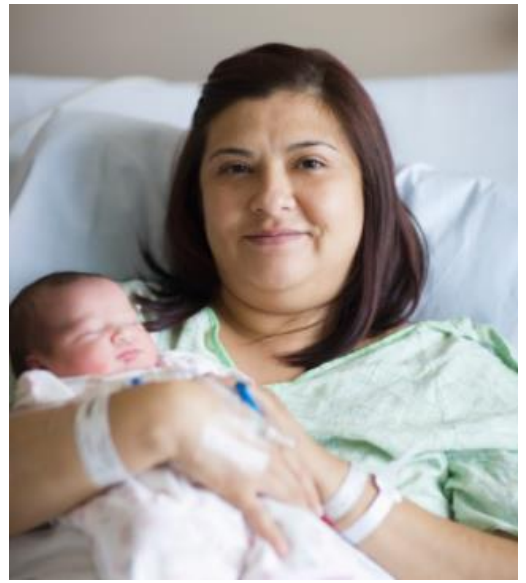
Breakout Session: Targeting Key Strategies for Success as we Plan for 2022

ILPQC
Illinois Perinatal Quality Collaborative

OB Breakout Session Objectives

- Opportunity to focus on key strategies we will need to consider in the year ahead to improve care and make progress in achieving initiative aims.
- We will share applied QI examples, break down into small discussion groups and have a panel discussion with QI leaders with each section.
- Please share ideas and post questions in the chat box. We need to hear from you!



OB Breakout Overview

- 2:30-2:50pm Mothers and Newborns affected by Opioids (MNO)- OB
- 2:50-3:20pm Promoting Vaginal Birth (PVB)
- 3:20-3:55pm Birth Equity (BE)
- 3:55- 4:00pm Discussion of future initiatives
- 4:00pm Transition back to main Zoom Webinar for 15 min Wrap-Up and Prizes

Speaker Panel:

- Ann Borders, MD, MSc, MPH
- Marilyn Kacica, MD, MPH
- Barbara O'Brien, MS, RN
- Neel Shah, MD, MPP
- Emily White VanGompel, MD, MPH

Mothers and Newborns affected by Opioids- OB

Key Strategies for Sustainability

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MNO-OB Initiative Aims: What Must We Achieve to Save Lives

≥80% Universal Validated OUD Screening
Prenatally & Labor & Delivery

≥80% Patient Education
Counseling/Materials, Peds Consults

≥70% Medication Assisted Treatment

≥60% Narcan Counseling

≥70% Recovery Treatment Services

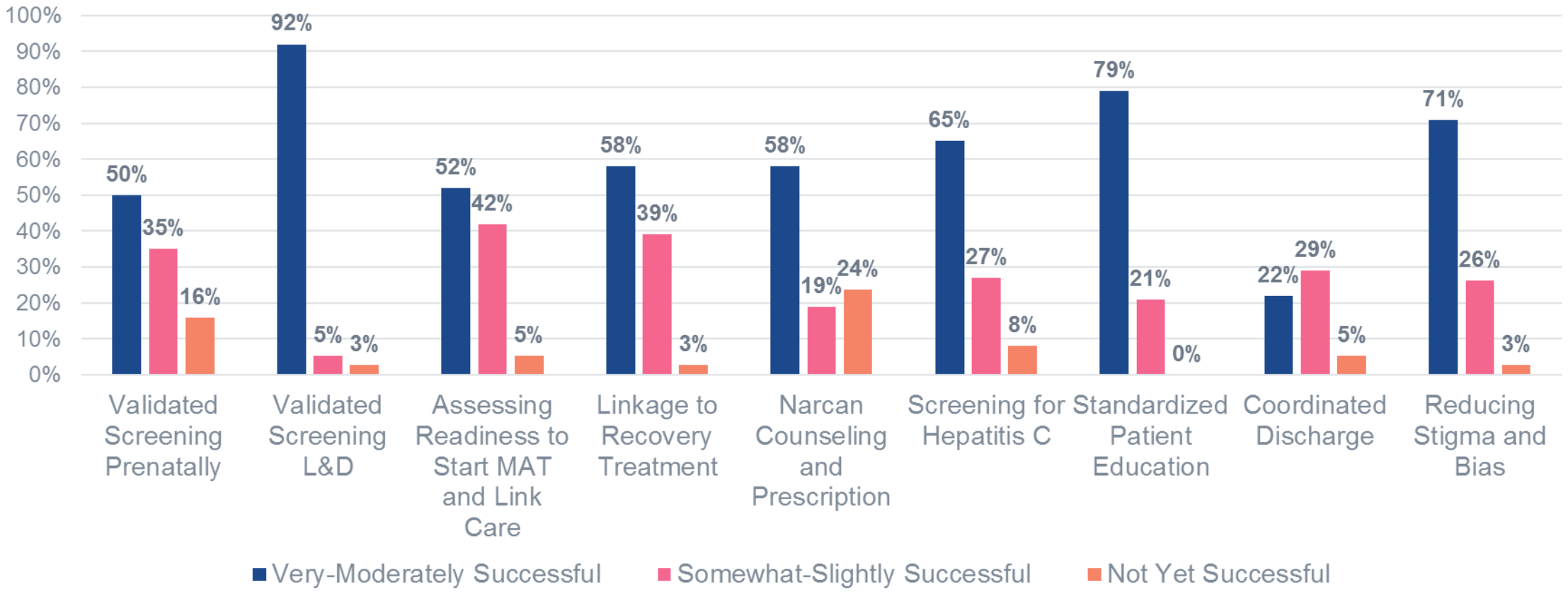
2021 Teams Survey Feedback

Team's Biggest Successes

- Implement universal screening in inpatient and outpatient
- Engaged providers
- Rooming in for improved bonding
- Debrief
- Linking patients with services prior to hospital admission

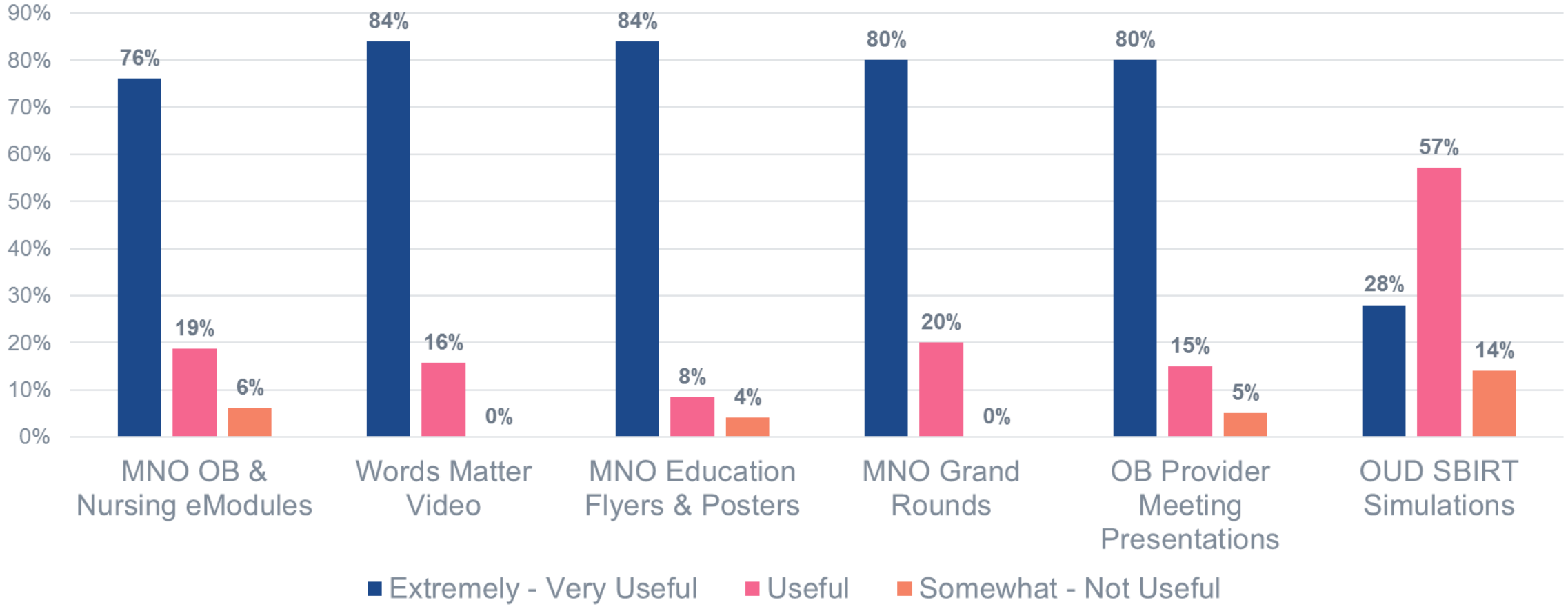
2021 Teams Survey Feedback

MNO-OB Components Integrated into Clinical Culture Change



2021 Teams Survey Feedback

Usefulness of MNO-OB OB Provider & Nursing Education Campaign



2021 Teams Survey Feedback

Most frequent strategies teams report to support Optimal OUD Care

MNO Folders
OUD Clinical Care checklist
Provider, Nurse, and Staff Education
Monthly review of compliance monitoring data
L&D Team Huddles
Missed Opportunity review/debrief
Prenatal Care Conferences

2021 Teams Survey Feedback

Teams report the most frequent MNO-OB key strategies

OUD Stigma/Bias Education	• Stigma/Bias Training Modules • Grand Rounds • Staff and Department meetings • Posters and Handouts
Prenatal Screening Validated Tool	• 5 P Screening Tool in EMR • Worked with Individual Practices; Requested Office Plans • Education at Department meetings
Narcan Counseling and Prescription	• Education to all team members • Created hospital wide policy • Pharmacy involvement, point of care distribution • Added to order set

MNO-OB Successes and Challenges

- Successes:
  - Achieved aims for linking >70% of patients to MAT and Recovery Treatment Services before delivery discharge.
  - Implemented universal validated SUD/OUD screening on L&Ds across IL and sustained > 80% screening aim
- Challenges:
  - We must continue our efforts to **improve prenatal SUD/OUD screening** and **increase Narcan counseling for every patient**
  - Significant variability in optimal OUD care remains across hospitals
- Given rising rates of opioid use disorder and increasing maternal deaths, **essential that all teams achieve optimal OUD care for every patient**

MNO-OB Moving Forward to 2022 – Hospital Team's Role

- Implement compliance monitoring plan
  - Track optimal OUD care
  - Emphasis on prenatal screening & Narcan
- Develop new hire & continuing MNO education plan for providers, nurses, and staff
- Monitor MNO-OB folder stock and reprint & compile as needed
- Review and update local mapped resources for MAT & Recovery Treatment Services

MNO-OB Call to Action

- Help every hospital achieve and sustain optimal OUD care for every patient
- Reduce variability across hospitals in providing optimal OUD care
- ILPQC will continue to reach out to hospitals that need additional support and collaborate with the regionalized perinatal system to support teams achieving success

MNO-OB Questions and Panel Considerations

- How can we best support teams not yet achieving aims?
- What strategies can teams use for ongoing and new hire education?
- What compliance monitoring data is most important?
- How do we continue to engage OB providers and nurses in providing optimal OUD care for every patient, every time?

Speaker Panel:
- Ann Borders, MD, MSc, MPH
- Marilyn Kacica, MD, MPH
- Barbara O'Brien, MS, RN

Share your questions and thoughts in the Zoom Chat Box!

