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Implementation of Preterm Labor Assessment Toolkit, a System-wide Initiative to Improve Preterm Labor Outcomes

Narrator:
Welcome to ReachMD. This is a special addition of Advances in Women's Health, sponsored by Hologic. Here is your host, Dr. Renee Allen.

Dr. Allen:
Preterm birth is a serious problem within the United States, with approximately 12% of all live infant births occurring before term, or 37 weeks' gestation. Given that preterm births are associated with neonatal and infant mortality, as well as several other longterm complications, it is clear that preterm birth poses a significant healthcare burden. My guest today authored an article titled, "Implementation of PLAT, or Preterm Labor Assessment Toolkit, a System-wide Initiative to Improve Preterm Labor Outcomes," that was published in the January issue of Contemporary OB/GYN. My guest joins me to explain how her own medical center has adopted and uses the PLAT system currently to diagnose preterm labor.

This is Advances in Women's Health, and I am your host, Dr. Renee Allen. I would like to welcome, Lashea Wattie, a nurse at Wellstar Kennestone Regional Medical Center in Marietta, Georgia. Ms. Wattie, welcome to the program and thank you for being with us today.

Ms. Wattie:
Thank you. Thank you for having me.

Dr. Allen:
Ms. Wattie, what are some of the challenges that healthcare professionals face in diagnosing or identifying preterm labor?

Ms. Wattie:
Yes. There are clear challenges to providing appropriate interventions such as antenatal corticosteroids, due to the difficulty in actually identifying women with preterm labor who will ultimately give birth prematurely. Uterine contractions pose a challenge, as noted in the ACOG Practice Bulletin, number 127, the assessment of preterm delivery risk, based on symptoms and physical examination alone, is inaccurate. Changes in the uterus and cervix occur as pregnancy progresses to term. In preterm labor, cervical ripening and decidual activation occur earlier than uterine contractions, and may be difficult to detect. Thus, per Iams, it is not uncommon that diagnosis of preterm labor is established based on the high threshold criteria of severe uterine contractions of 6 or more per hour, cervical dilatation of greater than 3 cm, and 80% effacement accompanied either by vaginal bleeding or rupture of fetal membranes. At this point, delivery may be inevitable, yielding insufficient time to prepare the fetus for premature birth. As low threshold criterion, uterine contractions alone are a poor positive predictor of true preterm labor. They will occur 4 or more times in an hour in up to 25% of pregnancies less than 32 weeks. Many women diagnosed with preterm labor based solely on the high threshold criterion of 6 or more uterine contractions per hour, will go on to deliver at term. And the second part of your question, and actually identifying those women with preterm labor, is difficult because more than half of the women who deliver preterm do not have identifiable risk factors. And the approximate two-thirds with known risk factors, do not deliver preterm, hence the confusion of management of women presenting with symptoms of labor. So, at the present time, fetal fibronectin and short cervix are strong predictors of spontaneous preterm birth than our traditional risk factors.

Dr. Allen:
So then, can you tell our listening audience, how is preterm labor currently assessed?

Ms. Wattie:
Well, if a hospital doesn't have a standardized process or standardized algorithm that they use to assess, typically they're going to be

using subjective data that comes from the patient of her cervical status, contractions. The patient pretty much is going to tell us if she contracting at all, having any pain, has she had any bleeding? And they are also going to be assessing her cervical change, by using cervical exam.

Dr. Allen:
In reference to your article, the March of Dimes has developed a preterm labor assessment toolkit, or PLAT, which enables standardization for the diagnosis of preterm labor. So, can you explain exactly how the PLAT system works?

Ms. Wattie:
Yes. Well, the PLAT system, as you just said, is a standardized initiative and it's really expected to ensure timely and appropriate interventions for improved neonatal outcomes. And it really helps us to provide treatment to patients that really do need it; identify those patients that are truly at risk for preterm labor, and using the appropriate tools to do that. So, this includes the use of standardized tools such as a collection of fetal fibronectin, assessment for premature rupture of membranes, cervical dilatation, and transvaginal ultrasound for cervical length. The March of Dimes PLAT algorithm offers specific interventions based on the risks of preterm birth and available tests. In general, it suggests that patients with preterm contractions accompanied by a positive fetal fibronectin test and/or short cervix, cervical dilatation greater than or equal to 2 cm, should receive antenatal corticosteroids, mag sulfate, and tocolytic therapy. There is a standardized list of interventions that are used within the PLAT system: sterile speculum exam, assessment of cervical status, assessment of cervical change, no tocolysis use prior to completion of assessment, no antenatal corticosteroid use prior to completion of assessment, appropriate disposition decisions, time to disposition, and provision and review of educational materials, are pretty much all of the steps that were included in our PLAT algorithm.

Dr. Allen:
You are listening to ReachMD, and I am your host, Dr. Rene Allen. Speaking with me today is Lashea Wattie, a nurse at Wellstar Health System in Georgia, and we are discussing a system-wide initiative to standardize the diagnosis of preterm labor. Okay, Lashea, getting back to the assessment toolkit, what are some of the benefits for using a standardized system like PLAT?

