State PQC Leaders Panel: National Perspectives on Improving Perinatal Care

State PQC Leaders
State PQC Leaders Panel

- Munish Gupta MD MMSc, *Perinatal Neonatal Quality Improvement Network of Massachusetts (PNQIN)*

- Marilyn Kacica, MD, MPH *New York State Perinatal Quality Collaborative (NYSPQC)*

- Barbara O’Brien, MS, RN *Oklahoma Perinatal Quality Improvement Collaborative (OPQIC)*
Neonatal Collaborative Quality Improvement: Some Thoughts from Massachusetts

Munish Gupta, MD MMSc

ILPQC Annual Conference
State PQC Panel
October 28, 2021
Goals

• A really quick overview of some of our neonatal projects in Massachusetts
• Highlights of what was good and not-so-good with each project
Projects

• CLABSIs (Alan Picarillo)
CLABSI Prevention in Level III NICUs

• Sharing practices, local QI efforts
• Very multidisciplinary (RNs, APPs)
• Easy data: VON any infection, NHSN CLABSI
• NCABSI project (NC) – CUSP, checklists
• Strong collaboration with DPH
• Some interest in antibiotic stewardship
• Minimal (no?) funding other than NCABSI
• Sustainment? Some, but not much
• Maintaining direct attention seems key
Projects

• CLABSIs (Alan Picarillo)
• Safe sleep (Susan Hwang)
Safe Sleep in High Risk Newborns

- Education, sharing interventions and ideas
- Largely nursing led
- Level II and level III units! (and some level I)
- Weekly audits, regular hospital progress reports
- Some funding – guest speakers, summits
- High priority for DPH – part of state CoILN work
- Selection for national NAPPSS-IIN
- Difficult to link to outcome measures!
- Improvements in practice seemed ‘hard-wired’
SSP Compliance Over Time (NICU)
Process Changes Nov 15, Jul 16, Aug 17

N= 8,167 (NICU)

Compliance Rate (%)}


・ Compliance Rate (%)  
UCL  Average  LCL  Target
Projects

• CLABSI (Alan Picarillo)
• Safe sleep (Susan Hwang)
• Mother’s milk (Meg Parker)
Mother’s Milk in VLBW Infants

- Level III NICUs -- lactation, nutrition!
- Funding from Kellogg foundation
- Strong partnership with DPH (WIC)
- Patient-level data (DUA), numerous measures
- PDSA form, run charts, control charts
- Explicit focus on equity
- Educational resources in multiple languages
- Process improvement yes – outcomes, less so
Prenatal education

Early milk expression

Skin-to-skin care

Any mother’s milk at discharge

Exclusive mother’s milk at discharge

Parker et al, Pediatrics, 2019
Human Milk Initiative Educational Written Materials

The one-page educational materials cover the following topics:
- Importance of breast milk
- Pumping and hand expression
- Skin-to-skin care
- Transition to direct breastfeeding

All materials have been written at a 6th grade reading level and have been translated into the following languages:
- Arabic
- Chinese
- French
- Haitian Creole
- Spanish
- Portuguese
- Vietnamese
- Tagalog

Use the menu below to access the materials in each language.

Contacto Piel Con Piel Para su Bebe Prematuro

https://www.neoqicma.org/human-milk-educational-materials

Human Milk Initiative Educational Videos

As part of the NeoQIC Human Milk Quality Improvement Collaborative, we created educational videos focused on the unique needs of premature infants cared for at the NICU. We encourage all NICUs to share with family members. These are short 1.5-minute videos of a diverse group of parents from Boston Medical Center describing their experiences providing milk for their infants. The videos are in both English and Spanish and can easily be viewed as a tablet of phone. These are freely available to anyone. Funding for the videos was provided by the W.K. Kellogg Foundation.

If you have any questions, please email Dr. Meg Parker at meg.parker@bmc.org

https://www.neoqicma.org/human-milk-educational-videos
Projects

- CLABSIs (Alan Picarillo)
- Safe sleep (Susan Hwang)
- Mother’s milk (Meg Parker)
- NAS (Alan Picarillo)
Neonatal Abstinence Syndrome

- Longest MA project – started in 2013!
- NAS (NeoQIC) to perinatal opioids (PNQIN)
- Numerous data streams, including core REDCap
- First true statewide project? Level I, II, and III
- REALLY strong partnerships – state, community
- REALLY strong involvement of families
- Explicit focus on equity
- Real improvements in hospital-based care
- Improving upstream and downstream difficult!
- Sustainment plan unclear at present
Figure 1: Pharmacotherapy among OENs, pre- and post- ESC implementation
Early Intervention referral and enrollment among NAS/SEN infants born at participating hospitals, 2016—2019, n=1,935
Adjusted odds ratios of maternal and infant outcomes by maternal race and ethnicity

- Any MOUD, Black NH*
- Any MOUD, Hispanic
- Any infant Pharm Tx, Black NH
- Any infant Pharm Tx, Hispanic
- Rooming-in, Black NH
- Rooming-in, Hispanic
- Any Maternal Breastmilk, Black NH
- Any Maternal Breastmilk, Hispanic
- Early Intervention Referral, Black NH
- Early Intervention Referral, Hispanic
- Discharge w/ Biologic Family, Black NH
- Discharge w/ Biologic Family, Hispanic

*All referents are White NH

Peeler et al, AJPH, 2020
Other Neonatal Projects

• Family engagement (Meg Parker)
  – Level II and III units
  – Family-reported measures
  – Family advisors!

• Respiratory care (Helen Healy)
  – Level III units
  – Respiratory therapists!
Some Lessons?