Promoting Vaginal Birth

Key strategies to engage OB providers in clinical culture change strategies to improve the utilization of ACOG/SMFM criteria

IL PQC
Illinois Perinatal Quality Collaborative

Supporting vaginal birth and reducing primary Cesareans for optimal maternal and neonatal outcomes

Aim: 70% of participating hospitals will be at or below the Healthy People goal of 23.6% cesarean delivery rate among NTSV births by December 31, 2022

UPDATED GOAL based in Health People 2030

Goal: Increase the percent of cesarean section deliveries among NTSV births that meet ACOG/SMFM criteria for cesarean

Goal: Increase the % of physicians/ midwives/ nurses educated on ACOG/SMFM criteria for cesarean, labor management strategies/response to labor challenges, protocol for facilitating decision huddles and/or decision debriefs

2021 Teams Survey Feedback

PVB Biggest Early Success Major Themes

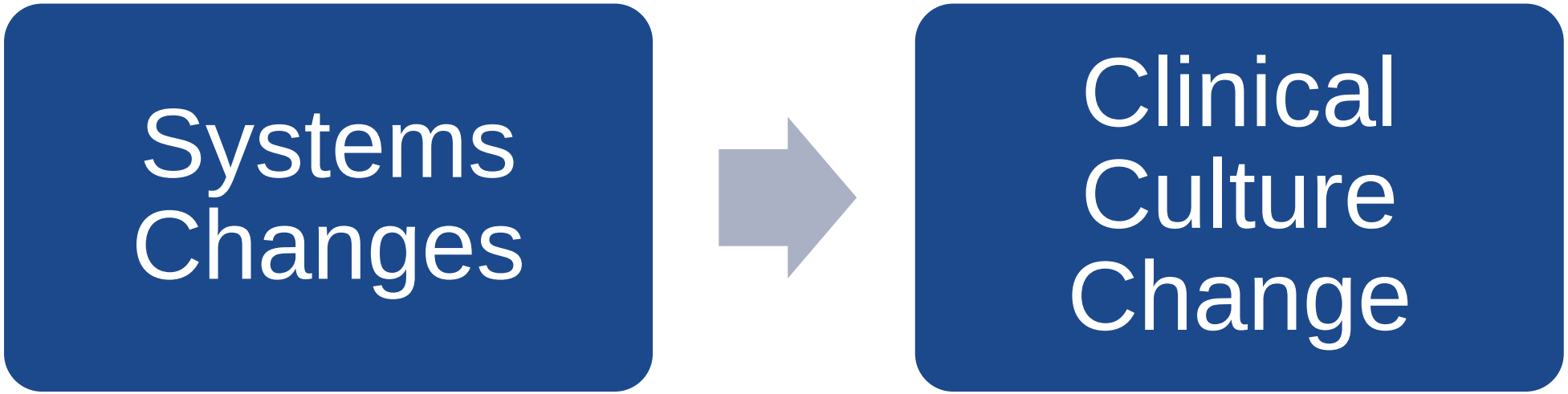
- Nurse Engagement
- Provider and Nurse Education
- Labor Management Support Classes
- Communication Tool/Checklist/Huddles/Debriefs
- Participation in the Labor Culture Survey

Labor Culture Survey in Illinois: shows opportunities for improvement

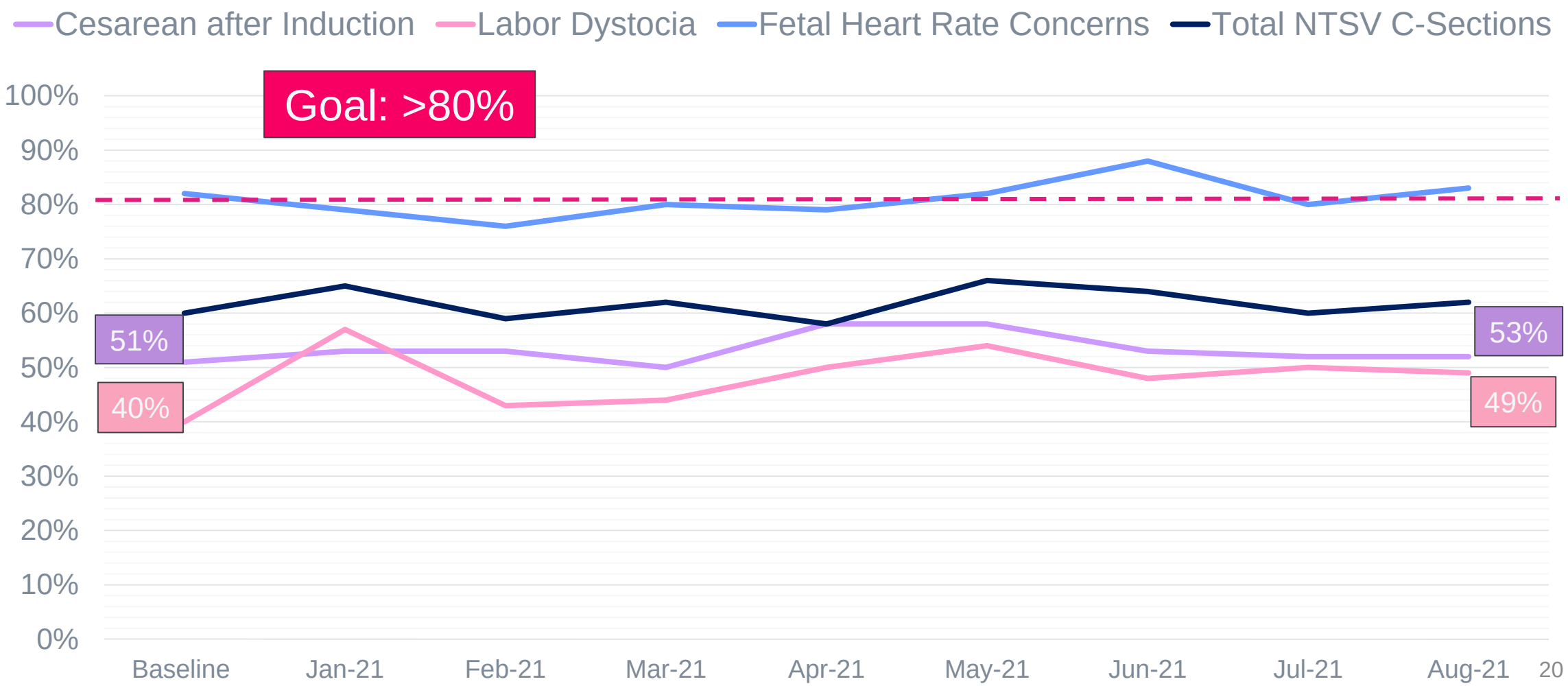
- Individual hospital reports sent June 2021
- Key statewide findings: (compared to Michigan) IL Hospitals were:
  - Less supportive of BEST PRACTICES to reduce cesarean ($p<.0001$)
  - Less likely to endorse their UNIT MICROCULTURE is supportive of vaginal birth ($p<.001$)
  - Less likely to endorse importance of MATERNAL ROLE in birth ($p<.003$)
- Facilitated application and interpretation using the Implementation Guide is ongoing

Systems changes lead to clinical culture change

Teams have had success with implementing system changes, looking ahead we will focus on engaging OB providers in meeting ACOG/SMFM Criteria



NTSV C-sections meeting ACOG/SMFM Criteria, across hospitals



Failed Induction and Labor Dystocia: ACOG/SMFM Guidelines

Failed Induction

- **Oxytocin administered for at least 12-18 hours after membrane rupture**, without achieving cervical change and regular contractions
- **Cervical Ripening used** when starting with unfavorable Bishop score
- **Longer duration of the latent phase** is preferable, **24 hours or longer** if maternal and fetal statuses permit

Active Phase Arrest

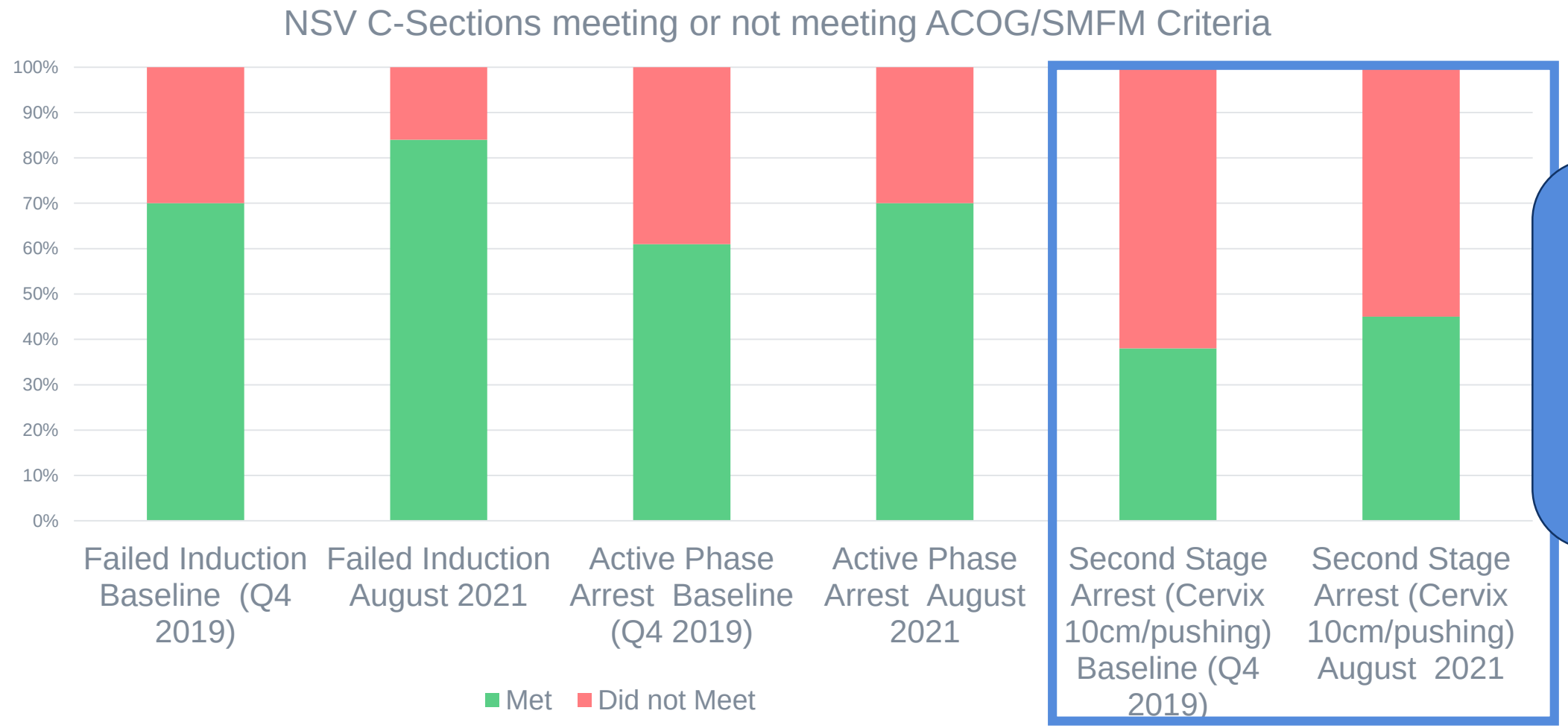
- Cervix **≥ 6cm**
- Membranes ruptured
- No cervical change after **at least 4 hours of adequate uterine activity or at least 6 hours of oxytocin administration with inadequate uterine activity**

Second Stage Arrest

- Fetal position known and rotated if OP
- For **Nullips 3 or more hours of pushing, 4 with epidural**
- For **Multips 2 or more hours of pushing, 3 with epidural**

ACOG Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery (Reaffirmed 2019)

Where do we need to focus improvements for meeting ACOG/SMFM Guidelines?



ACOG/SMFM Criteria for Nullips in the Second Stage:

Allowing 3 or more hours of pushing, 4 hours with epidural

Clinical Culture Change

Identifying NTSVs

Education of ACOG/SMFM criteria for providers and nurses

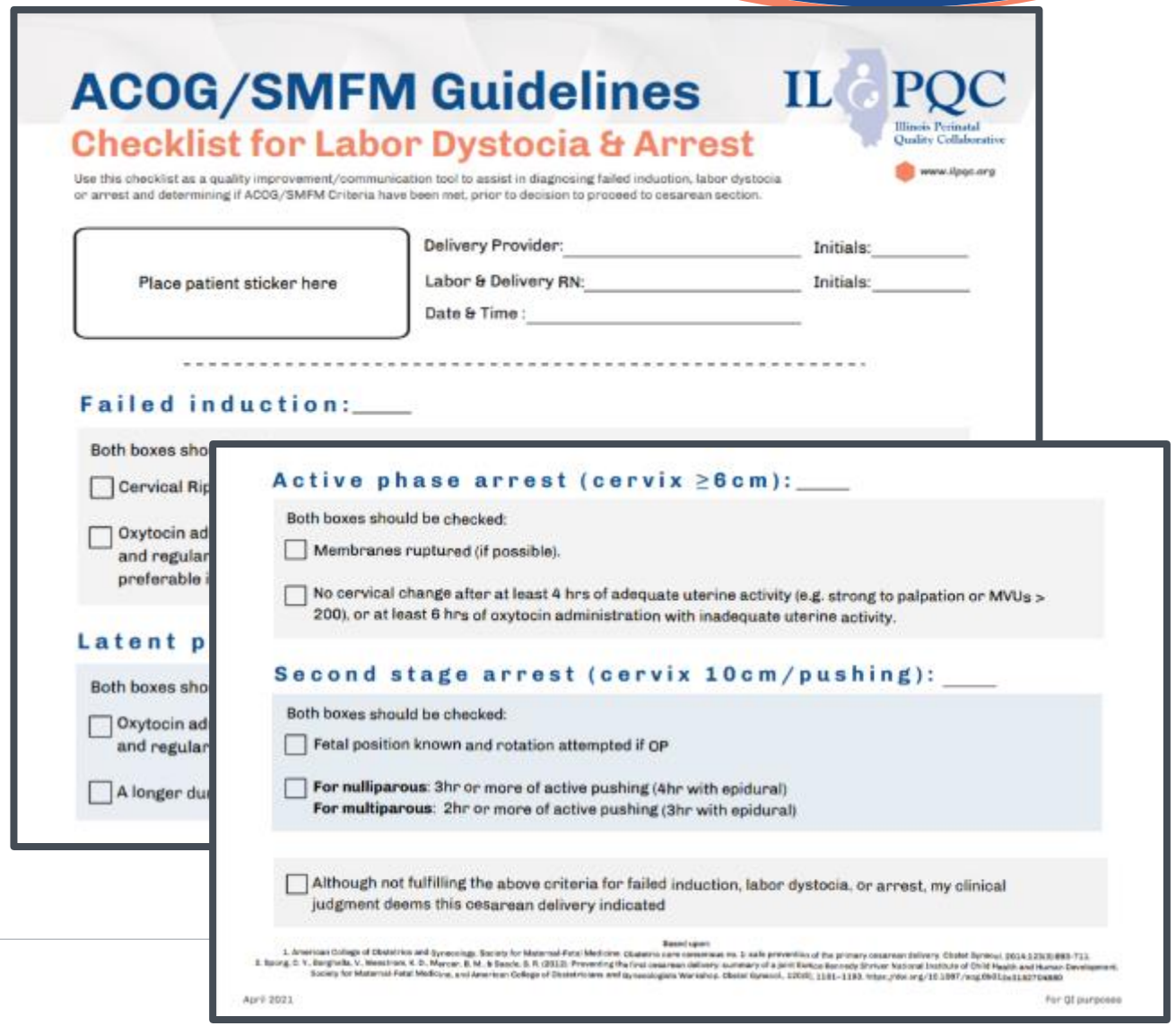
Implementing cesarean decision checklists and huddles