Ms. Wattie:
With standardization, you can reassure and guarantee that all patients are going to get the same treatment, no matter what time of day or when it is that they arrive at the medical center, or who is caring for them. No matter what the nurse or the physician is, with standardized care, we're going to reduce antepartum admissions and the length of stay, we're going to reduce the amount of tocolysis that we're using because we're using all of the tools that are in our diagnostic algorithm, we're going to increase antenatal steroid use to those patients once we've identified those that truly need steroids, and we're ultimately going to have cost savings.

Dr. Allen:
What about the challenges healthcare systems can face in the implantation of this PLAT system? How are these issues being addressed, in your opinion?

Ms. Wattie:
Well, for my own health system, I think one of the challenges is when you work at a very large facility. We do 6000 deliveries a year, so we have a large amount of physicians, but you need to communicate when there's a new process. We have a large amount of nurses. So, getting that communication out to everyone onboard when we implement new processes can always be a challenge. And the second thing is, again, large amount of nurses to communicate information: dayshift, nightshift, the weekend, of just making sure that everybody gets the message and understands what our standardization is, and what our system is, and how we're looking to address this can be a challenge. And how these issues have been addressed, your second question, is finding multiple ways of communication. What we learned in our PLAT project, that there isn't one right way of communicating information of a new standardized tool. So, utilizing all of the methods that you have available to you, meaning OB department meetings, staff meetings, in-services, CBLs -- clinical-based learning -- CBLs. We use flyers, we use email, huddle notes, so any way that you can communicate with your staff, we've found all of those areas to be effective in helping us to get the message out.

Dr. Allen:
I understand that Wellstar Health System in Georgia, where you work, has successfully implemented the PLAT system which resulted in decreased overall OB triage time and increased cost savings. How was this health system successful in utilizing the PLAT program?

Ms. Wattie:
Well, I have to say that at Wellstar we have created a culture of safety. So, it is part of the workflow that we use on a regular basis, that Wellstar really prides itself on providing the highest standard of care. We're committed to providing the highest standard of care, and whenever we're given an opportunity to be a part of a standardized process, or something that's evidence-based that will help us to improve that, I have to say that our nurses and physicians are always onboard. So, I'm very fortunate in working in that type of

environment where creating safety, and making changes related to that, is quite easy. The second thing is having that 200% accountability. And so, basically, if you have a physician and you see that he isn't using the PLAT, or you call him on the phone, as we've taught our nurses to say when they had a patient that arrived in triage, to rule out preterm labor, "Hi, I have your patient here, can I implement PLAT?" If a nurse has forgotten to do that, maybe a nurse that overhears the conversation saying, "Hey, you're supposed to ask him if you can implement PLAT. We really need to go through the algorithm." And so, holding each and every one of us accountable, has been one of the ways that we've also been successful in implementing a new process. The third thing is physician champions. We work with some really great physicians in our healthcare system that, again, really pride themselves on providing the highest standard of care and really are committed to improving patient outcomes, and helping our hospital system reduce cost at the same time. And so, those physician champions were very helpful in getting the communication out about how well we were doing in the PIC meetings, our Performance Improvement Committees, PIC, our OB department meetings, again, in staff meetings, and just having that voice to speak to the physicians about what we're doing and the great work that we're doing, and any changes that may have needed to occur. My physician champion was very supportive in that, in that way. And also, a desire just to always look at ways to reduce cost and perinatal outcomes. One of the things that we know from the literature is that our triage admissions, I think nationally, is increasing. The amount of patients that we're seeing in triage. So, any kind of standardized approach that can decrease disposition time, which this project did, and help us to truly identify those patients that need to stay in the hospital, and those that can be discharged, was definitely a win-win for us.

Dr. Allen:
Lashea, we are nearing the end of the interview and I just wanted to take the time in the last few remaining moments, if there was anything else that you wanted our listening audience to know, or to be able to relay to our listening audience regarding the PLAT system or preterm birth?

Ms. Wattie:
Yes, thank you. I actually wrote an article specifically about PLAT, "Implementation of PLAT, a System-Wide Initiative to Improve Preterm Labor Outcomes," in the Contemporary OB/GYN, January 2017, and I urge everyone to get that article and look at it. And it goes into more of the specifics of what our findings, our cost savings were for our entire health systems, and some of the clinical recommendations for future practice.

Dr. Allen:
I will definitely look out for your article, Lashea. Thank you so much.

Ms. Wattie:
Thank you.

Dr. Allen:
So with that, I want to thank so much, Ms. Wattie, for joining us and our ReachMD audience today. It was a pleasure having you on the program. Thank you, Lashea.

Ms. Wattie:
Thank you so much.

Narrator:
You have been listening to a special edition of Advances in Women's Health on ReachMD, sponsored by Hologic. If you have missed any part of this discussion, and to find other episodes from Advances in Women's Health, visit ReachMD.com/womenshealth. Thank you for listening.