• Not just a level III NICU collaborative
• Data is a must -- patient-level ideal, but others ok
• Rigorous QI is hard – some QI better than no QI
• Common toolkits can help, but a lot is local
• Tough to end projects!
• Multidisciplinary QI (with families) is awesome
• Hard to overstate the value of collaboration
New York State Perinatal Quality Collaborative Overview

Marilyn Kacica, MD, MPH
Executive Director, New York State Perinatal Quality Collaborative
Medical Director, Division of Family Health
New York State Department of Health

November 16, 2021
NYSPQC Mission & Strategy

The NYSPQC empowers NYS birthing hospitals to provide the best, safest and most equitable care for pregnant, birthing and postpartum people and their infants.

This is achieved through: the translation of evidence-based guidelines to clinical practice; collaboration amongst participants and stakeholders; and the utilization of quality improvement science.
Engagement with Stakeholders

• **Clinical and QI advisors:** Multidisciplinary clinical and QI advisors engaged to assist with planning, implementation and evaluation for every NYSPQC project.

• **Professional organizations:** NYSPQC has longstanding collaborative relationships with ACOG District II, hospital associations (HANYS and GNYHA) and AWHONN.

• **Birthing Facility Teams:** Hospital and birthing center teams are recruited and provided with: educational opportunities; networking time; data collection system and ongoing analysis and support; clinical and quality improvement advisement, including hospital-level coaching.
NYSPQC Focus Areas

Obstetric Projects
- Obstetrical Education (Scheduled Deliveries)
- Obstetric Hemorrhage
- Scheduled Deliveries without a Medical Indication
- Maternal Hemorrhage and Hypertension
- Antenatal Corticosteroid Treatment
- Birth Equity Improvement Project

Neonatal Projects
- Safe Sleep
- NICU CLABSI Reductions
- Opioid Use Disorder in Pregnancy & Neonatal Abstinence
- Infant Mortality CollN 2.0
- Enteral Nutrition
- NAPPSS-IIN (Safe sleep + breastfeeding)
- NICU Equity

Key:
- Completed
- Active
- Under Development
NYS Obstetric Hemorrhage Project

• Between March 2018 and June 2021, birthing hospitals across NYS worked to translate evidence-based guidelines to clinical practice to improve the assessment, identification and management of obstetric hemorrhage.

• 78 out of 120 (65%) NYS birthing hospitals participated in the initiative.
  – This represents 76% of births in NYS.
GLOBAL AIM:
Reduce maternal morbidity and mortality associated with obstetric hemorrhage in NYS.

SMART AIM:
By June 2019, increase hemorrhage risk assessment on admission and postpartum to 85% of maternity patients.

NEW YORK STATE OBSTETRIC HEMORRHAGE PROJECT – KEY DRIVER DIAGRAM

PRIMARY DRIVERS

READINESS (EVERY UNIT)
- Have a hemorrhage cart readily available
- Ensure rapid access to medication
- Establish a response team
- Establish massive transfusion and emergency release protocols
- Develop and implement unit education on protocols and unit-based drills with post-event debriefs
- Place copies of the hemorrhage protocols in prominent places in each patient room and OR
- Conduct drills* regularly and ensure all responders participate

RECOGNITION & PREVENTION (EVERY PATIENT)
- Assess hemorrhage risk and prepare based on risk level
- Perform on-going measurement of blood loss, estimated or quantified
- Manage 3rd stage of labor
- Educate patient and family on signs and symptoms and when to call staff/provider

RESPONSE (EVERY HEMORRHAGE)
- Adopt a standard, stage-based, hemorrhage management plan with checklists
- Develop a support program for patients, families and staff for all significant hemorrhages

REPORTING/ SYSTEMS LEARNING (EVERY UNIT)
- Huddle for high risk patients to prepare throughout care
- Debrief to identify successes and opportunities.
- Review of serious hemorrhages** by a multidisciplinary team
- Identify and utilize data collection plan to capture OB hemorrhage events

For more information:
- Council On Patient Safety In Women’s Healthcare
- ACOG District II Safe Motherhood Initiative (SMI)

* Drills = Right participants, scenarios, demonstration of competency in roles and responsibilities.
**Blood loss greater than ≥500 ml with a vaginal delivery and ≥1000 ml with a cesarean section.

April 30, 2018
NYS Obstetric Hemorrhage Project

• Educational focus areas:
  – Risk assessment for obstetric hemorrhage
  – Establishing a response team
  – Quantification of blood loss
    • Included one-on-one training with NYS AWHONN leadership and hospital teams
  – Drills and simulation
  – Engaging patients, families, and community
  – Massive transfusion protocol
  – Maternal stability: the role of vital signs in blood loss
  – Case reviews
  – Maternal mental health
Percent of Patients Receiving a Hemorrhage Risk Assessment on Admission and Postpartum

- 21% improvement in the on admission measure from baseline; and
- 97% improvement in the post-partum measure from baseline

GOAL MET!

COVID-19

TJC standards

New York State

Department of Health

Percent %

- 21% improvement in the on admission measure from baseline; and
- 97% improvement in the post-partum measure from baseline
Hemorrhage Response Team Established

- Q1 2019: 17% In Place, 6% Working On It, 5% Haven't Started
- Q2 2019: 14% In Place, 15% Working On It, 8% Haven't Started
- Q3 2019: 14% In Place, 12% Working On It, 4% Haven't Started
- Q4 2019: 12% In Place, 8% Working On It, 6% Haven't Started
- Q1 2020: 8% In Place, 12% Working On It, 6% Haven't Started
- Q2 2020: 6% In Place, 14% Working On It, 4% Haven't Started
- Q3 2020: 4% In Place, 14% Working On It, 4% Haven't Started
- Q4 2020: 4% In Place, 14% Working On It, 4% Haven't Started
- Q1 2021: 4% In Place, 14% Working On It, 4% Haven't Started

Legend:
- Green: In Place
- Yellow: Working On It
- Red: Haven't Started
Quantitative measurement of cumulative blood loss (QBL)