Labor management support

Unblinding Provider data

Resources: Cesarean decision checklists and huddles

- Determine whose buy-in is needed for implementation
- Find your physician and nurse champions
- Start small: Implement use of checklist and huddles with a small group
- Create incentives for use of checklist
- Share successes when checklist is completed, provide feedback



ACOG/SMFM Guidelines

Checklist for Labor Dystocia & Arrest

Use this checklist as a quality improvement/communication tool to assist in diagnosing failed induction, labor dystocia or arrest and determining if ACOG/SMFM Criteria have been met, prior to decision to proceed to cesarean section.

Place patient sticker here

Delivery Provider: _____ Initials: _____

Labor & Delivery RN: _____ Initials: _____

Date & Time : _____

Failed induction: ____

Both boxes sho

Cervical Rip

Oxytocin ad and regular preferable i

Latent p

Both boxes sho

Oxytocin ad and regular

A longer du

Active phase arrest (cervix ≥6cm): ____

Both boxes should be checked:

Membranes ruptured (if possible).

No cervical change after at least 4 hrs of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hrs of oxytocin administration with inadequate uterine activity.

Second stage arrest (cervix 10cm/pushing): ____

Both boxes should be checked:

Fetal position known and rotation attempted if OP

For nulliparous: 3hr or more of active pushing (4hr with epidural)
For multiparous: 2hr or more of active pushing (3hr with epidural)

Although not fulfilling the above criteria for failed induction, labor dystocia, or arrest, my clinical judgment deems this cesarean delivery indicated

Based upon:

1. American College of Obstetrics and Gynecology, Society for Maternal-Fetal Medicine. Obstetric care consensus no. 1: safe prevention of the primary cesarean delivery. Obstet Gynecol. 2014;123(3):693-711.
2. Spong, C. Y., Berghella, V., Wenstrom, K. D., Mercer, B. M., & Saade, G. R. (2012). Preventing the first cesarean delivery: summary of a joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop. Obstet Gynecol, 120(5), 1181–1193. https://doi.org/10.1097/aog.0b013e318270d880

April 2021

For QI purposes

2021 Teams Survey Feedback

PVB – Most Helpful Aspects of the Cesarean Decision Checklist

Makes the physician think about their decision… starts the conversation

Reviewing checklist and sometimes avoiding C/S when criteria is not met

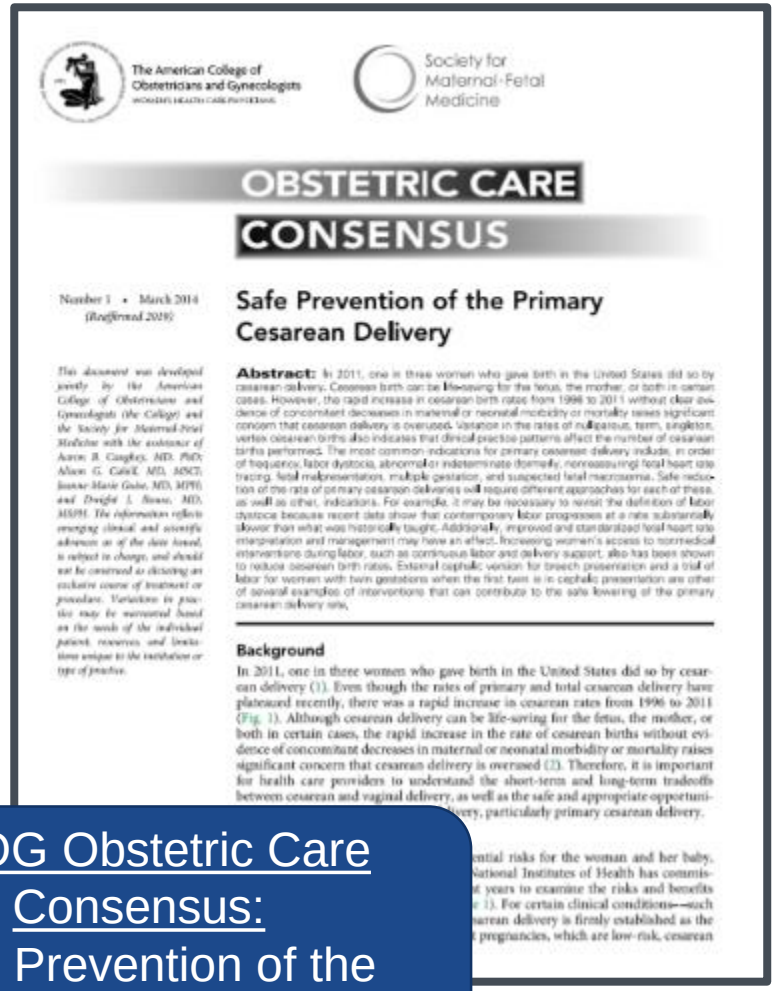
Standardized tool that engages a multidisciplinary collaboration

Setting guidelines for RN to escalate

Allowing open conversation between the provider, staff and patient about need of C/S

69% Implemented Cesarean Decision Checklist (31/45 hospitals)

Resources: Education of ACOG/SMFM criteria for providers and nurses



The American College of Obstetricians and Gynecologists

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Number 1 • March 2014
(Reaffirmed 2019)

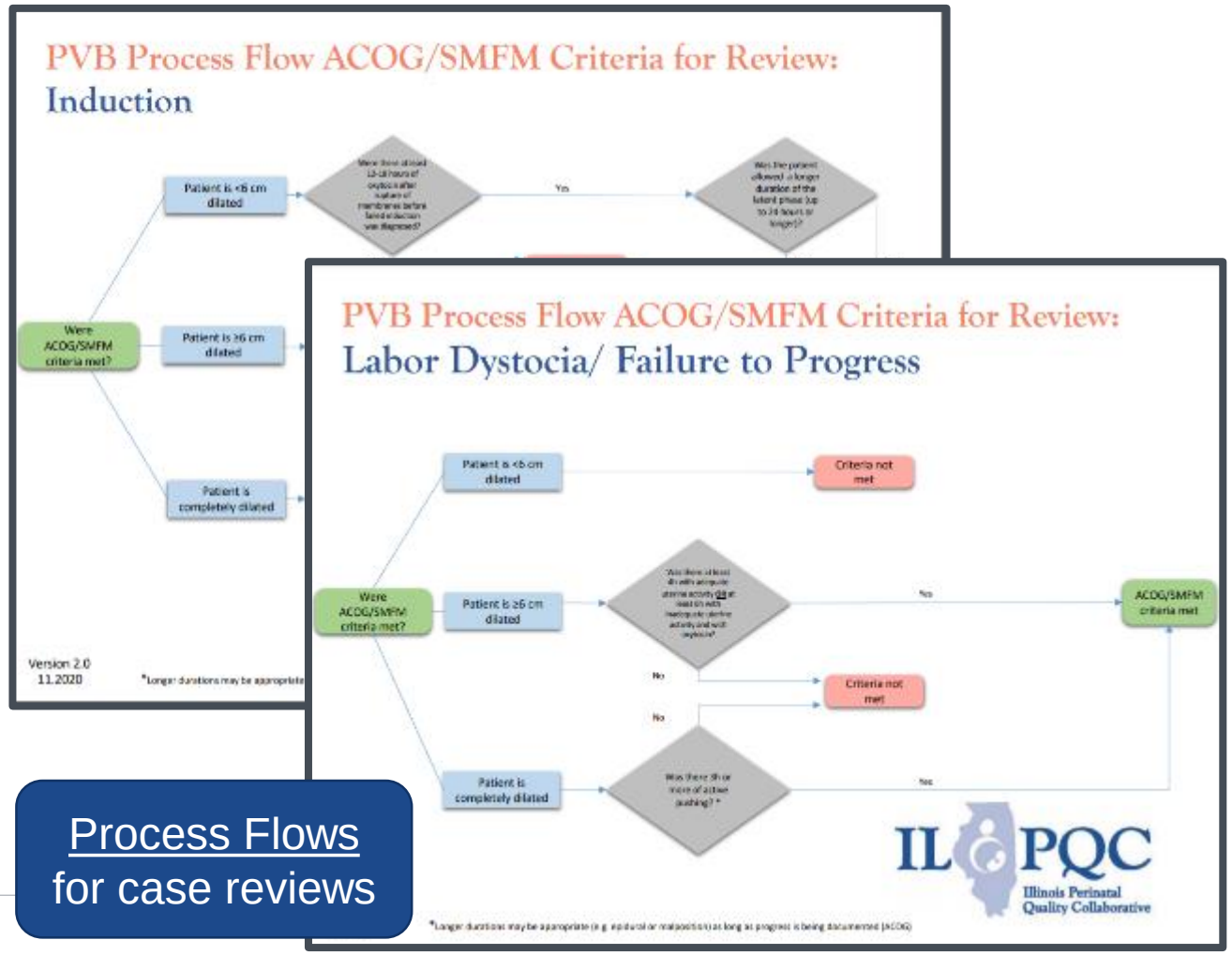
Safe Prevention of the Primary Cesarean Delivery

Abstract: In 2011, one in three women who gave birth in the United States did so by cesarean delivery. Cesarean birth can be life-saving for the fetus, the mother, or both in certain cases. However, the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. Variation in the rates of nulliparous, term, singleton, vertex cesarean births also indicates that clinical practice patterns affect the number of cesarean births performed. The most common indications for primary cesarean delivery include, in order of frequency, labor dystocia, abnormal or indeterminate (formerly, nonreassuring) fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. Safe reduction of the rate of primary cesarean deliveries will require different approaches for each of these, as well as other, indications. For example, it may be necessary to revisit the definition of labor dystocia because recent data show that contemporary labor progresses at a rate substantially slower than what was historically taught. Additionally, improved and standardized fetal heart rate interpretation and management may have an effect. Increasing women's access to nonmedical interventions during labor, such as continuous labor and delivery support, also has been shown to reduce cesarean birth rates. External cephalic version for breech presentation and a trial of labor for women with twin gestations when the first twin is in cephalic presentation are other of several examples of interventions that can contribute to the safe lowering of the primary cesarean delivery rate.

Background

In 2011, one in three women who gave birth in the United States did so by cesarean delivery (1). Even though the rates of primary and total cesarean delivery have plateaued recently, there was a rapid increase in cesarean rates from 1996 to 2011 (Fig. 1). Although cesarean delivery can be life-saving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused (2). Therefore, it is important for health care providers to understand the short-term and long-term tradeoffs between cesarean and vaginal delivery, as well as the safe and appropriate opportunities for delivery, particularly primary cesarean delivery.

ACOG Obstetric Care Consensus:
Safe Prevention of the Primary Cesarean Delivery



PVB Process Flow ACOG/SMFM Criteria for Review: Induction

Were ACOG/SMFM criteria met?

Patient is <6 cm dilated

Patient is ≥6 cm dilated

Patient is completely dilated

Version 2.0
11.2020

PVB Process Flow ACOG/SMFM Criteria for Review: Labor Dystocia/ Failure to Progress

Were ACOG/SMFM criteria met?

