</th>
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<table>
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<th>Perinatologist consultation (during peripartum period)</th>
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### Patient Characteristics

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<tr>
<th>Age</th>
<th>Weight/Height</th>
<th>Body mass index (BMI) at first prenatal visit</th>
<th>Most recent BMI</th>
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<th>Race (Indicate race patient identifies)</th>
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<td>Choose an item.</td>
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<tr>
<th>Hispanic or Latina</th>
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<tr>
<td>No ☐ Yes ☐ Unknown ☐</td>
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### Delivery Information

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<th>Gestational age at time of morbidity</th>
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CDC’s Form for State Reviews

<table>
<thead>
<tr>
<th>REVIEW DATE</th>
<th>RECORD ID #</th>
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PREGNANCY-RELATEDNESS: SELECT ONE

- **PREGNANCY-RELATED**
  - The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

- **PREGNANCY-ASSOCIATED, BUT NOT -RELATED**
  - The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy.

- **UNABLE TO DETERMINE IF PREGNANCY-RELATED OR PREGNANCY-ASSOCIATED, BUT NOT -RELATED**
  - (i.e. false positive, woman was not pregnant within one year of her death).

ESTIMATE THE DEGREE OF RELEVANT INFORMATION (RECORDS) AVAILABLE FOR THIS CASE:

- **COMPLETE**
  - All records necessary for adequate review of the case were available.

- **MOSTLY COMPLETE**
  - Minor gaps (i.e. information that would have been beneficial but was not essential to the review of the case).

- **SOMEWHERE COMPLETE**
  - Major gaps (i.e. information that would have been crucial to the review of the case).

- **NOT COMPLETE**
  - Minimal records available for review (i.e. death certificate and no additional records).

- **N/A**

**COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH**

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<th>TYPE</th>
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<td>IMMEDIATE</td>
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<tr>
<td>CONTRIBUTING</td>
<td></td>
</tr>
<tr>
<td>UNDERLYING</td>
<td></td>
</tr>
<tr>
<td>OTHER SIGNIFICANT</td>
<td></td>
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</table>

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH
Refer to page 3 for PMSS-MM cause of death list. If more than one is selected, list in order of importance beginning with the most compelling (1-2; no more than 2 may be selected in the system).

DID OBESITY CONTRIBUTE TO THE DEATH? [ ] YES [ ] PROBABLY [ ] NO [ ] UNKNOWN

DID MENTAL HEALTH CONDITIONS CONTRIBUTE TO THE DEATH? [ ] YES [ ] PROBABLY [ ] NO [ ] UNKNOWN

DID SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH? [ ] YES [ ] PROBABLY [ ] NO [ ] UNKNOWN

WAS THIS DEATH A SUICIDE? [ ] YES [ ] PROBABLY [ ] NO [ ] UNKNOWN

WAS THIS DEATH A HOMICIDE? [ ] YES [ ] PROBABLY [ ] NO [ ] UNKNOWN

IF HOMICIDE, SUICIDE, OR ACCIDENTAL DEATH, LIST THE MEANS OF FATAL INJURY:

- FIREARM
- SHARP INSTRUMENT
- BLUNT INSTRUMENT
- POISONING / OVERDOSE
- HANGING / STRANGULATION / SUICIDATION
- FALL PUNCHING / KICKING / BEATING EXPLOSIVE DROWNING FIRE OR BURNS MOTOR VEHICLE

INTENTIONAL NEGLECT

OTHER, SPECIFY: [ ] UNKNOWN [ ] NOT APPLICABLE
Causes of Death Codes from CDC

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH* PMSS-MM
If more than one is selected, please list them in order of importance beginning with the most compelling (1-2; no more than 2 may be selected in the system).

*PREGNANCY-RELATED DEATH: THE DEATH OF A WOMAN DURING PREGNANCY OR WITHIN ONE YEAR OF THE END OF PREGNANCY FROM A PREGNANCY COMPLICATION, A CHAIN OF EVENTS INITIATED BY PREGNANCY, OR THE AGGRAVATION OF AN UNRELATED CONDITION BY THE PHYSIOLOGIC EFFECTS OF PREGNANCY.