- **In Place**
- **Working On It**
- **Haven't Started**
Obstetric Hemorrhage Drills

- 78% (61/78) of hospitals reported completing at least one drill in the past year

- 78% (61/78) of hospitals reported completing at least one drill debrief in the past year
Structure Measures

• Policies and Protocols
  – 99% of hospitals have a unit policy and procedure(s) on obstetric hemorrhage (updated in the last 2-3 years)
  – 99% established a massive transfusion protocol
  – 100% established an emergency release protocol

• Supplies and Medication
  – 100% of hospitals have OB hemorrhage supplies readily available, typically in a cart or mobile box
  – 100% have STAT (immediate) access to hemorrhage medications (kit or equivalent)
Percent of Patients with an Intervention, among Patients Experiencing an OB Hemorrhage

*Transfer to higher care includes to the hospital’s ICU or to a higher-level hospital (e.g., the Regional Perinatal Center).
The project seeks to identify and manage the care of people with OUD during pregnancy, and improve the identification, standardization of therapy and coordination of aftercare of infants with NAS.

The project began in September 2018 as a pilot with 17 birthing hospitals and expanded in October 2020 to include an additional 26 hospitals.
New York State (NYS) Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project

Key Drivers

- Standardize patient education regarding mother and infant health during pregnancy and postpartum
  - Provide patient education on OUD, NAS, naloxone, the importance of maternal involvement in infant care postpartum, and the CPS reporting process
  - Facilitate prenatal consults with pediatrician and lactation specialist for opioid exposed newborns (OEN)
  - Provide lactation education and support to all pregnant people, including those on psychotherapy and MAT
  - Engage parent/family partners in quality improvement initiative to provide unique perspective

- Standardize provider and staff education on OUD and pregnancy/postpartum care
- Increase the number of providers trained in MAT to treat pregnant and postpartum people with OUD
- Provide staff-wide training on:
  - Opioid Use Disorder
  - Verbal screening and toxicology testing
  - Management and treatment of OUD
  - Stigma
  - Breastfeeding implications
  - Management of acute withdrawal
  - Trauma informed care
  - CPS reporting process
  - Cultural humility and non-judgmental care
  - Prescribing guidelines for pain management / alternative therapies for pain management
  - Maternal involvement in pediatric management of NAS and infant care postpartum

- Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective

Patient & Family Education

Provider Education

Identification of Pregnant People with Opioid Use Disorder

Optimize Medical Care of Pregnant People with OUD

Create a Multidisciplinary Coordinated Discharge Plan

Global AIM

Improve the identification and treatment of pregnant people with opioid use disorder.

SMARTIE AIM

By December 2021, increase the percent of pregnant people screened for substance use disorder (SUD) with a verbal screening tool by 20%.

By December 2021, increase the percent of pregnant people with opioid use disorder (OUD) who are referred for treatment by 20%.
New York State (NYS) Opioid Use Disorder in Pregnancy & Neonatal Abstinence Syndrome Project
Neonatal Abstinence Syndrome (NAS) Driver Diagram

Key Drivers

- Standardize parent and family education regarding mother/baby health postpartum
  - Provide parent and family education on OUD, NAS and the importance of maternal involvement in infant care
  - Provide lactation education and support to all pregnant people
  - Engage parent and family partners in quality improvement initiative to provide unique perspective

- Standardize provider and staff education on OUD and postpartum care
  - Provide staff-wide training on:
    - Opioid Use Disorder
    - Management and treatment of OUD
    - Verbal screening of mother and toxicity testing
    - CPS reporting process
    - Breastfeeding implications
    - Trauma-informed care
    - Cultural humility and non-judgmental care
    - Maternal involvement in pediatric management of NAS and infant care postpartum
  - Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective

- Collaborate with OB providers to identify mothers whose newborns may be opioid exposed
- Involve obstetricians in the discussion about OEN
- Train clinical staff to recognize signs and severity of NAS

Non-pharmacologic care
- Utilize function-based assessments consisting of symptom prioritization for the assessment and management of NAS (Eat, Sleep, Console)
- Establish and implement standardized protocols for non-pharmacological management including:
  - Low lighting / quiet environment
  - Encourage kangaroo care / skin-to-skin contact
  - Allow morning as appropriate
  - Encourage / support breastfeeding if appropriate
- Encourage and facilitate maternal involvement with the newborn
- Multidisciplinary care coordination
- Shared decision making approach between caregiver and providers

Pharmacologic care
- Establish and implement standardized protocols for pharmacological management of newborns with NAS
- Multidisciplinary care coordination
- Shared decision making approach between caregiver and providers

- Engage the multidisciplinary team with mother and identified care partner(s) in discharge planning
  - Create a plan for how the home environment will support the mother/baby dyad
  - Engage social work for assessment and link to community based services for the mother/baby dyad including WIC, Early Intervention, transportation assistance, etc.
  - Schedule a developmental follow-up appointment
  - Refer to Early Intervention services as needed
  - Engage families in safety planning and consider home safety assessment referral
- Ongoing communication between obstetric and pediatric teams

SMARTIE AIM
By December 2021, decrease the average hospital length of stay (ALOS) for newborns with NAS by 10%.

Global AIM
Improve the care of infants with NAS.

