



Vanderbilt University Hospital, Nashville TN

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Adverse Event Title and Baseline Rate: **Early Elective Delivery Baseline Rate 26.8% 2008**

Vanderbilt began to formally address the early elective delivery issue in 2006. In 2008, entered into a newly formed state-wide perinatal quality program Tennessee Initiative for Perinatal Quality Care (TIPQC). Vanderbilt is into its 4th year of the TIPQC <39 week initiative. We continue to actively monitor the scheduling of <39 week gestation patients. We report our progress annually to our peers at the TIPQC Annual meeting every March. Baseline rate in 2008 was 26.8%.

A group of Davidson County Hospitals gathered to look at an attempt to decrease the incidence of < 39 week deliveries. Our physician champions were Bennett Spetalnick, MD, and Frank Boehm, MD, and our data analyst was Chris Williams. The Center for Women's Health Quality Consultant, Kim Domaradzki, BSN, RN, joined the team in July of 2010. Individual hospitals formed their own customized process to address the process and submitted cyclic data into a RedCap system supported by TIPQC. Vanderbilt chose to follow the Leapfrog/Joint Commission guidelines for indications for elective deliveries, which was stricter than most others. Other measures at the time did not include higher order repeat cesareans or classical cesarean sections. Because we used the Leapfrog measure, our rates appeared higher than those who were using other measure definitions and criteria (Joint Commission and March of Dimes).

In 2009, our elective delivery rate according to Leapfrog criteria was 11.7% (including . repeat C-Sections) and .59% which were truly elective(2 cases). In 2010, our elective delivery rate according to Leapfrog criteria was 11.67% (including repeat C-Sections) and we had "zero" actual elective deliveries delivered at <39 weeks. During the early years of this project, rates were also high due to the lack of multiple hard stops.

Leadership Engagement: Since 2006, we have had the support from the OB GYN Chairman, the Vice Chairman of OB and the Medical Directors. As part of the leadership team, Nicole Herndon, MSN, RN, NNP-BC, NEA-BC, Assistant Administrator for the Center for Women's Health and Kim Domaradzki BSN RN, have provided consistent support to this initiative.

Implementation of Hard Stops: What distinguishes our hospital from others is that we have multiple hard stops instead of just one.

Hard stop #1: OB Scheduler

Hard stop #2: Labor and Delivery Medical Director

Hard Stop #3: Vice Chairman of OB Services

Finally, if the patient is admitted for delivery, the charge nurse becomes hard stop #4 if the patient does not meet criteria. To support this effort, the multidisciplinary OB team meets in a daily huddle and they “run the board.” Occasionally, patients are sent home if they do not meet medical criteria with extensive patient education provided. This needs to happen only one time, for a physician to change their practice.

Education for Physicians, Staff and Patients:

All providers and staff received education specific to the best practice guidelines and the medical criteria for induction. We have a fabulous electronic newsletter that goes out to all multidisciplinary staff every Thursday evening – all services across the continuum of care (OR, Anesthesia; L&D; Postpartum; OB Clinics, etc) receive timely updates about changes in policy, new decisions, best practice guidelines, new technology, supplies, and news that we request all providers and staff to know.

We also have an OB Patient Care Center Committee which consists of provider representatives from midwifery, OB, Maternal Fetal Medicine, Nursery, Anesthesia, and NICU as well as nursing management and educators from L&D, Postpartum, Nursery and the NICU who meet monthly to plan and implement changes in process and policy across the service.

The patient education program is currently being revised to add a stronger emphasis on education regarding EED in the prenatal period through changing our childbirth class’s curriculum, placement of March of Dimes Late Preterm Brain Development Card and AWHONN “Go The Full 40” Posters in the clinic. All serve to present a more robust message to women and their families specific to the need for EED reduction and the potential health impact on mother and baby.

The biggest challenge to holding firm to refusing to schedule elective deliveries <39 weeks has been those requested for social situations – they are the most heart wrenching. We are located near a military base and there are times when expecting mothers want to deliver before their husband is deployed, so that the father can see his child before he goes, uncertain as to whether or not he will return. These decisions are made based on the situation and the gestational age of the neonate.

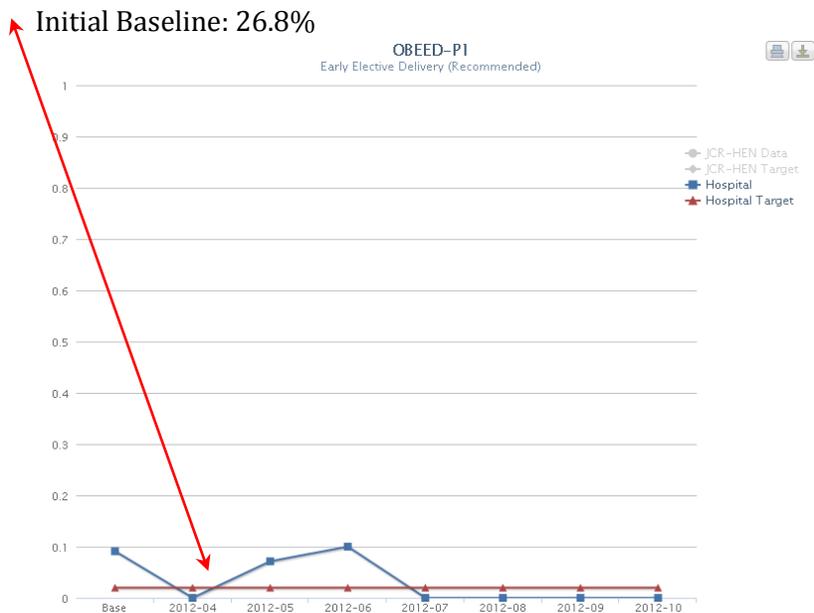
Communication Plan: The communication plan including the high level goal of reducing all early elective delivery excluding those meeting medical criteria was discussed at various venues across the department from faculty meetings to the OB-Patient Care Center meetings, and was disseminated via various departmental newsletters, etc.

Evaluation Strategy:

We manually review all <39 week deliveries for outliers, which are then escalated to our medical director. There has not been an issue for the past 1.5 years. Our progress is reviewed monthly on our quality dashboard, and discussed at departmental meetings. It is then reported annually to Leapfrog, and now monthly to our JCR HEN. We currently are using the Joint Commission EED measure which denotes the July 2012 change in the data overall to zero defect.

Maintenance and Improvement Strategy:

The scheduler continually reviews online submissions of induction or Cesarean Section scheduling requests and notifies the medical director if any do not appear to be medically indicated.



	Base	2012-04	2012-05	2012-06	2012-07	2012-08	2012-09	2012-10
Hospital	0.09091	0.00000	0.07143	0.10000	0.00000	0.00000	0.00000	0.00000
JCR-HEN Data	0.05556 (21)	0.03642 (17)	0.03183 (20)	0.04201 (22)	0.04219 (20)	0.06820 (14)	0.04643 (15)	0.06667 (7)

What has been embedded in the system that has sustained the change?

1. Multiple Hard stops – with team support
2. Development of a cultural norm over time
3. Persistent Teamwork
4. Vigilant Monitoring and Reporting

Respectfully submitted by: Nicole Herndon and Kim Domaradzki

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