Patient is <6 cm dilated

Criteria not met

Patient is ≥6 cm dilated

ACOG/SMFM criteria met

Criteria not met

Patient is completely dilated

IL PQC Illinois Perinatal Quality Collaborative

Process Flows
for case reviews

Resources: Education of ACOG/SMFM criteria for providers and nurses

CMQCC Labor Duration Guidelines

CMQCC
California Maternal Quality Care Collaborative

Labor Duration Guidelines

FIRST STAGE LATENT LABOR: Cervical dilation of 0-6 cm

NORMAL	Difficult to define due to challenge of determining the onset of la • No range exists for the new latent labor definition of 0-6 cm per o Nulliparas (data exists only for 3-6cm): Median dur 17.7 hours o Multiparas (data exists only for 4-6cm): Median dur 10.7 hours • Per Friedman: <20 hours in the nulliparas, and <14 hours in the m
PROLONGED	• No range exists for the new latent labor definition of 0-6 cm o Nulliparas: >18 hours from 3-6cm o Multiparas: >10.7 hours from 4-6cm • Per Friedman: >20 hours in the nulliparas, >14 hours in the multip

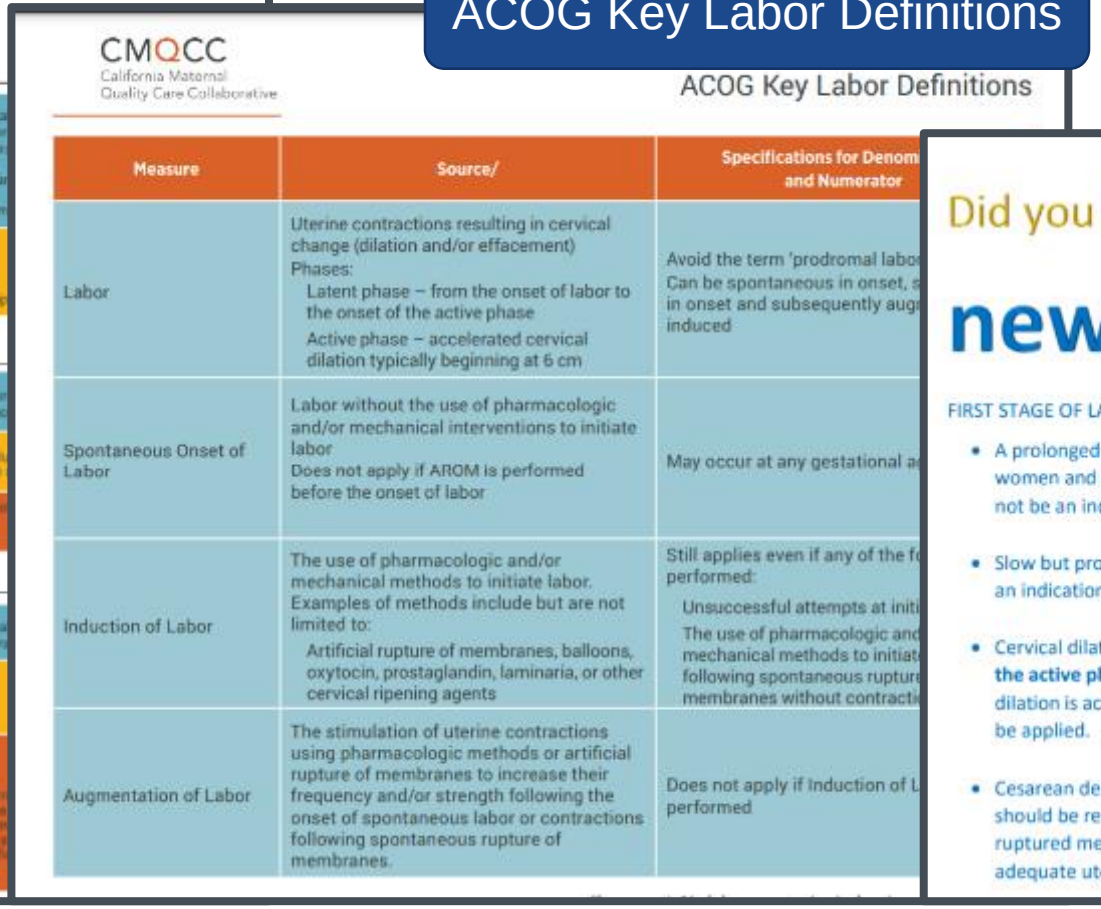
FIRST STAGE ACTIVE LABOR: Cervical dilation of 6-10 cm

NORMAL	• Nulliparas: Median duration of 2.1 hours; 95th percentile 7 hour • Multiparas: Median duration of 1.5 hours; 95th percentile 5.1 ho
PROLONGED/ SLOW SLOPE	• Slow progress from 6-10cm: Presence of labor progress, but du range of normal (> 7 hours in a nulliparas, or > 5 hours in
ARREST	Dilation of 6 cm or more, with membrane rupture and absence o • 4 hours OR MORE of adequate UCs (MVUs >200) OR • 6 hours OR MORE with Pitocin if UCs inadequate

SECOND STAGE LABOR: Complete dilation to birth of the neonate

NORMAL	• Nulliparas: <3 hours WITHOUT epidural, <4 hours WITH epidura • Multiparas: <2 hours WITHOUT epidural, <3 hours WITH epidur
PROLONGED	Presence of descent, but duration outside normal range. • Nulliparas: >3 hours without epidural, >4 hours with epidural • Multiparas: >2 hours without epidural, >3 hours with epidural
ARREST	No (or minimal) descent after good pushing efforts for: • Nulliparas: >3 hours without epidural, >4 hours with epidural •Multiparas: >2 hours without epidural, >3 hours with epidural *NOTE: According to a 2014 retrospective cohort study by Che who delivered vaginally and had normal neonatal outcomes, tha stage labor with epidural anesthesia is more than two hours gre (as opposed to one hour when compared to women in second s Additionally, according to the ACOG/SMFM guidelines, a specifi for the second stage of labor has not been identified.

ACOG Key Labor Definitions

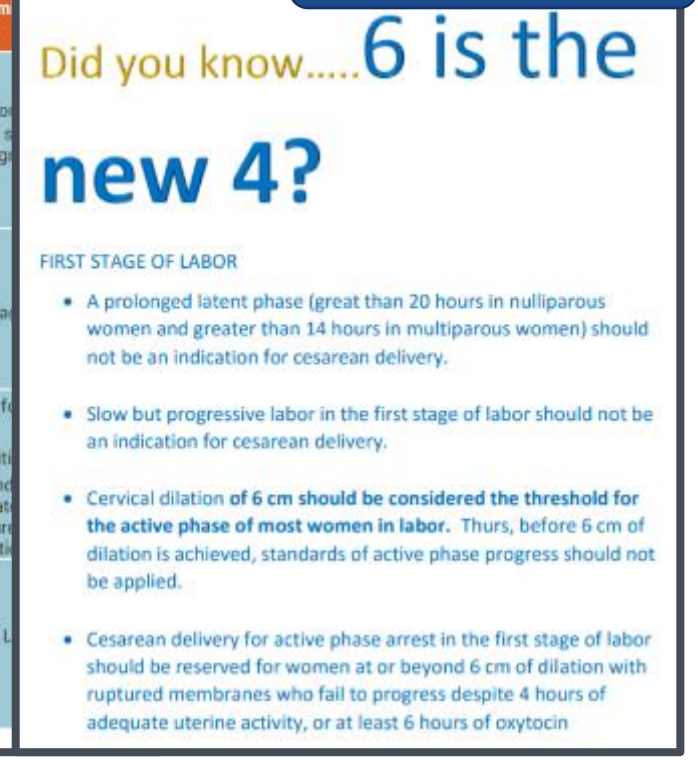


CMQCC
California Maternal Quality Care Collaborative

ACOG Key Labor Definitions

Measure	Source/	Specifications for Denom and Numerator
Labor	Uterine contractions resulting in cervical change (dilation and/or effacement) Phases: Latent phase – from the onset of labor to the onset of the active phase Active phase – accelerated cervical dilation typically beginning at 6 cm	Avoid the term 'prodromal labo Can be spontaneous in onset, a in onset and subsequently aug induced
Spontaneous Onset of Labor	Labor without the use of pharmacologic and/or mechanical interventions to initiate labor Does not apply if AROM is performed before the onset of labor	May occur at any gestational a
Induction of Labor	The use of pharmacologic and/or mechanical methods to initiate labor. Examples of methods include but are not limited to: Artificial rupture of membranes, balloons, oxytocin, prostaglandin, laminaria, or other cervical ripening agents	Still applies even if any of the f performed: Unsuccessful attempts at init The use of pharmacologic and mechanical methods to initiat following spontaneous ruptur membranes without contracti
Augmentation of Labor	The stimulation of uterine contractions using pharmacologic methods or artificial rupture of membranes to increase their frequency and/or strength following the onset of spontaneous labor or contractions following spontaneous rupture of membranes.	Does not apply if Induction of L performed

6 is the new 4



Did you know.....6 is the new 4?

FIRST STAGE OF LABOR

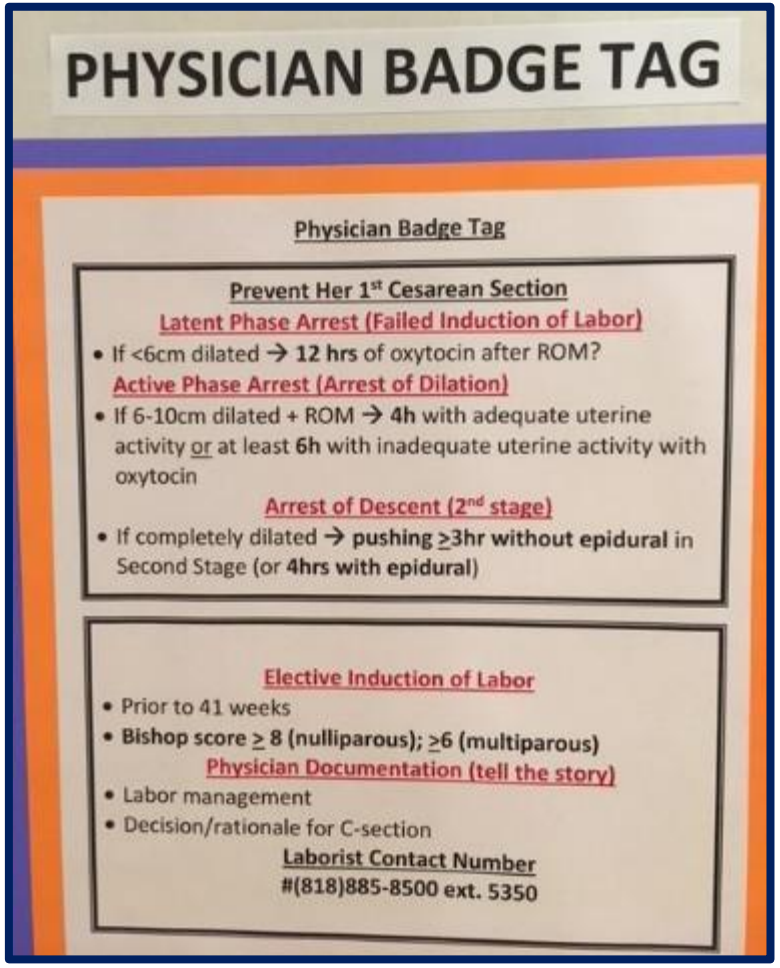
- A prolonged latent phase (great than 20 hours in nulliparous women and greater than 14 hours in multiparous women) should not be an indication for cesarean delivery.
- Slow but progressive labor in the first stage of labor should not be an indication for cesarean delivery.
- Cervical dilation **of 6 cm should be considered the threshold for the active phase of most women in labor.** Thurs, before 6 cm of dilation is achieved, standards of active phase progress should not be applied.
- Cesarean delivery for active phase arrest in the first stage of labor should be reserved for women at or beyond 6 cm of dilation with ruptured membranes who fail to progress despite 4 hours of adequate uterine activity, or at least 6 hours of oxytocin

Implementation: Education of ACOG/ SMFM criteria for providers and nurses

Schedule a PVB Grand Rounds for physicians at your hospital

Share educational materials with clinicians during staff meetings and huddles

Post education resources on your unit, in break room, at nurse's station, OB provider charting areas



Resource and Implementation: Unblinding Provider Data

Identify OB champions

Reveal blinded data and plan for unblinded data sharing

Provide opportunities for discussion and support from OB leaders

CMQCC
California Maternal Quality Care Collaborative

Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates at Start of Project

Before the process of unblinding NTSV cesarean rates begins, it is important for teams to have a baseline understanding of their underlying practices. This can be determined through an examination of the drivers for primary cesarean rates, followed by a chart review of a sample to assess how well the providers follow the national ACOG guidelines for Failure to Progress and other key primary cesarean indications. Ongoing monthly review for consistency with guidelines is also quite useful (recognizing that not every case will follow the guidelines perfectly). The Readiness Assessment and Structure Measures Checklist will assist with this baseline review. Success of the project hinges upon system improvements that support providers in reducing individual rates.

