Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Adverse OB & Early Elective Deliveries (EED)

Background

- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 10 of 17 hospitals with OB services responded (59 percent).

Report Information

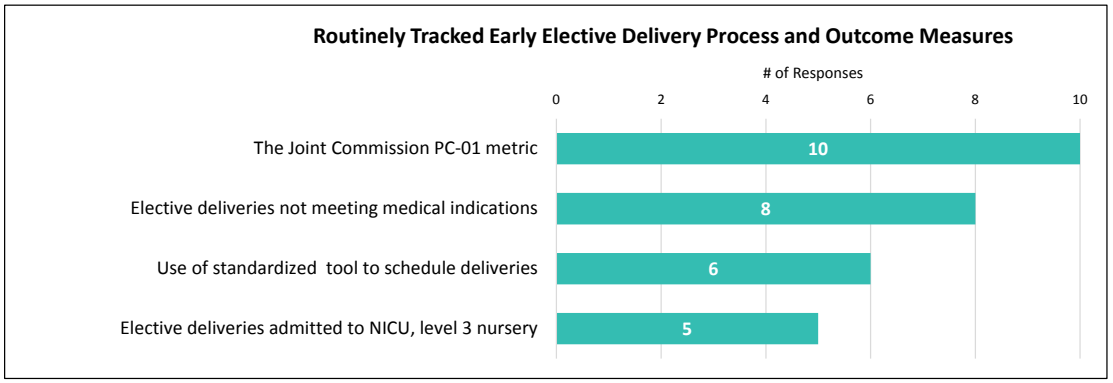
- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The highlight section provides comparisons between conditions and associations with relevant outcome data. The outcome data was collected though UHC's Web Data Entry Portal. The remainder of the report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

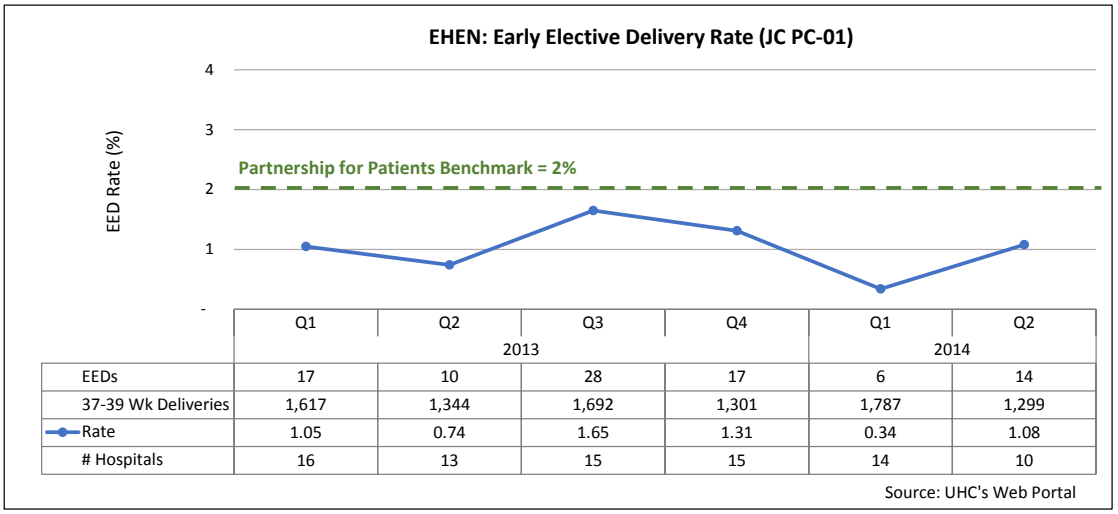
Adverse OB: Best Practice Survey Highlights

In their own words... Top three effective strategies for assessing and managing hypertensive emergencies.