Create a Multidisciplinary Coordinated Discharge Plan

* Refer to project Change Package for additional detail.
Universal screening protocol for OUD with a standardized questionnaire on admission to labor and delivery

Percent %

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2019 Q1</th>
<th>2019 Q2</th>
<th>2019 Q3</th>
<th>2019 Q4</th>
<th>2020 Q1</th>
<th>2020 Q2</th>
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<td>Percent</td>
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<td>7%</td>
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<td>7%</td>
<td>43%</td>
<td>43%</td>
<td>29%</td>
<td>21%</td>
<td>21%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Colors:
- **In Place**
- **Working On It**
- **Haven't Started**
Protocol / process flow (e.g., SBIRT) for pregnant patients who report or screen positive for OUD to assess and link to MAT/addiction treatment services/behavioral health support.
Neonatal Measures

• 100% of pilot hospitals have:
  – Standardized non-pharmacologic guidelines for opioid-exposed newborns (as of Q4 2020)
  – Standardized pharmacologic guidelines for opioid-exposed newborns (as of Q1 2020)
NYSPQC Resources

NEONATAL ABSTINENCE SYNDROME (NAS)

What You Need To Know

1. Hold your baby: When your baby is fussy or upset, hold your baby. Your family can help, too.
2. Practice these calming techniques:
   - Swaddle or tightly wrap your baby in a blanket to help soothe him or her.
   - Ask your nurse to show you how to swaddle your baby.
   - Offer a pacifier.
   - Try soothing.
   - Use slow, rhythmic, up-and-down movements.
3. Feed on demand: If you can, feed your baby breast milk. Feed your baby on demand by watching for signs your baby is hungry instead of the clock.
4. Skin-to-skin: Holding your baby skin-to-skin can help calm your baby. Be careful, though—avoid falling asleep while holding your baby. If you are feeling sleepy, place your baby on his or her back in a bassinet or crib close to your bed.
5. Room In: Stay in the same room with your baby in the hospital if possible. This will help make sure you will be close by when your baby cries or is fussy, so you can hold and comfort your baby.
6. Quiet room: Keep the noise level as low as possible by limiting visitors, asking your family, friends and hospital staff to speak softly, keeping the TV volume low, and talking quietly on the phone.
7. Dim the lights in your room.
8. Cluster care: Ask your doctors and nurses to group their care visits together when possible to help limit disruptions for your baby.
9. Medications: Some babies with NAS require medication to help with their symptoms of withdrawal, to allow them to sleep, eat, and be comfortable.

NYSDOH and NYPQC gratefully acknowledge Boston Medical Center for its contributions to this brochure.

Newborn Care Journal

<table>
<thead>
<tr>
<th>Baby's Name</th>
<th>Baby's Date of Birth</th>
<th>Today's Date:</th>
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<table>
<thead>
<tr>
<th>Time of Feeding</th>
<th>Breastfeeding (total oz)</th>
<th>Bottle Feeding (total oz)</th>
<th>Did baby need milk?</th>
<th>Check for Fever</th>
<th>Check for Sleep</th>
<th>Time when baby will wake up</th>
<th>Time when baby woke up</th>
<th>Did baby sleep for 10 min or more?</th>
<th>Did baby cry in 10 min?</th>
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<td>6:15 am - 6:45 am</td>
<td>1 - 20 oz</td>
<td>0 - 30 oz</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>8:00 am</td>
<td>8:00 am</td>
<td>Yes</td>
<td>Yes</td>
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New York State Department of Health

Departments of Health
NYSPQC Resources

Perinatal Substance Use
5 ways you can improve care during pregnancy and beyond

- Educate Yourself
  Learn more about the pharmacology of substance use. Promote evidence-based care by communicating with patients in a way that separates fact from fiction. Understand the cycles of sobriety and relapse so that you can help patients plan for their recovery. Advise on the risks associated with polysubstance use.

- Use the Right Words
  Know the difference between substance use, substance misuse, and Substance Use Disorder (SUD). Recognize that substance use carries a stigma, which is a barrier to seeking care. Reject language that shames.

- Verbally Screen Every Patient
  Talking about substance use should be a routine part of every patient’s medical care. Get comfortable discussing it. Ask questions and listen to what your patients have to say. You may be the first person to ever ask.

- Get Trained to Offer MAT
  Medication-Assisted Treatment is the Standard of Care during pregnancy, but there are not enough providers. Contact the New York State Health Department at https://health.ny.gov to become an MAT provider. Make naloxone available to all your patients who use opioids.

- End the Stigma

OPIOIDS and Neonatal Abstinence Syndrome (NAS)
LANGUAGE MATTERS

I am not an addict.
I was exposed to substances in utero. I am not addicted. Addiction is a set of behaviors associated with having a Substance Use Disorder (SUD).

I was exposed to opioids.
I was exposed to the medications and substances my parent used. While I was in the womb, we shared a blood supply. I may have become dependent on some of those substances.

NAS is a temporary and treatable condition.
It can be treated with prescription medications and care that comforts, such as breastfeeding, swaddling, and offering pacifiers.

My parent may have a SUD.
They might be receiving Medication-Assisted Treatment (MAT). My NAS may be a side effect of their appropriate medical care. It is not evidence of abuse or mistreatment.

My potential is limitless.
I am so much more than my NAS diagnosis. My drug exposure will not determine my long-term outcomes. But how you treat me will. When you invest in my family’s health and well-being you can expect that I will do as well as any of my peers!

How to Care For a Baby with Neonatal Abstinence Syndrome (NAS)

- Use the Right Words
  I was exposed to substances in utero. I am not an addict. My parent may or may not have a Substance Use Disorder (SUD).

- Treat Us as a Dyad
  Parents and babies need each other. Help us bond. Whenever possible, provide my care alongside yours and teach them how to meet my needs.

- Support Rooming-In
  Babies like me do best in a calm, quiet, dimly lit room where we can be close to our caregivers.

- Promote Kangaroo Care
  Skin-to-skin care helps me stabilize and self-regulate. It helps relieve symptoms that occur during withdrawal. It also promotes bonding.

- Try Non-Pharmacological Care
  Help me self-soothe. Swaddle me snugly. Offer me a pacifier to suck on. Protect my sleep by “clustering” my care.

- Support Breastfeeding
  Breast milk is important to my gastrointestinal health. Breastfeeding is recommended when moms are HIV negative and receiving medically-supervised care. Help my parents reach their pumping and breastfeeding goals.