Resources: Labor management support

ILPQC held 2 labor management support workshops in partnership with Jessica Brumley, CNM from the Florida PQC

405 Attendees from 70 ILPQC hospitals

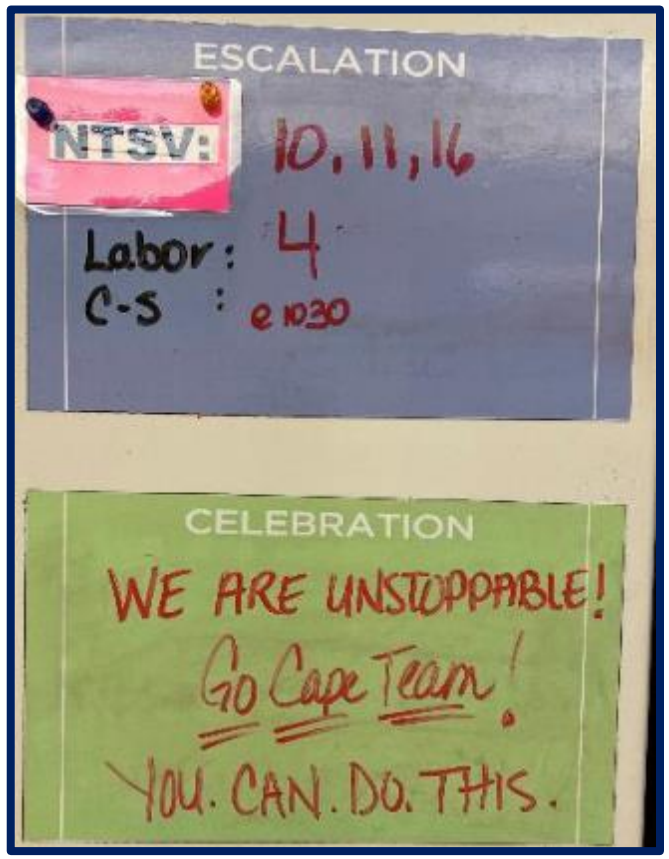
"The most applicable labor support class for an L&D nurse"
"Even better than Spinning Babies!"

COMING SOON: ILPQC Labor Management Support E-Modules for physician and nurse education adapted from Labor Management Support Workshops

Identifying NTSVs

Median LOS: 23:01 Total: 15 WR: 0 Filter: OB Inpatient, OBS, OB Che

Bed	S	Name	Status	EGA	RN	Extension	Provider	Anesthesia	To Do	Notifications	
2101,A	Avail										
2101,B	Avail										
2102,A	Avail										
2103,A	Avail										
2104,A	Avail										
2105,A	Assi	RC	PP Vag	✓	Rachel	DP	SMG		B		0:6:39
2106,A	Assi	ME	Labor	35 0/7	Denise/KL	Name Alert	OBHG				0:5:58
2107,A	Assi	NS	PP Vag	✓	Rachel/	DP	OBHG		B		0:8:30
2108,A	Assi	MF	Labor	41 1/7	Abby/LM		OBHG	Indwelling/infusin	R		1:19:59
OF 1,A	Avail										
OF 2,A	Avail										
2109,A	Assi	SE	PP Vag	✓	Sarah	2109	SMG		B		0:2:17
2110,A	Assi	RD	PP C/S	✓	Vanessa/-------		OBHG	Discontinued			4:2:51



Recognizing success

Achieving PVB Aims: Key strategies leading to clinical culture change

Identifying NTSVs

Education of ACOG/SMFM criteria for providers and nurses

Implementing cesarean decision checklists and huddles

Labor management support

Unblinding Provider data

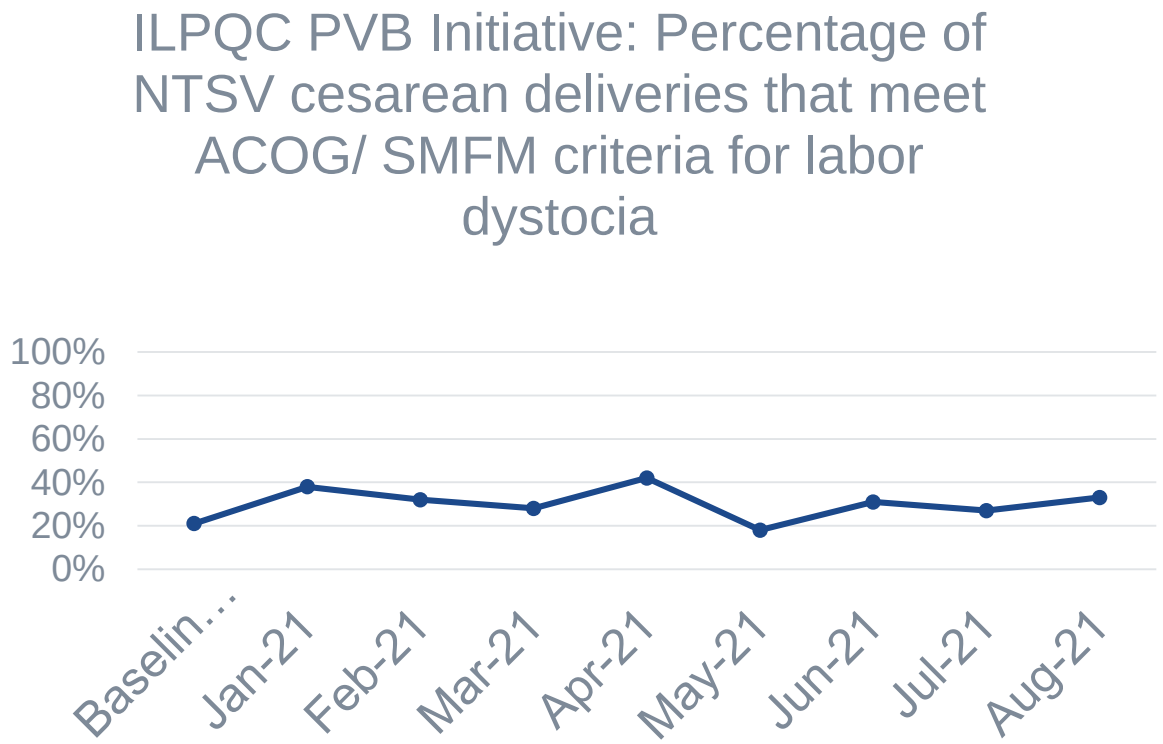
Using Applied QI Strategies for Success for PVB

Patricia Lee King, PhD, MSW; Autumn Perrault, RN, BSN, LCCE; Emily White VanGompel, MD

QI Team Meeting

Quality Collaborative Hospital

- **Challenge to address:** Strategies to improve the utilization of ACOG/SMFM criteria especially with labor dystocia
- **Celebrating progress**: Implemented the ILPQC ACOG/SMFM Checklist
- **QI Tools**: Use a 30/60/90day worksheet to help implement ILPQC PVB Key Strategies to improve % meeting ACOG/SMFM criteria



QI Team's 30/60/90 day plan

30 DAY

Overall Goal:

Identifying NTSV patients and begin RN recognition

TASKS TO ACHIEVE GOAL:	RESPONSIBLE PARTY:
1. Determine where it is best to identify NTSV & recognition prizes	
2. Create a recognition board for vaginal NTSV	
3. Educate staff on upcoming process	

60 DAY

Overall Goal:.

Implement NTSV Huddles to increase OB provider engagement and awareness of criteria

TASKS TO ACHIEVE GOAL:	RESPONSIBLE PARTY:
1. Post criteria and schedule PVB Grand Rounds	
2. Engage OB Champion to promote huddle/Checklist	
3. Implement shared decision huddle with checklist ensure OB provider engagement	
4. Track to ensure huddles are completed	

90 DAY

Overall Goal:

Create a feedback loop and explore unblinding provider level data

TASKS TO ACHIEVE GOAL:	RESPONSIBLE PARTY:
1. Missed opportunity review and feedback	
2. Unblinding provider data	
3. Connect OB department leadership for support	

Group Discussion Activity

- We will break you out into groups of 5-7 people for a brief brainstorm session
- You will be assigned to a discussion group, simply click the JOIN BREAKOUT
- Goal of the activity is to discuss how best to engage OB providers and increase compliance with the ACOG/SMFM criteria
- Please ask one group member to take notes to post in the chat after you return to share your group's ideas and share with info@ilpqc.org

Please discuss the following:

1. *If you were doing a 30/60/90day sheet, what key strategies are most important to engage OB Providers and increase compliance with ACOG/SMFM criteria specifically with dystocia and failed induction*
2. *What key strategies would you start with when creating a 30/60/90 day worksheet?*

PVB Questions and Panel Considerations

- What do we think are the most important strategies for helping teams achieve ACOG/SMFM criteria goals to promoted NTSV vaginal births?
- What are the best methods to engage OB providers with education and feedback?
- How can shared decision making help lead to clinical culture change?
- How can teams best use the labor culture survey results?

Speaker Panel:
Ann Borders, MD, MSc, MPH
Neel Shah, MD, MPP
Barbara O'Brien, MS, RN
Emily White VanGompel, MD

Share your questions and thoughts in the Zoom Chat Box!

Birth Equity OB Breakout Session

Helping teams get started with key strategies

What is the focus of Birth Equity (BE)?

BE AIM: By December 2023, more than 75% of Illinois birthing hospitals will be participating in the Birth Equity Initiative and more than 75% of participating hospitals will have the key strategies in place.

- Addressing Social Determinants of Health
- Review race/ethnicity medical record and quality data
- Promote patient-centered approach to engage patients and communities
- Develop respectful care and bias education for providers, nurses, and staff

Breaking down bias by providing equitable care

Optimize race/ethnicity data collection & review key maternal quality data by race, ethnicity & Medicaid status

Universal **social determinants of health screening** tool (prenatal/L&D) with system for linkage to appropriate resources

Share **respectful care practices** on L&D and survey patients before discharge on their care experience (using the PREM) for feedback

Engage patients and community members for input on quality improvement efforts

Standardize postpartum safety education and schedule early postpartum follow up prior to hospital discharge

Implicit Bias / Respectful Care training for providers, nurses and other staff

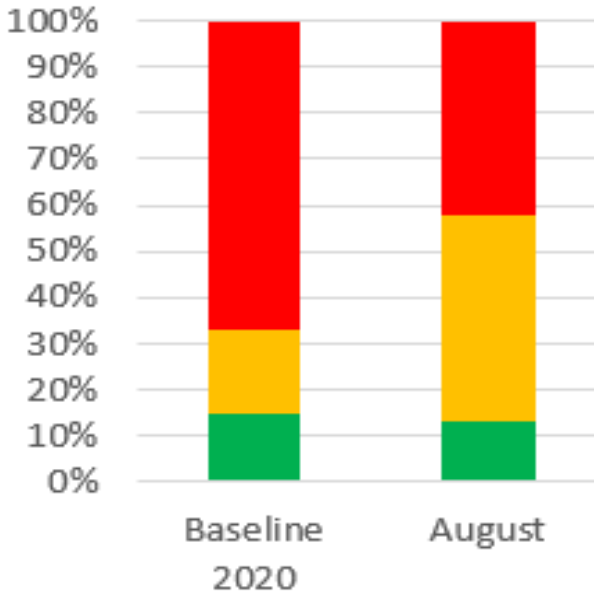
2021 Teams Survey Feedback

Birth Equity – Early Successes

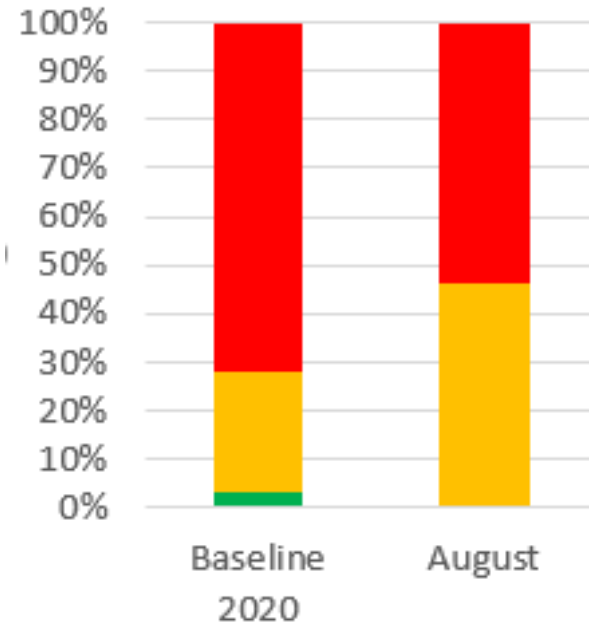
- Access to resources in the BE toolkit
- Getting Team Together
- Data Collection and Review
- Identified Patient Members
- System Working on Incorporating SDOH into EMR