	Top Three Effective Strategies (Identified by the Hospital)		
	#1	**#2**	**#3**
Maricopa Integrated Health System	Development of a protocol to standardize treatment of several elevated blood pressures (aligned with ACOG guidelines)	OB skills fair in March, 2013, and continuing education regarding preeclampsia in October 2013	Provider Ascom phones, specifically to use for hypertensive crisis or hemorrhage
MetroHealth System	Resident didactics	Maternal fetal medicine (MFM) covering L&D	MFM on back-up call for nights and weekends
Regional One Health	Skills fairs for both MD's and RN's	Twice daily huddles attended by entire Women's Services staff (consistently since 2008)	Patient Safety Rounds held every shift with MD's, RN's, Safety RN, and Charge RN
Santa Clara Valley Medical Center	Revised EHR order sets	Increased staff education (RN & MD) via Grand Rounds and materials	

In regard to early elective deliveries... Hospitals in large part took up the challenge by the Partnership for Patients to reduce early elective deliveries (EED) by making it a priority and tracking their processes.





	Q1	Q2	Q3	Q4	Q1	Q2
	2013				2014	
EEDs	17	10	28	17	6	14
37-39 Wk Deliveries	1,617	1,344	1,692	1,301	1,787	1,299
Rate	1.05	0.74	1.65	1.31	0.34	1.08
# Hospitals	16	13	15	15	14	10

Source: UHC's Web Portal

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Adverse OB Events/Early Elective Deliveries

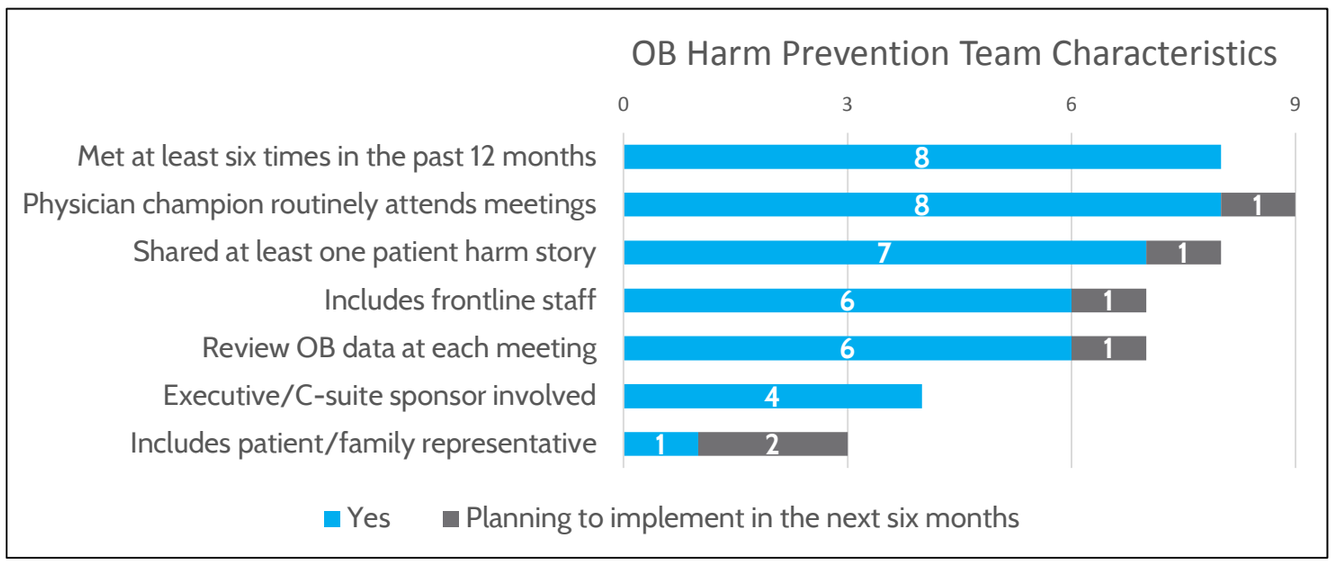
Red Numbers Represent Responses (n=10; Excludes hospitals with no OB services)