- Treat My Symptoms
  If I am experiencing withdrawal symptoms that make it hard for me to eat, sleep, and be soothed, create a care plan to help me be comfortable.
Community Resource Mapping Tools

Together with NYS Office of Addiction Services and Supports (OASAS), the NYSQPC developed county-level community mapping tools for each participating hospital.

### Hospital Name:

#### Hotlines

SAMHSA Treatment Hotline: 1-800-662-HELP (4357)
Substance Abuse and Mental Health Services Administration
Confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members seeking referral to treatment facilities, support groups, and community-based organizations.

NYS OASAS HOPeline: 1-877-8-HOPENY (1-877-848-6369)
HOPeline Services Include:
- Masters level clinicians who are professional, well-trained and knowledgeable
- Crisis and motivational interviewing for callers in need
- Referrals to more than 1,500 local prevention and treatment providers
- 48 hours call back to those who wish to be contacted
- Multi-lingual
- Informational materials

### Substance Use Treatment Services

Substance Use Disorder Treatment - Opioid Treatment Provider:
Program Name: PROMSEA
Contact Information:
Street: 175 Central Avenue
City: Albany
State & Zip: NY, 12206
Phone: 518-729-5659
Website: https://www.acacianetwork/services-guide/
Helpful Tips for Successful Referral:

Program Name: Whitney M. Young, Jr Health Center
Contact Information:
Street: 10 DeWitt Street
City: Albany
State & Zip: NY, 12207
Phone: 518-591-4894
Website: https://www.wmyhealth.org/
Helpful Tips for Successful Referral:
NYSPQC Safe Sleep Project

• Between September 2015 and July 2017, 72 hospitals participated in improvement practices related to infant safe sleep and focused on:
  – Collaborating across hospital teams to share and learn;
  – Implementing policies to support/facilitate safe sleep practices;
  – Educating health care professionals so they understand, actively endorse and model safe sleep practices; and
  – Providing infant caregivers education and opportunities so they have the knowledge, skills and self-efficacy to practice safe sleep for every sleep.
SAFE SLEEP

**DRIVERS**

- **Health care professionals understand, actively endorse and model safe sleep practices**
- **Infant caregivers have the knowledge, skills and self-efficacy to practice safe sleep for every infant**
- **Engage and activate infant caregivers, community to support safe sleep**
- **Policies support/facilitate safe sleep practices**
- **Spread bright spots within facility and to other facilities**

**CHANGES**

- **Medical and nursing staff model safe sleep practices in hospital before discharge**
- **Standardized education and training for health professionals on current AAP guidelines for infant safe sleep, including promoting breastfeeding in a safe sleep environment**
- **Train and support healthcare professionals in using engagement techniques (e.g., motivational interviewing, teach back, etc.)**
- **Individualized education to families, encourages honest conversation and includes skill building, explains rationale behind recommendations and addresses misconceptions and caregiver concerns on safe sleep**
- **Reduce barriers and provide families with needed supports to keep infants safe within the context of their daily realities**
- **Parents offered teach back and provided written materials on safe sleep at pre-natal visits and classes, hospital discharge, lactation consultations, the post-partum visit, and newborn well child visits**
- **Utilize a harm reduction message on safe sleep**
- **Safe sleep messaging and teach back (including promoting breastfeeding in a safe sleep environment) promoted through all state agencies and programs that interact with pregnant women and families such as home visiting, WIC, injury prevention, substance abuse, child welfare, breastfeeding promotion, immunization, housing assistance**
- **Safe sleep behavior is understood and championed by trusted individuals and groups who are influential in the lives of mothers, fathers, grandparents and other infant caregivers**
- **Develop and implement culturally congruent education materials, social marketing/media messages and communication strategies on safe sleep in partnership with families and communities**
- **Standardized policies, practices and reporting for infant deaths and death scene review**
- **Hospital policy consistent with AAP guidelines and addresses the need for family-centered parent education and staff training/behavior modeling**
- **Identify high risk populations and implement a comprehensive plan to support individuals and families at greatest risk for sleep-related infant deaths to implement safe sleep practices**
- **Utilize local data to identify bright spots within facility and across facilities in the Collaborative**
- **Build partnerships with families and activate champions within the community**

**CoRIN AIM Statement**

By July 2016, reduce infant sleep-related deaths by improving safe sleep practices so that states:

1. Decrease sleep-related SUID mortality rate by 10%;
2. Reduce relative disparities between white and non-Hispanic Black and American Indian/Alaska natives for all aims by 10%;
3. Increase the % infants placed on their backs for sleep by 16% or more;
4. Increase the % of infants placed to sleep in a safe sleep environment by 10% or more;
5. Increase the % of infants sleeping alone by 10% or more

**IYSQPC AIM Statement**

By September 2016, we AIM to reduce infant sleep-related deaths in IYS by improving safe sleep practices for infants. To accomplish this, we will form a multidisciplinary team (with members from our OB and neonatal care units) and work to implement evidence based infant mortality reduction strategies to achieve:

1. > 10% increase in infants placed to sleep in a safe sleep environment during hospitalization
2. Document education for > 95% of caregivers prior to discharge; and
3. > 95% of caregivers reporting prior to discharge that they understand safe sleep educational messages (infant to sleep alone, on back, in crib).
System Change: Improving Safe Sleep Practices

- Increased understanding by hospital staff members regarding safe sleep practices
- Increased modeling of safe sleep practices in hospital (flat crib, no objects, safe sleep clothing/blankets)
- Increased safe sleep practices by caregivers/parents (flat crib, no objects, safe sleep clothing/blankets)
Percent of Medical Records with Documentation of Safe Sleep Education