10 Hemorrhage (excludes aneurysms or CVA) 10.1 Hemorrhage – rupture/laceration/intra-abdominal bleeding 10.2 Placental abruption 10.3 Placenta previa 10.4 Ruptured ectopic pregnancy 10.5 Hemorrhage - uterine atony/postpartum hemorrage 10.6 Placenta accreta/increta/percreta 10.7 Hemorrhage due to retained placenta 10.8 Hemorrhage due to primary DIC 10.9 Other hemorrhage/NOS 20 Infection 20.1 Postpartum genital tract (e.g. of the uterus/pelvis/perineum/necrotizing fasciitis) 20.2 Septis/septic shock 20.4 Chorioamnionitis/anteptum infection 20.5 Non-pelvic infections (e.g. pneumonia, TB, meningitis, HIV) 20.6 Urinary tract infection 20.9 Other infections/NOS 30 Embolism - thrombotic (non-cerebral) 30.9 Other embolism/NOS 31 Embolism - amniotic fluid 40 Preeclampsia 50 Eclamspia 60 Chronic hypertensión with superimposed preeclampsia 70 Anesthesia complications 80 Cardiomyopathy 80.1 Postpartum/peripartum cardiomyopathy 80.2 Hypertrophic cardiomyopathy 80.9 Other cardiomyopathy/NOS 82 Hematologic 82.1 Sickle cell anemia 82.9 Other hematologic conditions including thrombophilies/TTP/HUS/NOS 83 Collagen vascular/autoimmune diseases 83.1 Systemic lupus erythematosus (SLE) 83.9 Other collagen vascular diseases/NOS 85 Conditions unique to pregnancy (e.g. gestational diabetes, hyperemesis, liver disease of pregnancy) 88 Injury 88.1 Intentional (homicide) 88.2 Unintentional 88.9 Unknown/NOS 89 Cancer 89.1 Gestational trophoblastic disease (GTD) 89.3 Malignant melanoma 89.9 Other malignancies/NOS 90 Cardiovascular conditions 90.1 Coronary artery disease/myocardial infarction (MI)/atherosclerotic cardiovascular disease 90.2 Pulmonary hypertension 90.3 Valvular heart disease congenital and acquired 90.4 Vascular anurexia/dissection (non-cerebral) 90.5 Hypertensive cardiovascular disease 90.6 Marfan Syndrome 90.7 Conduction defects/arrhythmias 90.8 Vascular malformations outside head and coronary arteries 90.9 Other cardiovascular disease, including CHF, cardiomegaly, cardiac hypertrophy, cardiac fibrosis, non-acute myocarditis/NOS 91 Pulmonary conditions (excludes ARDS-Adult respiratory distress syndrome) 91.1 Chronic Lung disease 91.2 Cystic fibrosis 91.3 Asthma 91.9 Other pulmonary disease/NOS 92 Neurologic/neurovascular conditions (excluding CVAs) 92.1 Epilepsy/seizure disorder 92.9 Other neurologic diseases/NOS 93 Renal disease 93.1 Chronic renal failure/end-stage renal disease (ESRD) 93.9 Other renal disease/NOS 95 Cerebrovascular accident (hemorrhage/thrombosis/anemurysm/malforation) not secondary to hypertensive disease 96 Metabolic/endocrine 96.1 Obesity 96.2 Diabetes mellitus 96.9 Other metabolic/endocrine disorders 97 Gastrointestinal disorders 97.1 Crohn's disease/ulcerative colitis 97.2 Liver disease/failure/transplant 97.9 Other gastrointestinal diseases/NOS 100 Mental health conditions 100.1 Depression 100.9 Other psychiatric conditions/NOS 999 Unknown COD

Reviewtoaction.org
Objectives

• Describe the key elements of a quality and safety program that is designed to improve the outcomes of perinatal patients.