Adverse OB Events/EED

1. **Does your facility have a multidisciplinary committee/team (can be an existing committee/team) *actively* working on improving safety and reducing harm from OB/perinatal adverse events?**

9	Yes
0	No (Go to Question 3)

2. **Please answer the following for your OB/perinatal committee/team:**



3. **Which events are your OB/perinatal committee/team actively working to reduce/routinely monitor? Please check all that apply.**

8	Elective deliveries between 37 and 39 weeks gestation/PC-01
9	C-section rates/PC-02
8	Episiotomy rates
9	Maternal hemorrhage
8	Hypertensive emergencies
6	Newborn birth trauma
2	Other: Santa Clara- Maternal Length of Stay

Questions 4-8 pertain to elective deliveries <39/0 weeks gestation

4. **In the past two years, has your organization participated in a state/regional, national, grant-funded or systemwide initiative to reduce elective deliveries < 39 weeks?**

6	Yes, name of the initiative:
3	No

5. **Is reducing elective deliveries a current organizational priority? Check all that apply.**

6	Part of our organizational strategic plan
5	A metric (event count or rate) is included on our senior leadership and/or board reports
9	Part of our quality improvement committee metrics
1	No, not at this time

6. **For process and outcome data related to elective deliveries, does your organization routinely track:**

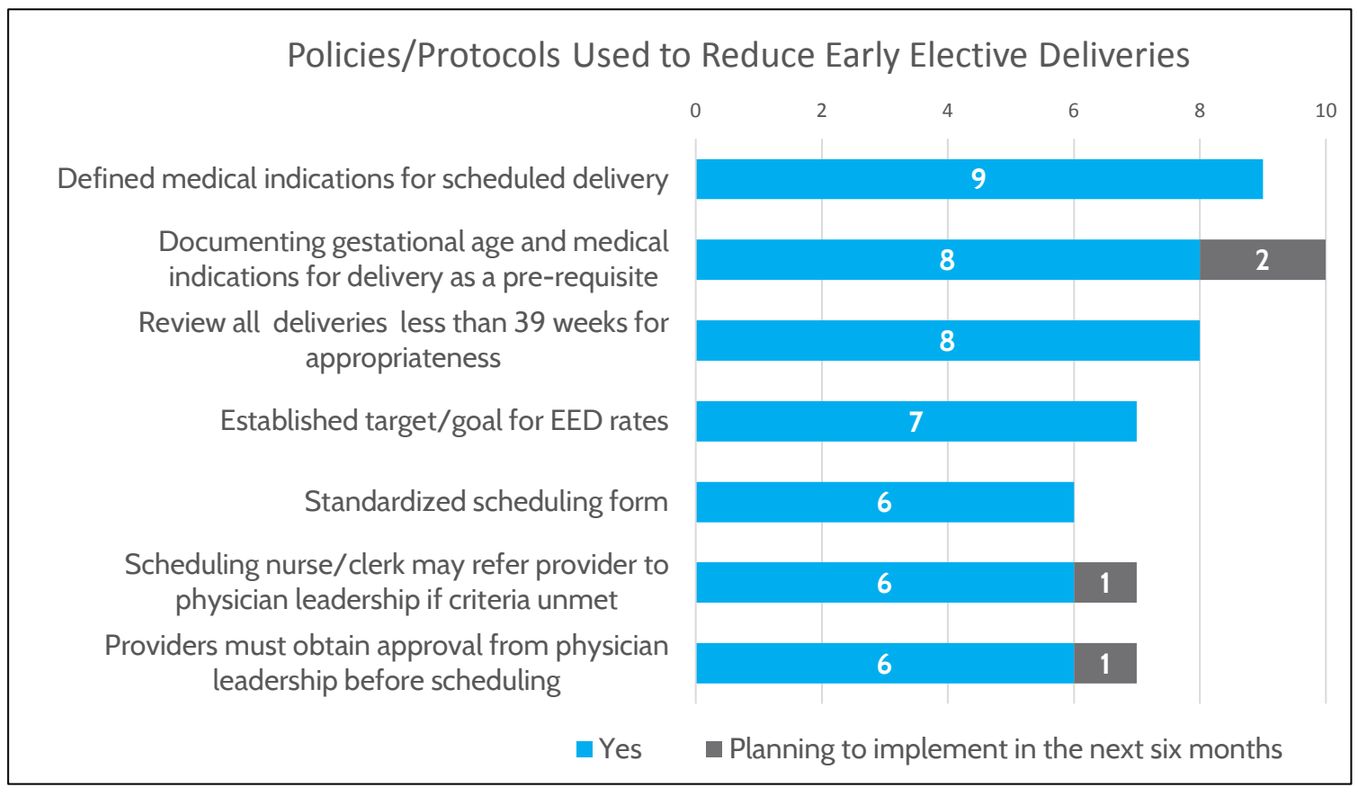
Process and Outcomes	Yes	No
Use of standardized tool to schedule deliveries	**6**	**2**
Elective deliveries not meeting medical indications	**8**	**1**
The Joint Commission PC-01 metric	**10**	
Elective deliveries admitted to NICU, level 3 nursery	**5**	**4**