Percent %

<table>
<thead>
<tr>
<th>Month</th>
<th>Percent</th>
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<td>Sep-15</td>
<td>90.3</td>
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<tr>
<td>Oct-15</td>
<td>92.6</td>
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<tr>
<td>Nov-15</td>
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<tr>
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<td>98.0</td>
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<td>May-17</td>
<td>98.0</td>
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<tr>
<td>Jun-17</td>
<td>98.0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>98.0</td>
</tr>
</tbody>
</table>
Percent of Infants, Sleeping or Awake-and-unattended, in a Safe Sleep Environment

*A safe sleep environment is defined as infants who were positioned supine, in safe clothing, with head of crib flat and no objects in the crib.
Percent of Primary Caregivers Indicating They Understand Safe Sleep Practices*

*Understanding safe sleep practices is defined as reporting that infants should sleep alone, on their back, in a crib, with the crib free of objects.
NYSPQC Safe Sleep Project: Lessons Learned

– Providing staff education:
  • Nurses – small groups
  • Residents – grand rounds
  • Promoting NICHD nurse training

– Educating all staff members who encounter babies (i.e., audiologists)

– Heightened awareness in hospital units using signage, crib cards, etc.

– Participation in Cribs 4 Kids hospital safe sleep program
NYSPQC Safe Sleep Project: Lessons Learned

- Distribution of wearable blankets
- Cultural considerations:
  - Utilization of translators
  - Materials available in multiple languages
  - Various tools for different population – video, brochure, poster, low literacy tool, etc.
- Modeling!!! → Crib audits
- Safe sleep champion on rounds
  - Champion may be an RN, PT, etc.
Contact Us!

New York State Perinatal Quality Collaborative
Empire State Plaza
Corning Tower, Room 984
Albany, NY 12237

Ph: (518) 473-9883
F: (518) 474-1420
NYSPQC@health.ny.gov
www.nyspqc.org
OPQIC
Oklahoma Perinatal Quality Improvement Collaborative
Creating a culture of excellence, safety and equity in perinatal care
OPQIC ...Creating a culture of excellence, safety and equity in perinatal care

- Oklahoma = 46 birthing hospitals, 49,000 annual births
- Collaborative of hospital teams, physicians, nurses, patients, public health and community stakeholders. Established 2014
- 5 paid staff – 4.25 FTE
- opqic.org launched in 2015
- Primary areas of focus:
  - Reduce early elective deliveries (sustainment)
  - Improve outcomes of OB Hemorrhage & Severe Hypertension (sustainment)
  - Amplify AWHONN's Post-birth Warning Signs education (sustainment)
  - Improve reliability & timeliness of newborn screening
  - Improve outcomes in Maternal OUD & NAS
  - Increase Patient and Family Engagement
Need more information?

https://opqic.org

info@opqic.org

Facebook | Twitter | YouTube | Instagram
CURRENT PRIORITIES
Oklahoma Mothers and Newborns Affected by Opioids

Launched with 17 pilot hospitals on March 3, 2020
Reboot September 2020

Oklahoma Perinatal Quality Improvement Collaborative
OPQIC.org
1. Reduce opioid use in pregnancy and fetal exposure to opioids
2. Prevent opioid overdose and death
3. Increase percentage of pregnant women with OUD who receive MAT and Behavioral Health Counseling
4. Reduce LOS for newborns with NAS
5. Improve post-discharge social and developmental outcomes for families affected by opioid use disorder
Our Partnership

Digital health company focused on the lifecycle of substance use disorder (SUD), from prevention to intervention to treatment to recovery.
Data Collection
### Maternal Data Collection Form

**Data Collection:**
- Complete this data collection for all women with Opioid Use Disorder (OUD) delivering at your hospital. This includes all cases when:
  - Mother has a positive self-report screen or assessed to have OUD.
  - Mother has positive opioid or alcohol test before delivery (includes hospital opioid administration for acute pain).
  - Mother reports OUD.
  - Mother is using any non-prescribed opioids during pregnancy (2nd or 3rd trimester).
  - Mother is using opioids chronically for longer than a month in the third trimester.
  - Newborn has a positive screen for opioids.
  - Newborn has symptoms associated with opioid exposure or neonatal abstinence syndrome (NAS/NOWS).

**RedCap Identifiers:** TO be automatically assigned upon data entry.

<table>
<thead>
<tr>
<th>RedCap Record ID</th>
<th>RedCap Record ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Demographics**

<table>
<thead>
<tr>
<th>Maternal Age (years)</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of infants born male from the current pregnancy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3 or more</td>
</tr>
<tr>
<td>Number of fetal deaths and/or infants born deceased from the current pregnancy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3 or more</td>
</tr>
</tbody>
</table>

**Race/Ethnicity**

- Asian
- Black or African descent
- Native American Indian or Alaskan Native
- Hawaiian or other Pacific Islander
- White or European descent
- Other
- Unknown

**Maternal Insurance Status**

- Indian Health Service
- Private insurance
- SomanCare
- TRICARE/Military
- Uninsured/self-pay
- Other
- Unknown

**Delivery Information and Disposition**

<table>
<thead>
<tr>
<th>Maternal Zip code</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3 or more</th>
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<tbody>
<tr>
<td>Date of Delivery</td>
<td>1/2/3/4/5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal age at delivery, weeks or days</td>
<td>0-45</td>
<td>45-90</td>
<td>90-180</td>
<td>180-365</td>
</tr>
<tr>
<td>Gestational age at delivery, weeks or days</td>
<td>0-40</td>
<td>40-42</td>
<td>42-43</td>
<td>43-44</td>
</tr>
</tbody>
</table>

### Neonatal Data Collection Form

**Data Collection:**
- Include all infants who were opioid exposed.

- Mother has a positive self-report screen or assessed to have OUD.
- Mother with positive maternal opioid use disorder test before delivery.
- Mother reports OUD.
- Mother is using any non-prescribed opioids during pregnancy (2nd or 3rd trimester).
- Mother is using prescribed opioids chronically for longer than a month in the third trimester.
- Newborn has a positive screen for opioids.
- Newborn has symptoms associated with opioid exposure or neonatal abstinence syndrome (NAS/NOWS).