Structure Measures: Implementing Systems Changes

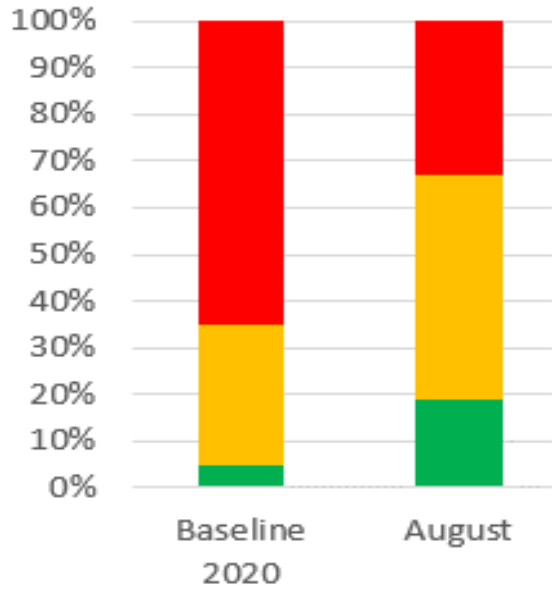
Implemented standardized social determinants of health screening tools for delivery admission



Completed and shared social determinants of health community resources mapping tool

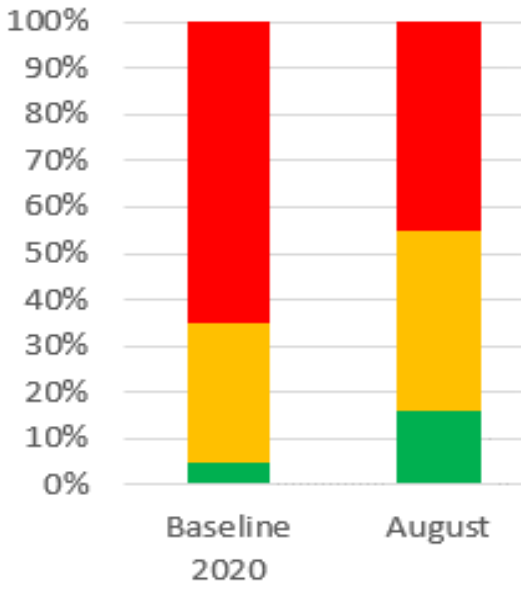


Protocol for improving the collection and accuracy of patient-reported race/ethnicity data

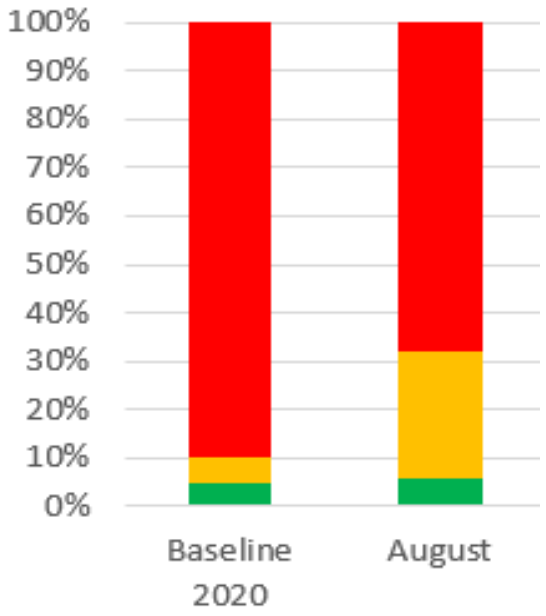


Structure Measures: Implementing Systems Changes

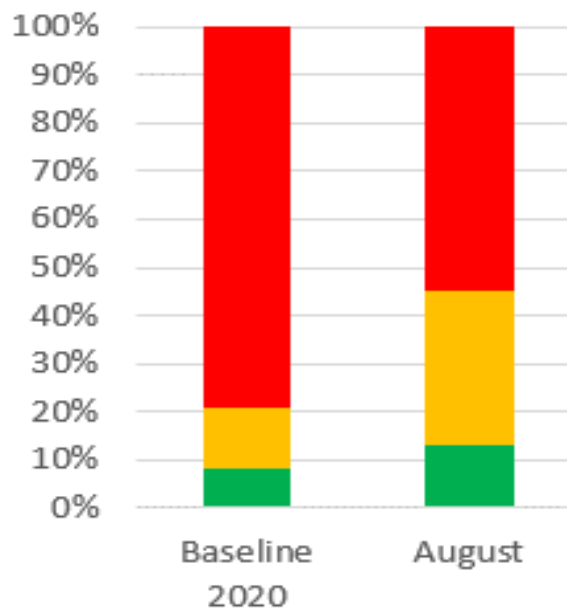
Process to review maternal health quality data stratified by race/ethnicity and Medicaid status



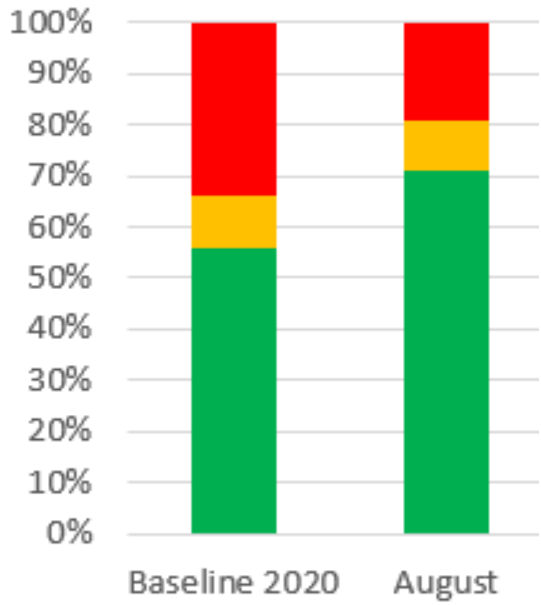
Engaged patients and/or community members to provide input on QI efforts



Sharing expected respectful care practices with delivery staff and patients

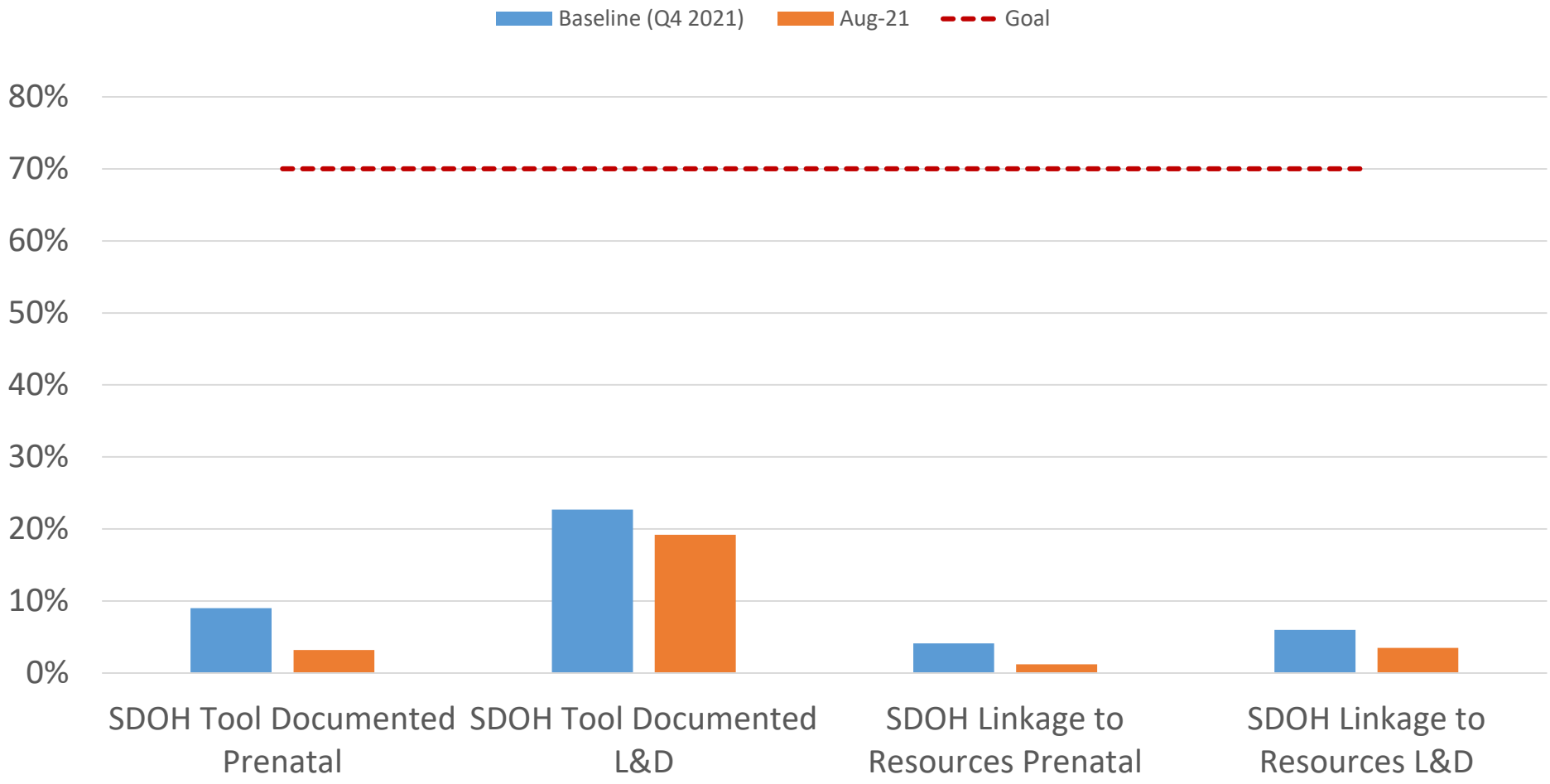


System to provide patients postpartum safety education, where to call, and early follow-up



