Disclosures

- We have no affiliations with any vendors that may be mentioned in this presentation

Goals for Presentation

- By the end of the presentation it is our hope that you gain insight into the safety initiatives occurring within the Saint Alphonsus Health System and CHE/Trinity

- Appreciate that for every improvement statistic is a life better served
Saint Alphonsus Health System Background

- Saint Alphonsus is part of CHE/Trinity Health System

CHE Trinity Health at a Glance

- One of the largest Catholic health systems in the United States (based on Operating Revenues)
- 21 States
- 20 Health systems, encompassing 66 hospitals
- 37 Hospitals provide Obstetrical services
- More than 607,000 total births annually — about 1.7 percent of the nation’s total
- Average annual births at each Hospital ranges from 90 to 9,700


Question: Do MDs and RNs work as a well-coordinated team?
Perinatal Safety Is for Every Patient- Every Time

Consistent delivery of the highest quality, safe, efficient care for every person, every time, in every CHE/Trinity Health location.

History of OB Safety Initiative for Saint Alphonsus

- In 2009 Trinity Health (who was later joined by CHE) committed themselves to the Perinatal Patient Safety Initiative (PPSI)
  - The Goal of PPSI:
    - Develop Obstetrical practice across CHE/Trinity consistent with the principles of patient safety and perinatal teamwork
    - Establish practice and policy consistent with professional society published guidelines and standards for practice
    - Implement process improvements based on scientific evidence and safest practice
    - Standardize high-risk obstetrical clinical processes
    - Standardize processes for notification of events, analysis of events, case review and peer review

OB Safety Initiative-Steps to Develop

- **Step One**: Patient Stories: The Stories of patients who could have had better outcomes were shared with CHE/Trinity Risk and Board of Directors and there was an overwhelming commitment to give the best care possible to each mom and baby.

- **Step Two**: Needs Assessment: Dr. Eric Knox and Dr. Kathleen Rice Simpson visited each OB unit to identify needs/gaps for developing the CHE/Trinity Perinatal Patient Safety Action Plans
Step 3: Develop a Steering Team

PPSI Developed Steering Team

- The Steering Team consists of:
  - A small group of clinical experts from various Regional Health Initiatives
  - Members of the system office Perinatal Patient Safety Initiative team

Team Purpose:
- Provide direction for the CHE Trinity Health PPSI
- Provide professional practice standards, strategies, and clinical pipelines to the organization
- Utilize recommendations from Perinatal Patient Safety Initiative Collaborative in decision-making
- Reports to the Unified Clinical Organization (UCO)
- Meets monthly

Beyond the Steering Teams were the people implementing the work...

The Collaborative Team:
The Collaborative Team Consists of:
- A nurse and physician representative from each Regional Health Initiative
- System office Perinatal Patient Safety Initiative team

Team Purpose:
- Provide feedback to Steering Team
- Make recommendations regarding the identification and implementation of key care processes in perinatal care
- Implement Perinatal Patient Safety Initiative programs at the local level
- Meets Quarterly

The Local Collaborative Team:
The Collaborative Team Consists of:
- Physician and Nurse Champion
- Multidisciplinary Team

Team Purpose:
- Assist in development of PPSI initiatives
- Implement initiatives locally

Implementation

- Implementation for safety initiatives occurs at each hospital through the local collaborative team
- The Local Collaborative Team is responsible for:
  - Updating Policies
  - Archiving old Policies
  - Educating Staff
  - Initiating Training
  - Motivating Staff/Buy-in: From Teams by Presenting Data; Articles
  - Communicating to Data Team
  - Collecting and Reporting Quality Data
  - Performing Local Audits as needed
  - Supplying records as needed to Corporate offices for yearly Random Audits
  - Reporting questions/Feedback to PPSI
Sustainability

- Patient care is at the core of nursing and the majority of the Providers, so if it makes sense for their well-being it makes sense to implement and sustain.
- Some initiatives tied into Credentialing
- Some initiatives provide a quality discount for Malpractice Insurance
- Some initiatives are now pay for performance
- “Hard Stops;” for quality: It is policy and when you practice at the organization this is the policy and the provider will have to write a note to justify going against organizational/corporate policy.

What Have We been Up Too?

Perinatal Patient Safety Initiative (PPSI)

**PPSI Initiatives Implemented**
- Simulation/TeamSTEPPS Training/Safety huddles and debriefs
- Cervical Ripening
- Electronic Fetal Monitoring
- 39 Week Elective Inductions
- Magnesium Sulfate
- OB Hemorrhage
- OB Staffing
- Second Stage Labor
- VBAC
- Sponge “Accounting”
- Management of Tachysystole

**PPSI Current and Future**
- Continuation of OB Hemorrhage Education
- Safe Use of Oxytocin after birth with 30 mIU in 500mL IV solution
- Quality measurements of administration of antenatal corticosteroids
- Joint Commission Exclusive Breastfeeding Initiative
Results CHE/Trinity Results

- In OB, losses as a percentage of total professional liability costs and average cost per claim have steadily declined
  - These savings allow funds to be redeploed to provide improved patient care
- Elective delivery rates for 39 week gestation results
  - 2009= 15%
  - 2010= 4.9%
  - 2014= .4%
- EFM Certification
  - 95% of Clinicians (Physicians, Nurses, Midwives) are NCC certified in EFM
  - 15 Regional Health Ministries have 100% Certified (Saint Alphonsus Boise, Nampa and Baker City are some of them!)

Results of OB Hemorrhage Education

An average of 25 OB claims per year (FY04 to FY09) decreased to 23 claims in FY10, 13 claims in FY11, and 7 claims in FY12
- 44 children and their families avoided life-changing injuries since the inception of PPSI
Perinatal Patient Safety Win at Saint Alphonsus Regional Medical Center Family Maternity Center

- Elective 39 week Induction Rate Policy has had very Positive Results
  - We have a hard stop for elective 39 week inductions
  - If there is a question it is reviewed by MFM
  - Patients are sent home on date of arrival to FMC if the dates/diagnosis is not correct or appropriate for induction
  - We do provide them information regarding risk of early elective induction

**INDUCTIONS:** Elective inductions can only be scheduled 7 days in advance

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<th>Patient</th>
<th>Phone #</th>
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If the induction is elective and the patient is less than 39 weeks gestation it must be cleared by the OB Medical Director, Dr. Renee Bobrowski at 866-2499:

CLEARED Y / N

Elective Induction Policy

- Elective Induction Policy With Bishop Score Criteria
  - Instituted January 1, 2010
- Data Review
  - July 2009 – December 2009: Pre-policy
  - January 2010 – December 2013: Policy in effect

**Question:** Has using the Bishop Score for elective inductions made a difference for our Patients?

Bishop Score is part of our Induction Policy
Results
Decrease in Elective Induction C/S Rates; Decreases in Primip Elective Induction C/S Rates; Multip Elective Induction C/S Rates

Questions?

"He's a lot more supportive after his nap."