• Describe methods of evaluating the outcomes of high-risk and critically ill pregnant women based on the national recommendations for performing maternal morbidity and mortality reviews.

• Discuss how to set priorities for action based on the maternal morbidity and mortality reviews and develop a tailored safety and quality action plan.
Make a List of QI Opportunities

QI Opportunities:
How could Mary's care have been improved?
1.
2.
3.
4.
5.
6.
(List as many QI opportunities as you can)
QI Tools for Selecting Priorities

- Driver Diagrams
- Cause and Effect Diagrams
- Logic Models
- Using dots to vote on priorities for action
Help Identity 1-3 QI Priorities for Our Facility

• Each of you have been given 3 sticker dots.

• Put your 3 dots next to the QI opportunities that you think are the 1-3 biggest priorities for action at your facility.
  – You can put 1, 2, or even 3 of your dots next to any of the QI opportunities on the list.

Refer to the next slide to see an example of how to do this step.
Put an Asterisk Next to 1-3 QI Priorities

Prioritize QI Opportunities:
*1. Only induce labor for a medical indication

*2. Measure and record actual amounts of blood lost

3. Perform more frequent checks when someone has a vaginal laceration

*4. Implement the massive hemorrhage protocol immediately when a woman shows signs of extensive blood loss
Driver Diagram to Reduce Postpartum Hemorrhage-Related Morbidity and Mortality

GOAL(s) PRIMARY SECONDARY CHANGE IDEAS

EXAMPLES OF CHANGE IDEAS

Goal(s)
1.1 Postpartum Hemorrhage

1) PowerPoint slide set
   a. Section 1: Case Study and guidance for identifying and setting priorities
   b. Section 2: Education on postpartum hemorrhage
   c. Section 3: Education on quality improvement concepts, methods, and tools

2) Facilitator Notes
3) Action Plan Templates
Action Brief 2.1: Neonatal Resuscitation

1) PowerPoint Slide Sets
   Section 1: Case Study and Setting Priorities
   Section 2: Education on Neonatal Resuscitation
   Section 3: Education on quality improvement concepts, methods, and tools
2) Facilitator Notes
3) Action Plan Templates

Sign-Up at www.perinatalQI.org
Baseline Assessment

Postpartum Hemorrhage Preparedness Elements Vary Among Hospitals in New Jersey and Georgia

Debra Bingham, Benjamin Sceheich, Renée Byfield, Barbara Wilson, and Brian T. Bateman

Figure 1: PPH Project Process Metrics

Note. Percent improvement is the median percentage of the data abstracted from randomly select chart audits each month. The charts audits were performed by the hospital-based PPH Project Leaders who then entered their data into to the Association of Women’s Health, Obstetric and Neonatal Nurses PPH Project data portal.
There currently are 154 QI Projects on the Maps; over 30 states, 4 countries and territories.
Pin your QI Projects on the Maps

Helping perinatal health professionals expand their use of improvement science to eliminate preventable perinatal injuries and deaths.

QI SAVES LIVES!

Mothers and newborns depend on quality improvement (QI) leaders to implement safer, healthier baby policies and practices. In the past 15 years, QI has been shown to improve outcomes for women and babies. The Institute for Perinatal Quality Improvement (IPQI) is the leading national organization focused on perinatal health QI. Our work begins with a strong research base covering the entire continuum of pregnancy, birth, and the first year of life.
Clinical Leaders Share QI Project Details, Contact Information and Tools

Morristown Medical Center

Last updated: 11/7/2017
Pamela Mellin, Morristown Medical Center
Premium 3 Facility Subscription (3000+ Births)
pamela.mellin
5 Steps to Success

1. Assemble the Perinatal QI Action Team (Mobilize)

2. Review data & Identify QI opportunities (Assess)

3. Develop the Action Plan, set goals & metrics (Plan)

4. Implement the Action Plan (Implement)

5. Measure your progress (Track)
Structural changes are sustainable changes

Dig a ditch and that is where the water will flow