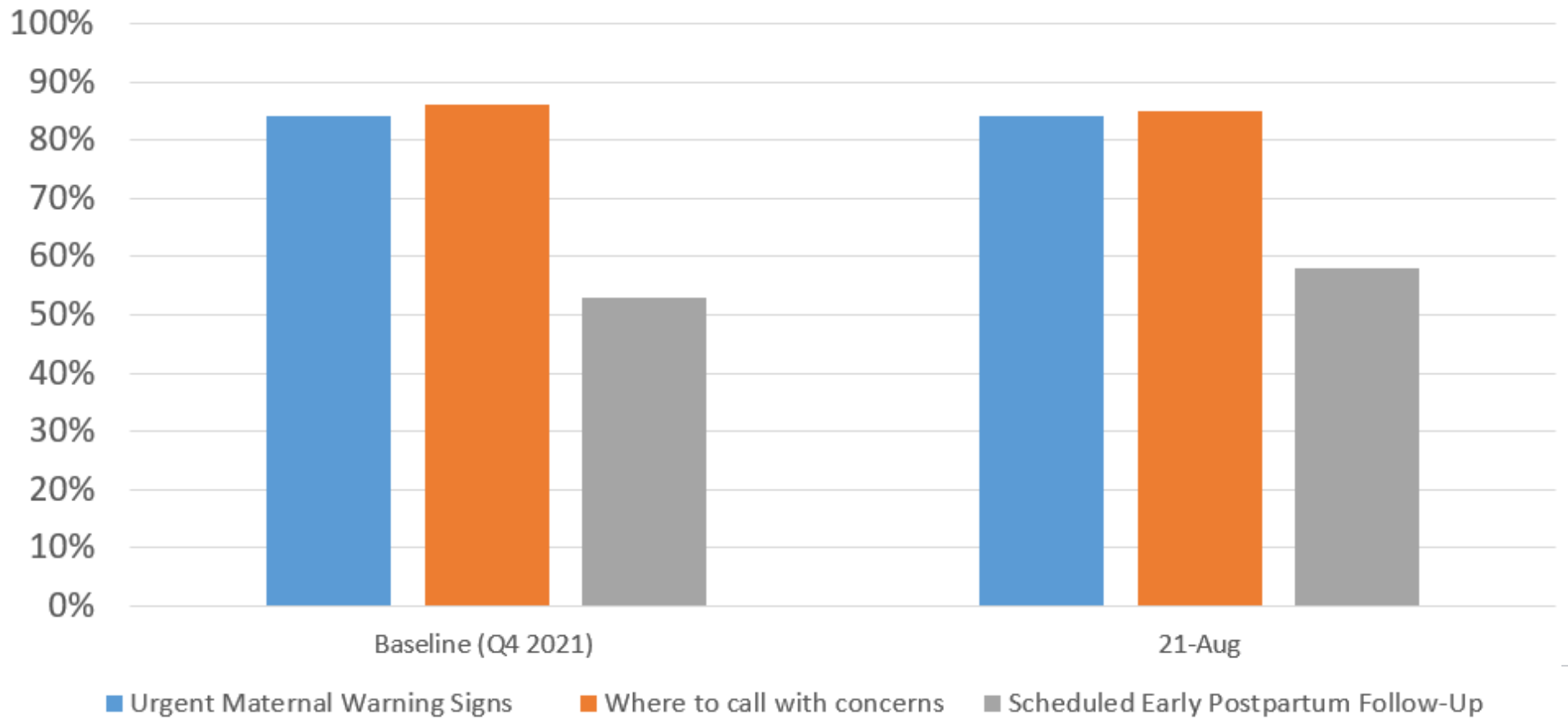
In Place Working on it Not Started

Process Measures:
Social Determinants of Health Screening



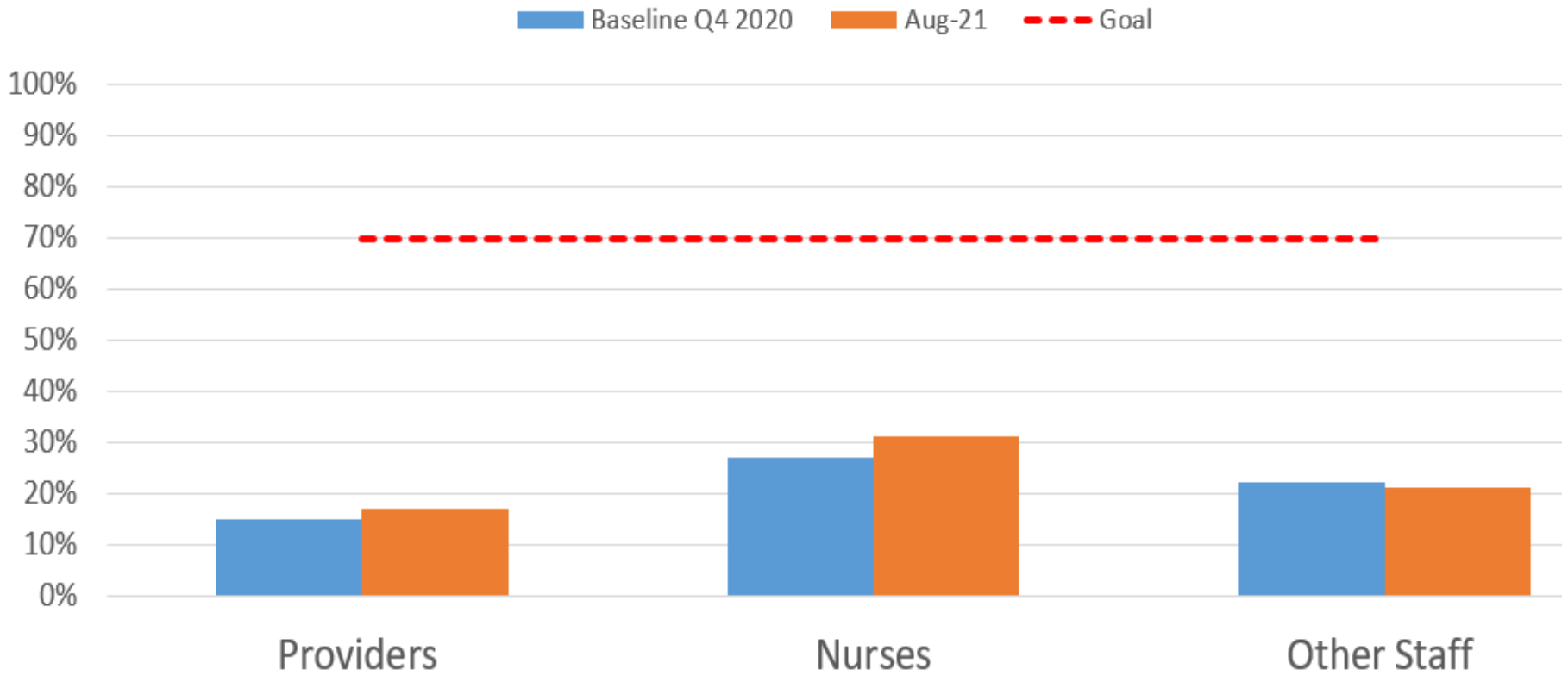
Process Measures: Postpartum Safety

Patients receiving postpartum safety education prior to hospital discharge including urgent maternal warning signs, where to call with concerns, and scheduling early postpartum follow-up



Process Measures: Staff Training

Providers, nurses, and other staff completing education addressing implicit bias and respectful care



1. Addressing social determinants of health

1. Mapping social determinants of health community resources and services

2. Screening all patients for social determinants of health needs during prenatal care and at the delivery admission and linking to resources/ services

3. Incorporating social determinants of health and discrimination factors in hospital maternal morbidity reviews

Linking Patients to Social Determinants of Health

- ILPQC is sponsoring access for hospitals to an online tool
- NowPow supports hospitals for addressing social determinants of health for birthing patients across the state
- Tools to screen and identify maternal and familial needs for referrals and local resources
- Now available free on ILPQC website

Three ways teams can access NowPow:

1. **Already have NowPow at your hospital?** Expand NowPow access and usage to OB department, if not already in place
2. **Interested in NowPow at your hospital?** Designated NowPow contact and special rate
3. **Looking to access NowPow resources?** Free access to ILPQC sponsored self-serve version of the NowPow platform

NowPow Demonstration to link patients to SDoH resources

https://ilpqc.org/

2. Utilize race/ethnicity medical record & quality data

Implement processes and protocols for improving the collection and accuracy of patient-reported race/ethnicity data

Review maternal health quality data stratified by race, ethnicity, and Medicaid status to identify disparities and address opportunities for improvement

3. Engage patients, support partners, & communities with patient-centered respectful care

- Take steps to engage patients and/or community members to provide input on quality improvement efforts
- Implementing a strategy for sharing respectful care practices with patients and delivery staff
- Implement the Patient Reported Experience Measure (PREM) patient survey to obtain feedback
- Providing postpartum safety patient education on urgent maternal warning signs, how to communicate with providers and scheduling early follow up

https://www.acog.org/store/products/patient-education/tear-pad/my-postpartum-care-tear-pad

Respectful Care Practices

Available in:

- ✓ Tear pads
- ✓ Posters
- ✓ Bi-Fold

1 **Treating you with dignity and respect** throughout your hospital stay

2 **Introducing ourselves and our role** on your care team to you and your support persons upon entering the room

3 **Learning your goals for delivery and postpartum:** What is important to you for labor and birth? What are your concerns regarding your birth experience? How can we best support you?

4 **Working to understand you,** your background, your home life, and your health history so we can make sure you receive the care you need during your birth and recovery

5 **Communicating effectively** across your health care team to ensure the best care for you

6 **Partnering with you for all decisions** so that you can make choices that are right for you

7 **Practicing "active listening"**—to ensure that you, and your support persons are heard

8 **Valuing personal boundaries and respecting your dignity and modesty at all times,** including asking your permission before entering a room or touching you

9 **Recognizing your prior experiences with healthcare may affect how you feel during your birth,** we will strive at all times to provide safe, equitable and respectful care

10 **Making sure you are discharged after delivery with an understanding of postpartum warning signs,** where to call with concerns, and with postpartum follow-up care visits arranged

11 **Ensuring you are discharged with the skills, support and resources** to care for yourself and your baby

12 **Protecting your privacy** and keeping your medical information confidential

13 **Being ready to hear any concerns** or ways that we can improve your care

1. **I could take part in decisions about my care.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

2. **I could ask questions about my care.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

3. **My health care team did a good job listening to me, I felt heard.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

4. **My health care choices were respected by the health care team.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

5. **My health care team understood my background, home life and health history, and communicated well with each other.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

6. **My health care team introduced themselves to me, and my support persons, and explained their role in my care when they entered my room.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

7. **The health care team asked for my permission before carrying out exams and treatments.**

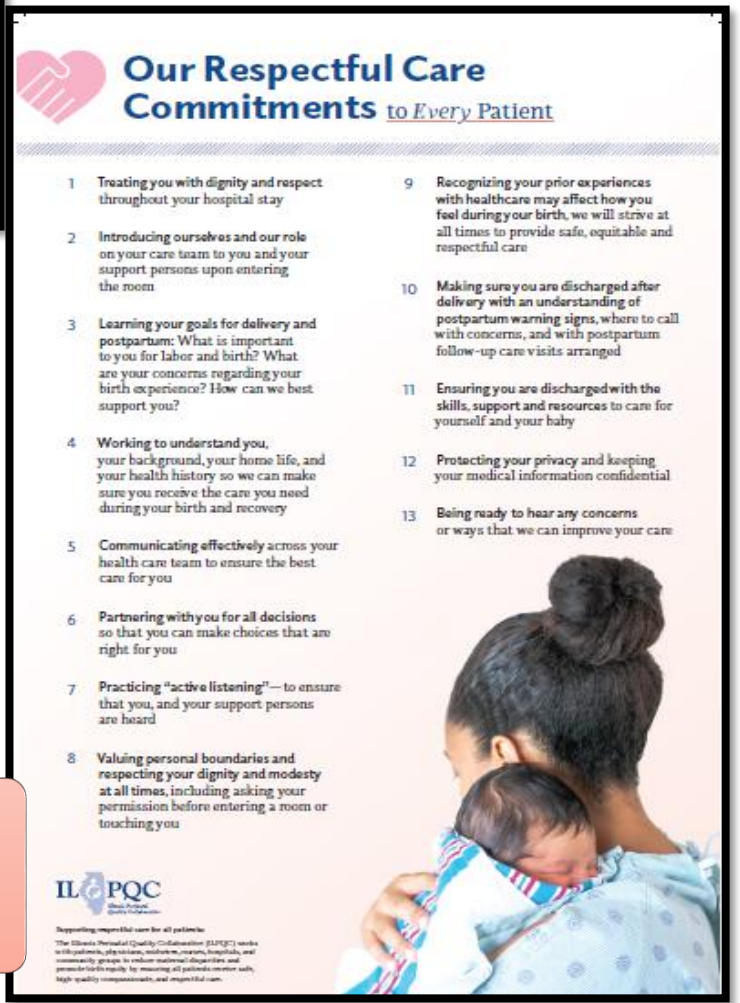
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

Labor & Delivery

PREM

Respectful Care Practices

IL PQC
Illinois Perinatal Quality Collaborative



Our Respectful Care Commitments to *Every* Patient

1. Treating you with dignity and respect throughout your hospital stay
2. Introducing ourselves and our role on your care team to you and your support persons upon entering the room
3. Learning your goals for delivery and postpartum: What is important to you for labor and birth? What are your concerns regarding your birth experience? How can we best support you?
4. Working to understand you, your background, your home life, and your health history so we can make sure you receive the care you need during your birth and recovery
5. Communicating effectively across your health care team to ensure the best care for you
6. Partnering with you for all decisions so that you can make choices that are right for you
7. Practicing "active listening"— to ensure that you, and your support persons are heard
8. Valuing personal boundaries and respecting your dignity and modesty at all times, including asking your permission before entering a room or touching you
9. Recognizing your prior experiences with healthcare may affect how you feel during your birth, we will strive at all times to provide safe, equitable and respectful care
10. Making sure you are discharged after delivery with an understanding of postpartum warning signs, where to call with concerns, and with postpartum follow-up care visits arranged
11. Ensuring you are discharged with the skills, support and resources to care for yourself and your baby
12. Protecting your privacy and keeping your medical information confidential
13. Being ready to hear any concerns or ways that we can improve your care

IL PQC

1. **I could take part in decisions about my care.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

2. **I could ask questions about my care.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

3. **My health care team did a good job listening to me, I felt heard.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

4. **My health care choices were respected by the health care team.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

5. **My health care team understood my background, home life and health history, and communicated well with each other.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	O	o	o

6. **My health care team introduced themselves to me, and my support persons, and explained their role in my care when they entered my room.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

7. **The health care team asked for my permission before carrying out exams and treatments.**

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
o	o	o	o	o

en the health care team could not meet my wishes, they explained why.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagre
o	o	o	o	o

rusted the health care team to take the best care of me.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagre
o	o	o	o	o

11. I was treated differently by the health care team because of:

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
My race or skin color	o	o	o	o	o
My ethnicity or culture	o	o	o	o	o
My sexual orientation or gender identity	o	o	o	o	o
The type of health insurance I have	o	o	o	o	o
The language I speak	o	o	o	o	o

12. I was treated with respect and compassion:

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
During my check-in	o	o	o	o	o
During my labor and delivery	o	o	o	o	o
During my care after delivery	o	o	o	o	o
During discharge	o	o	o	o	o

4. Engage and educate providers, nurses & staff

- **Educating providers, nurses, and staff** on the importance of **listening** to patients, providing **respectful care** and addressing **implicit bias**
- Implementing strategies for **addressing diversity in health care team** hiring

Laboring with Hope

Every Mom. Every Time

ACOG
The American College of Obstetricians and Gynecologists

Dignity in Pregnancy and Childbirth Course

DIVERSITY SCIENCE

Laboring with Hope

Laboring with Hope is a short documentary about loss, grief, and the hope for change.

The documentary provides the backdrop for improving health outcomes for Black women.

