Forming And Sustaining A Large Quality Improvement Collaborative:

Northwest Obstetric Patient Safety Collaborative

The Quality Colloquium
August 2008

Presented by
Marion Constable CNM, MSN
Kristine Larison RN, MBA-HCA
Objectives

- Crisis leads to opportunity
- Collaborative Formation
- Work of the Collaborative
- Accomplishments/results
Crisis and Opportunity
Oregon Malpractice Crisis

- 1999 The Oregon Supreme Court struck down the cap on non-economic damages as unconstitutional.
- Loss of OB providers in critical access areas
- In 2002 the board of NPIC determined that OB claims frequency and severity warranted serious analysis in order to mitigate risk exposure.
Traditional Approach Professional Liability:
Retrospective review of claims: Actuarial perspective (frequency, severity by specialty class, premium)

Change in thinking: Clinical Review

- Review of all OB claims, whether dismissed, settled or went to trial from the inception of the company through the year 2001 (22 years).
- Determine what where the professional liability risks in Obstetrics.
Claims Analysis Findings

- Identified areas of risk:
  - Fetal monitoring: pattern recognition & documentation
  - VBAC: lack of ability to respond and resource uterine rupture
  - Injuries associated with operative vaginal delivery
  - Shoulder Dystocia-management of OB emergency
  - Cesarean Delivery-decision to incision delays
  - Teamwork (lack of)
  - Communication (ineffective, ambiguous, absent)
Once the NPIC task force identified these risk areas they put together a full day OB Symposium in 2003 to address them. “Current Issues in Patient Safety, Practice Performance and Professional Liability Protection”

**Attendance Mandated:** All “insured's” as a condition for future insurability.

**Physicians** asked to invite Perinatal nursing leaders, hospital risk managers and nurse educators.
Collaborative Formation
Shift to Collaborative Learning

- Didactic education programs for the individual practitioner were not producing learner satisfaction or desired results.
- Research ways to more effectively learn and produce change in cross disciplinary teams.
Why a Collaborative?

- **Collaborative Benefits:** Intense effort to share knowledge and improve Perinatal patient safety.

- **Networking**
  - Frequent communication
  - Best practices, access to experts

- **Cooperation**
  - Leap Frog
  - Share experience, shared information, shared ideas

- **Coordination**
  - Intensity
  - Repetition
  - Support structure-coaches-documented progress-
  - Collaborative work products
Original Collaborative Structure

Northwest Physicians Insurance Company OB Collaborative (NPIC)

VP Patient Safety  
D. Zimmer

Program Director  
M. Constable

Chairman OB Task Force  
L. Marzano

Participating Hospitals Oregon/Idaho

Adventist Medical Center-Asante Rogue Valley Medical Center -Asante Three Rivers Medical Center-Holy Rosary Hospital-  
Kaiser Sunnyside Medical Center-Legacy Health System-Legacy Emmanuel-McKenzie Willamette  
Mercy Medical Center-Oregon Health &Science U.( OHSU)-Peace Health Corporation-Peace Health Sacred Heart-Peace Health Harbor Hospital-Providence Health System-Providence St. Vincent-Salem Hospital -Samaritan Albany General- 
Wildamette Falls Hospital-Willamette Valley Medical. Center-Kootenai Medical Center- **17 hospitals**

OB Emergency Team Response  
EFM Common Nomenclature  
Communication SBAR+R

Experts:
Consumers Advancing Patient Safety( CAPS) ,Parents of Infants & children w/ Kernicterus( PICK)  
Hospital Corp. of America (HCA)-Kaiser Permanente: Perinatal Patient Safety Project,  
Partnership for Patient Safety -Physician Insurers Association of America (PIAA)
Current Collaborative Structure

Northwest Physicians Insurance Company OB Collaborative (NPIC)

- VP Patient Safety: D. Zimmer
- Program Director: M. Constable
- Chairman OB Task Force: L. Marzano

Participating Hospitals Oregon/Idaho
- 25 Hospitals
- 3 Health Systems

- OB Emergency Team Response Workgroup
- Simulation Based Training Workgroup

Experts:
- Consumers Advancing Patient Safety (CAPS)
- Parents of Infants & children w/ Kernicterus (PICK)
- Hospital Corp. of America (HCA)-Kaiser Permanente: Perinatal Patient Safety Project,
  Partnership for Patient Safety -Physician Insurers Association of America (PIAA)
Collaborative Structure

- Monthly Conference Call
- Quarterly Topic of interest Webinar
- Annual Patient Safety Symposium
- Content Experts
- Work Group Coach/Facilitator
- Collaborative Member Hospital Teams
Collaborative Learning
Established need for standardized language in the interpretation, description & discussion of EFM tracings. NICHD selected, ACOG endorsed

Researched options for training

Advanced Practice Strategies *Advanced Electronic Fetal Monitoring* e-learning courseware reviewed & offered to collaborative members.