Adverse OB Events/EED

7. Does your organization have a hard stop policy in place to prevent elective deliveries <39/0 weeks without medical indication?

7	Yes
1	No
1	Not at this time, but we will have in the next six months

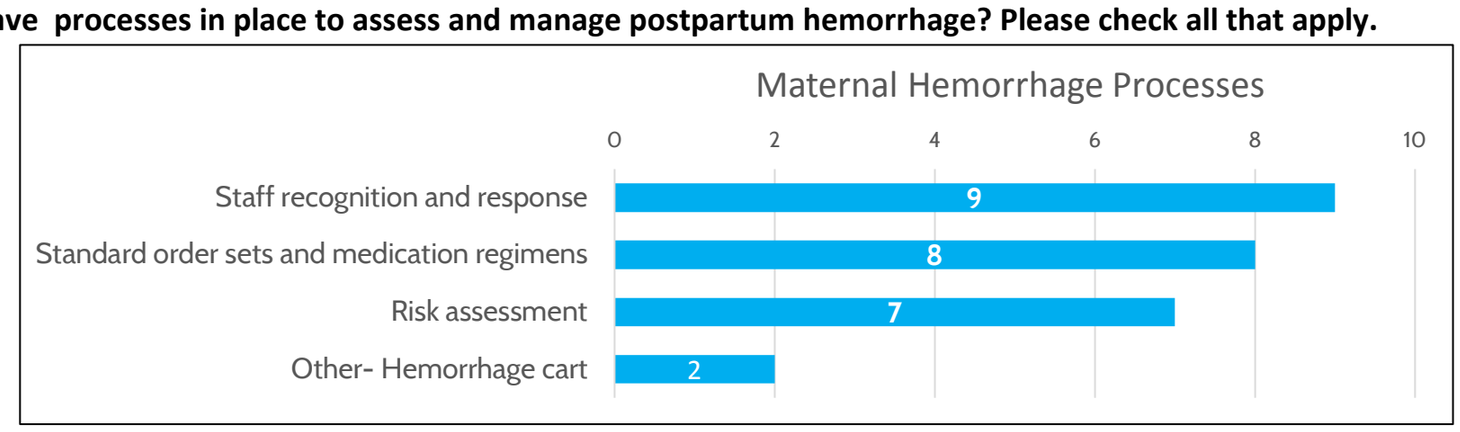
8. Has your organization implemented the following evidence-based policies/protocols to reduce non-medically indicated elective deliveries?



Questions 9-14 pertain to OB adverse events.

9. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for assessing and managing hypertensive emergencies you have implemented in the past 18 months

10. Do you have processes in place to assess and manage postpartum hemorrhage? Please check all that apply.



11. For which hemorrhage measures do you routinely collect and analyze data? Please check all that apply.

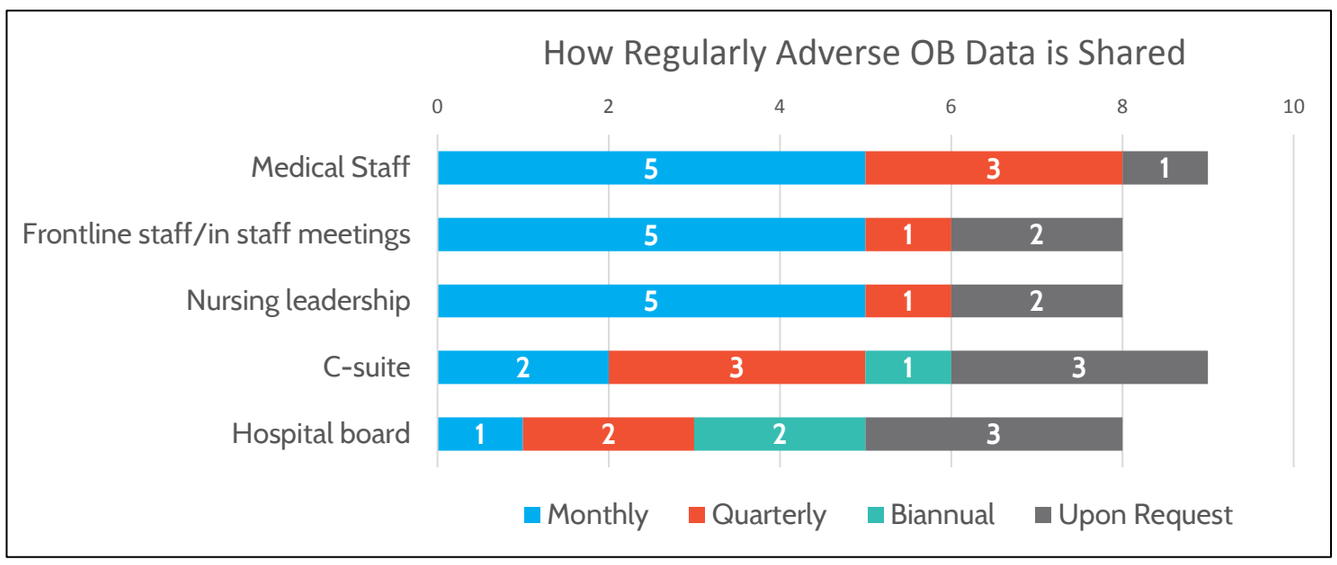
3	Number of women admitted to the labor and delivery unit whose risk of OB hemorrhage has been assessed and recorded in the medical record
6	Number of women who have given birth who were transfused with >4 units of any blood product
3	Other: Santa Clara- Women with EBL>2,000cc ; Contra Costa- Women with excessive blood loss (>500 ml vaginally, > 1,000 ml surgically) Maricopa - Women transfused for postpartum hemorrhage and patients that had a Cesarean Hysterectomy.

12. Our facility provides periodic education/certification on maternal/newborn crisis issues

Topic	Providers	Nurses	Other staff	Education/certification not provided
Shoulder dystocia	**8**	**7**	**4**	**1**
Postpartum hemorrhage	**9**	**9**	**4**	**0**
Hypertensive emergency	**8**	**8**	**1**	**0**
Newborn resuscitation	**9**	**8**	**1**	**0**
Electronic fetal monitoring using NICHD common language	**8**	**7**	**1**	**0**

Adverse OB Events/EED

13. How do you share data on OB adverse events on a regular basis to promote systemwide learning and transparency? Select the best answer for each.



14. Which patient/family engagement strategies are in place in your OB unit(s)? Check all that apply.

7	Routine leadership rounds
4	Patient/family involved in leadership rounds
3	Other: Harbor- Baby Friendly; Regional One- Pt. Safety Rounds