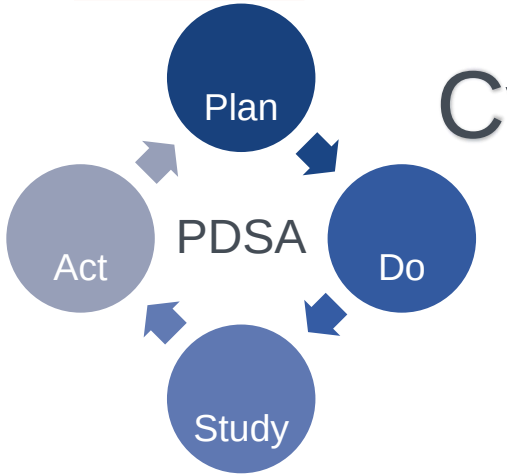
Using Applied QI Strategies for Success for BE

Patricia Lee King, PhD and Autumn Perrault, RN, BSN, LCCE

QI Support Call
BE Quality Collaborative Hospital

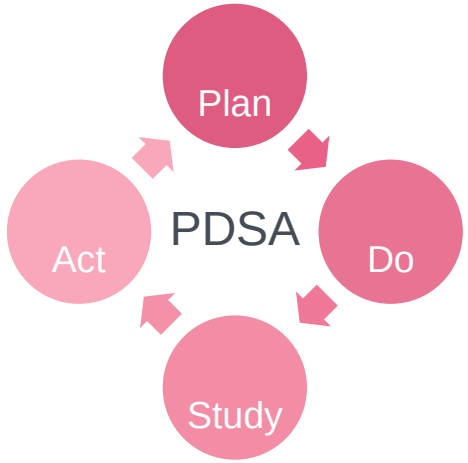
- Background:
  - Provider Champion and RN Champion just finished the IHI QI training offered by ILPQC
  - Teams desires to utilize a PDSA cycle when rolling out the Respectful Care Practices Handout
  - Reached out to ILPQC for QI Support and to process their ideas for a PDSA as they are unsure where to start

PDSA- Small tests of change



Cycle 1

Adopt?
Adapt?
Abandon?



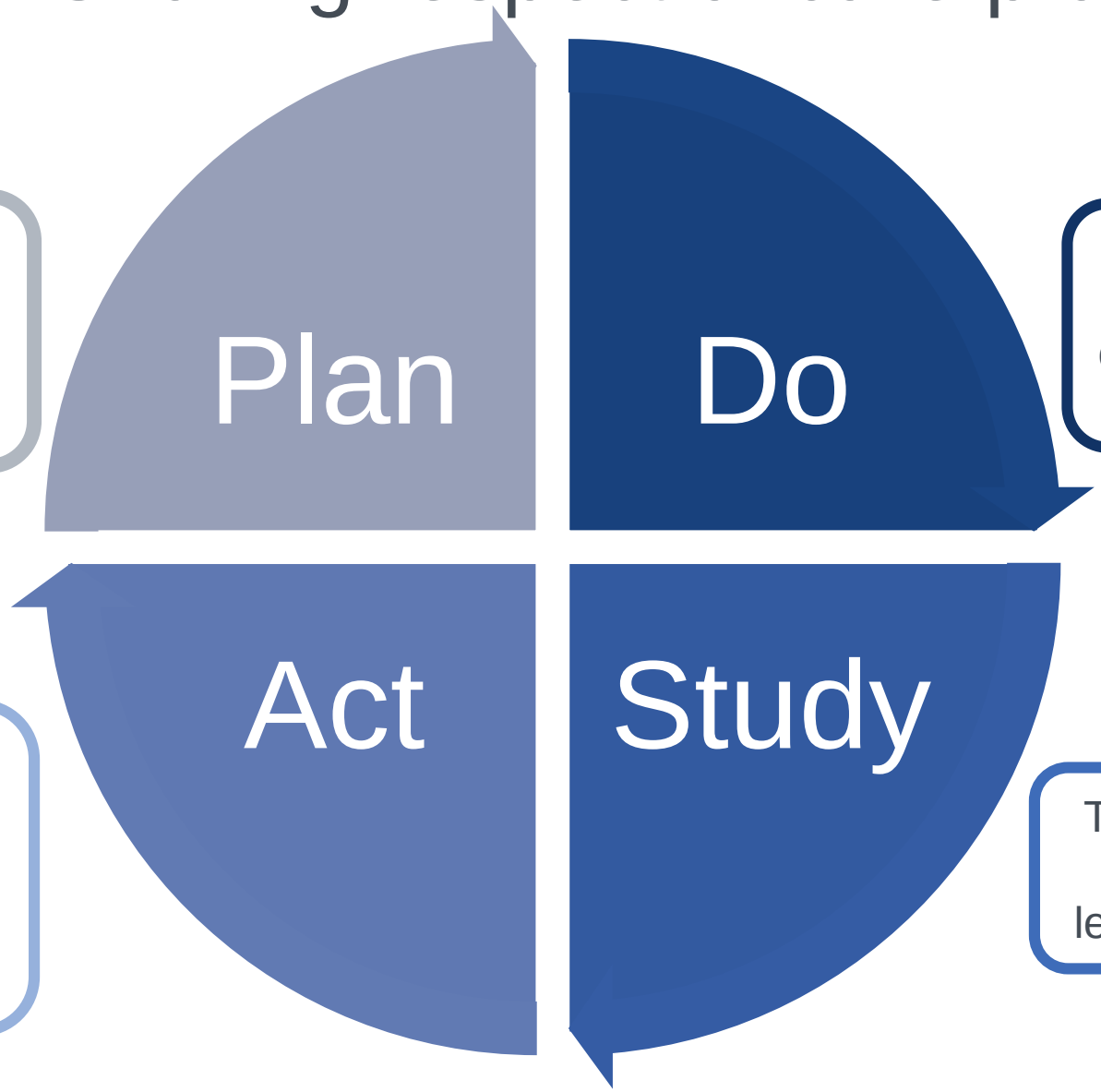
Cycle 2

- What do we want to achieve?
- How do we know if a change will be an improvement?
- What change will result in improvement?
- Begin the PDSA cycle

- Is there anything we need to improve?
- What caused variations?
- How can we reduce the variations?
- Begin the PDSA cycle

PDSA Example – Sharing respectful care practices with patients

Front desk person will try with 1 patient on admit with one nurse who will follow-up



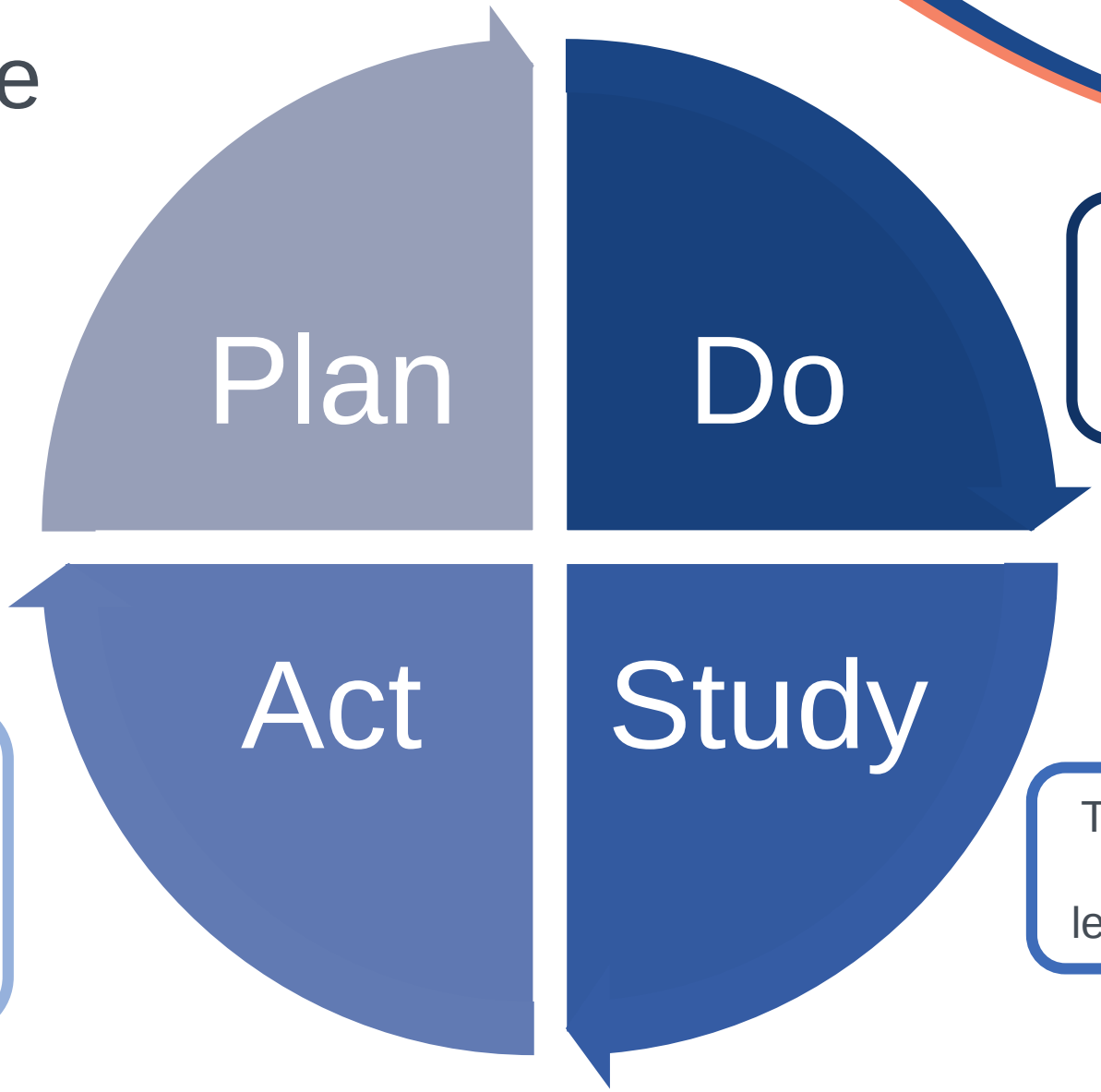
Jane will test on Tue when ONE RN and ONE unit concierges schedules align with ONE patient

Next PDSA: RN provide respectful care practice handout a part of the nursing admission process and confirmed the patient has understanding

Team met that afternoon to hear what everyone learned and get feedback

Cycle 2
PDSA Example

ONE RN provide respectful care practice handout a part of the nursing admission to ONE patient and confirmed the patient's understanding



Jane will test on Wed when ONE RN with ONE during her nursing admission process

Next PDSA: RN provide respectful care practice handout a part of the nursing admission process during ONE day

Team met that afternoon to hear what everyone learned and get feedback

Group Discussion Activity

- We will break into small groups for a brief brainstorm session
- You will be assigned to a discussion group, simply click the JOIN BREAKOUT
- Goal of the activity is to brainstorm together ideas to implement the Respectful Care Practices Handout or the PREM Survey on your Labor and Delivery Unit
- Assign one person to take notes to share in the chaat box.

Please discuss the following:

1. *Brainstorm ideas for providing patient with Respectful Care practices during delivery admission and/or implementing the PREM survey prior to hospital discharge.*
2. *Please identify at least one idea to test these strategies with a small test of change (PDSA)*

BE Questions and Panel Considerations

- What strategies are most important to consider to start implementing the PREM Survey and Respectful Care Practices?
- How can teams be most successful engaging patients and community members in QI work?
- What strategies have been most helpful to promote respectful care and shared decision making on L&D?
- How can we increase SDOH screening and linkage to needed resources and services?

Speaker Panel:

- Ann Borders, MD, MSc, MPH
- Neel Shah, MD, MPP
- Barbara O'Brien, MS, RN
- Marilyn Kacica, MD, MPH

Share your questions and thoughts in the Zoom Chat Box!

Hemorrhage and HTN continuing Education

IL PQC
Illinois Perinatal
Quality Collaborative

Maternal Hypertension & OB Hemorrhage Continuing Education

- Public Act 101 0390 passed by the State of Illinois in 2019 requires all birthing facilities to conduct annual continuing education on maternal hypertension and obstetric hemorrhage.

- All **obstetric, emergency department, and other staff** that care for pregnant and postpartum women must **complete the training requirement each year by December 31. Please report by February 28th, 2022.** Please visit https://ilpqc.org/continuinged/ for more information.

- e-modules, simulations, or drills from AIM, ACOG and other leading national groups available on the ilpqc.org website.

Discussion of Future ILPQC Initiatives

ILPQC
Illinois Perinatal
Quality Collaborative

Potential Future Initiative for 2024 or beyond to start considering

- Cardiovascular Health
- Maternal Mental Health
- Improving Access to Postpartum Care

IL PQC
Illinois Perinatal Quality Collaborative

Thanks to our Funders

IDPH
Illinois Department of Public Health

I PROMOTE-IL
Innovations to Improve Maternal Outcomes in Illinois

IDHS
Illinois Department of Human Services

AIM
Alliance for Innovation on Maternal Health

CDC
Centers for Disease Control and Prevention

In kind support:

NorthShore University HealthSystem

Northwestern Medicine
Northwestern University Feinberg School of Medicine

Saint Louis University

Ann & Robert H. Lurie Children's Hospital of Chicago