**RedCap Identifier:** To be automatically assigned upon data entry.

<table>
<thead>
<tr>
<th>RedCap Record ID</th>
<th>RedCap Record ID</th>
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</table>

**Demographics**

<table>
<thead>
<tr>
<th>Infant's Birth Order</th>
<th>1</th>
<th>2</th>
<th>3 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational age at delivery, weeks or days</td>
<td>0-40</td>
<td>40-42</td>
<td>42-43</td>
</tr>
</tbody>
</table>

**Birth Weight (grams)**

- Birth weight

**Birth Defecation Code**

- Male
- Female/Unsure/unable to determine
- Unknown

**Race/Ethnicity**

- Asian
- Black or African descent
- Native American Indian or Alaskan Native
- Hawaiian or other Pacific Islander
- White or European descent
- Other
- Unknown

**Maternal Insurance Status**

- Indian Health Service
- Private insurance
- SomanCare
- TRICARE/Military
- Uninsured/self-pay
- Other
- Unknown
Average Length of Stay for Opioid-Exposed Newborns

Each set of bars represents one hospital

Q2 2021 Collaborative-Wide
with Withdrawal = 12.7
ALL OEN = 9.1

With NAS
ALL OEN
Percent of Women with OUD During Pregnancy who receive medication-assisted treatment OR behavioral health treatment

Each bar represents one hospital

Q2 2021 Collaborative-Wide
47/78 = 60%
Prenatal Care Sites with Universal Screening Policy

- Q4 2020: 52% Sites with Universal Screening, 48% Sites without Universal Screening
- Q1 2021: 67% Sites with Universal Screening, 33% Sites without Universal Screening
- Q2 2021: 73% Sites with Universal Screening, 27% Sites without Universal Screening

Legend:
- Red: Sites without Universal Screening
- Green: Sites with Universal Screening
Proposed Solution: Family Care Plans

SBIRT at prenatal visits and other points of contact with pregnant individuals

Referral to SUD treatment agency for assessment/treatment

Treatment agency or other provider develops the Family Care Plan; parent is the holder of the plan.

Family Care Plan informs discharge planning and evolves to a postpartum Family Care Plan for up to a year

Family Care Plan is shared with hospital prior to birth event

Parent shares plan with additional providers
TEAMBIRTH IN OKLAHOMA
TeamBirth: Process Innovation for Clinical Safety, Effective Communication, and Dignity in Childbirth

Oklahoma First Statewide Initiative

3-year Collaborative Agreement

This project is Supported by the State Maternal Health Innovation Program Grant, Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services.
Our vision is a world in which every person can choose to grow their family with dignity.
TeamBirth Components
### Labor and Delivery Planning Board

<table>
<thead>
<tr>
<th>TEAM</th>
<th>DATE</th>
<th>ROOM</th>
<th>LAST HUDDLE</th>
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<table>
<thead>
<tr>
<th>PREFERENCES</th>
<th>EARLY LABOR</th>
<th>ACTIVE LABOR</th>
<th>PUSHING</th>
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</table>

### PLAN

- **Mom:**
- **Baby:**
- **Labor Progress:**
“Including me and my family in communication during labor would have eliminated so many questions that I still have about what the team did or didn't do to help me.”

"I would have had confidence to ask for more testing, and maybe the multiple doctors working on my case would have worked more collaboratively with me and together to get an effective plan in place."

-Members of Oklahoma Patient Partner Network
Timeline and Components

Prepare (Jul - Aug 2021)
- Build Implementation team
- IRB

Engage & coach (Sep - Jan 2022)
- Monthly webinars
- Coaching calls

Launch (Feb/Mar - Jun 2022)
- Monthly webinars
- Coaching calls

Sustain (Jul 2022 ->)
- Coaching calls
- Add Cohort 2 hospitals
OPQIC UPDATE: EMPOWERING PREGNANT AND POSTPARTUM PATIENTS

Sarah Johnson
OPQIC Maternal Peer Navigator
Empowering Pregnant and Postpartum Patients

For use with Empowering Pregnant and Postpartum Patients Implementation Guide.

1. Urgent Maternal Warning Signs
   - Prenatal Care Visit
     - Engage patients and support persons by educating on Urgent Maternal Warning Signs and how to seek care.
     - Place Urgent Maternal Warning signs posters in clinic exam rooms and waiting areas. Give patients and support persons written materials to keep as a reference. Provide explanations and review with patient and support persons.
     - Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document these conversations.

2. AWHONN POST-BIRTH Warning Signs
   - Postpartum Hospitalization
     - Educate patients and support persons on the AWHONN POST-BIRTH Warning Signs and how to seek care.
     - Use the AWHONN POST-BIRTH Warning Signs handout as tool. Provide a copy to patients and support persons.
     - Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document this conversation.

3. Helpful Post-Birth Resources
   - Postpartum Hospitalization
     - Review OPIQC Helpful Post-Birth Resources with all patients and support persons. Encourage to use for non-emergent needs.
     - Urge patients to send questions to patientsupport@opqic.org. Document this conversation.

4. Post-Birth Clinical Summary
   - Postpartum Hospitalization
     - Educate all patient and support persons on the clinical circumstances of their birth using the Clinical Summary as a tool, particularly those with complications. Provide written summary to patient.
     - Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document this conversation.

All handouts can be found by visiting https://opqic.org/patienthandouts/
1. Urgent Maternal Warning Signs

Prenatal Care Visit

- Engage patients and support persons by educating on **Urgent Maternal Warning Signs** and how to seek care.
- Place Urgent Maternal Warning Signs posters in clinic exam rooms and waiting areas. Give patients and support persons written materials to keep as a reference. Provide explanations and review with patient and support persons.
- Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document these conversations.
URGENT MATERNAL WARNING SIGNS

If you have any of these symptoms during or after pregnancy, contact your health care provider and get help right away. If you can’t reach your provider, go to the emergency room.