2,500+ seats purchased

Single contract avoid legal fees

>40% volume discount
Perinatal Bundle-2008

- Second collaborative initiative **Perinatal e-learning bundle**
- Shoulder Dystocia
- Operative Vaginal Delivery
- Structured Communication
- 2,800+ seats purchased
- 38% volume discount
The group developed a “SBAR+R Toolkit” Consisting of 26 educational aids designed to facilitate the implementation.
OB Emergencies Team Response

- Evaluate perceptions about the value of team training to improve preparedness for OB emergencies.
- Anonymous survey administered to all staff who respond to obstetric emergencies in 7 Oregon Collaborative hospitals from June 2006-August 2006.
- 614 (74.5%) staff responded
Teamwork

- 90% felt confident the appropriate staff would respond to an OB emergency.
- 50-70% reported that other staff were confused about their role in an OB emergency.
- 84% were confident that emergency drills or simulation-based team training would improve team performance.
Teamwork

Figure 2. Rating of Teamwork Effectiveness (1=least effective versus 10=most effective)

By Hospital Delivery Volume

P for trend < 0.0001

Deliveries/Year

* Adjusted for team, delivery and OB emergency experience, training to work as a team, length of training and working in same institute

STORC Safety Initiative: A Multicenter Survey on Preparedness & Confidence in Obstetric Emergencies

Jeanne-Marie GUISE, MD, MPH123, Sally Y. SEGEL, MD1, Kristine LARISON RN4, Sarah M. JUMP MD, MPH1, Marion CONSTABLE, RN, MSN, CNM4, Hong LI MD2, Patricia OSTERWEIL BS1, Dieter ZIMMER FAAMA4
Teamwork

Figure 2. Rating of Teamwork Effectiveness (1=least effective versus 10=most effective)

* Adjusted for hospital size, delivery and OB emergency experience, training to work as a team, length of training and working in the same institute

STORC Safety Initiative: A Multicenter Survey on Preparedness & Confidence in Obstetric Emergencies
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Teamwork: Simulation

- Established network to support hospitals
- Develop a sustainable simulation program.
- Develop Simulation Specialists
- Access to simulation training opportunities
- 15 hospitals in the NPIC Simulation program attend training sessions, network, share ideas and information as they develop simulation programs in their organizations.
- Simulation focus group
Collaborative Structure

- Monthly Conference Call
- Quarterly Topic of interest Webinar
- Annual Patient Safety Symposium

Work Group Coach/Facilitator

Content Experts

Collaborative Member Hospital Teams
Collaborative Learning: Webinars

Team Stepps
Collaborative Structure

- Work Group Coach/Facilitator
- Monthly Conference Call
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Collaborative Learning: Annual Symposium

From Team Building To Team Performance:
"Putting Theory into Practice"

Raising the Bar in OB Patient Safety

OB Collaborative Symposium
April 20-21, 2007

Achieving Safety and Excellence in the Inpatient Setting

Joint OB/Surgical/Medical Collaboratives Annual Conference
May 7, 2008
Oregon Convention Center
Portland, Oregon
Collaborative Results
Results

- Variables Impacting reduction in claims frequency-
  - National impact-Tort reform
  - Increase awareness
  - Local patient safety efforts
Partnering with Harvard’s Risk Management Foundation and Advanced Practice Strategies, The Doctors Company is offering its physician members free of charge the online bundle of Perinatal courses. To qualify for the premium credit, physicians must complete the courses and implement a patient safety communication protocol plan in a 12-month period.
Collaborative Funding

- **Annual Cost-2005**
  - Consulting Costs—Includes all facilitation activities) $65,000
    Includes travel, lodging and meals expenses, etc.
  - Conference call telephone and webinar charges $5,000
  - Annual OB Symposium (includes faculty/speaker fees) $17,000
  - Printed materials and mailings $2500

- **Total Annual Cost:** $89,500

- Total cost underwritten by NPIC
## Collaborative Funding

- **Annual Cost-2006-2007**
  - **Consulting Costs**—Includes all facilitation activities: $65,000 ($65,000)
    - Includes travel, lodging and meals expenses, etc.
  - **Conference call telephone and webinar charges**: $5,000 ($5,000)
  - **Annual OB Symposium** (includes faculty/speaker fees): $17,000 ($17,000)
  - **Printed materials and mailings**: $2,000 ($2,000)
  - **Simulation Program**: $50,000 ($38,000)

**Total Annual Cost**: $139,500 ($127,500)

**Simulation Program offset by Voluntary Sponsorship Support**

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**Total Annual Cost**

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Collaborative Sustainability

- Moving toward a sustainable funding model for the future. Hospitals are being asked to participate in a shared fee structure based on staffed beds according to the American Hospital Association annual report.

- NPIC will continue to fund 50% of the collaborative costs with hospitals funding the remaining 50%.
Thank you

- Questions

- Contact Information
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