- Headache that won’t go away or gets worse over time
- Dizziness or fainting
- Thoughts about hurting yourself or your baby
- Changes in your vision
- Fever
- Trouble breathing
- Chest pain or fast-beating heart
- Severe belly pain that doesn’t go away
- Severe nausea and throwing up (not like morning sickness)
- Baby’s movements stopping or slowing during pregnancy
- Vaginal bleeding or fluid leaking during pregnancy
- Vaginal bleeding or fluid leaking after pregnancy
- Swelling, redness, or pain of your leg
- Extreme swelling of your hands or face
- Overwhelming tiredness

https://safehealthcareforeverywoman.org/
https://opqic.org/patienthandouts/
URGENT MATERNAL WARNING SIGNS

- Headache that won't go away or gets worse over time
- Dizziness or fainting
- Thoughts about hurting yourself or your baby
- Changes in your vision
- Fever
- Trouble breathing
- Chest pain or fast-beating heart
- Severe belly pain that doesn't go away
- Severe nausea and throwing up (not like morning sickness)
- Baby's movements stopping or slowing
- Vaginal bleeding or fluid leaking during pregnancy
- Vaginal bleeding or fluid leaking after pregnancy

https://www.cdc.gov/hearher/index.html
https://opqic.org/patienthandouts/
AWHONN POST-BIRTH Warning Signs

Postpartum Hospitalization

- Educate patients and support persons on the AWHONN POST-BIRTH Warning Signs and how to seek care.
- Use the AWHONN POST-BIRTH Warning Signs handout as tool. Provide a hard copy to patients and support persons.
- Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document this conversation.
AWHONN Post-Birth Warning Signs Education Program

SAVE YOUR LIFE:

Get Care for These POST-BIRTH Warning Signs

Most women who give birth recover without problems. But any woman can have complications after giving birth. Learning to recognize these POST-BIRTH warning signs and knowing what to do can save your life.

Call 911 if you have:

- Pain in chest
- Obstructed breathing or shortness of breath
- Seizures
- Thoughts of hurting yourself or someone else

Call your healthcare provider if you have:

(If you can’t reach your healthcare provider, call 911 or go to an emergency room)

- Bleeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger
- Incision that is not healing
- Red or swollen leg, that is painful or warm to touch
- Temperature of 100.4°F or higher
- Headache that does not get better, even after taking medicine, or bad headache with vision changes

Trust your instincts. Always get medical help if you think you have a life-threatening condition or situation.

Tell 911 or your healthcare provider:

“I gave birth on _________ (Date) and I am having _________”

These post-birth warning signs can become life-threatening if you don’t receive medical care right away because:

- Pain in chest
- Obstructed breathing or shortness of breath
- Seizures
- Thoughts of hurting yourself or someone else
- Bleeding (heavy), soaking more than one pad in an hour or passing an egg-sized clot or bigger may mean you have an obstetric hemorrhage
- Infection that is not healing, increased redness or any pain from episiotomy or C-section
- Headache (very painful), vision changes, or pain in the upper right area of your belly may mean you have high blood pressure or post-birth preeclampsia


https://opqic.org/patienthandouts/
Helpful Post-Birth Resources

Postpartum Hospitalization

- Review [OPQIC Helpful Post-Birth Resources](#) with all patients and support persons. Encourage to use for non-emergent needs.

- Urge patients to send questions to [patientsupport@opqic.org](mailto:patientsupport@opqic.org). Document this conversation.
Helpful Post-Birth Resources

Breastfeeding Support
Oklahoma Breastfeeding Hotline
1-877-271-MILK (6455) or Text OK2BF to 61222
Coalition of Oklahoma Breastfeeding Advocates
https://www.okbreastfeeding.org/breastfeeding-help.html

New Mom Health & Family Support
The 4th Trimester Project
A village for mothers
www.newmomhealth.com
www.saludmadre.com

Mental Health Support
www.postpartum.net
1-800-944-4773 English & Español
Text in English: 800-944-4773
Text en Español: 971-203-7773

Post-Birth Resources
For more information and links to resources.
https://opqic.org/opqicv2

Don’t hesitate!
Contact your provider with questions
Call 911 for an emergency

For further assistance contact: PatientSupport@opqic.org

PATIENT RESOURCES

Please select from the topics below to view the resources.

- Oklahoma Patient Resources
- Advocacy/ Awareness Campaigns
- Birth Trauma Support
- Grief & Loss Support
- Medical Condition Specific Support
- Postpartum Mental Health Support
- Social Media Support Groups
- Reading Suggestions

OPQIC Patient Handout
- Post-Birth Support Resources - English
- Post Birth Support Resources - Spanish
- Post-Birth Clinical Summary (for provider use)

Oklahoma Based Support Resources
- Oklahoma Breast Feeding Hotline
- Oklahoma Family Network
  - NEST
- OSDH Resource Directory
- Oklahoma Mother’s Milk Bank
- Postpartum Support International (PSI) trained mental health providers

https://opqic.org/forpatients/patient-resources/
4 Post-Birth Clinical Summary

Postpartum Hospitalization

- Educate all patient and support persons on the clinical circumstances of their birth using the Clinical Summary as a tool, particularly those with complications. Provide written summary to patient.

- Urge patient to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document this conversation.
<table>
<thead>
<tr>
<th>Clinical Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name</strong></td>
</tr>
<tr>
<td><strong>Date of Delivery</strong></td>
</tr>
<tr>
<td><strong>Hospital</strong> Phone</td>
</tr>
<tr>
<td><strong>Type of Birth</strong> □ Vaginal □ C-section Comments: Blood Type</td>
</tr>
<tr>
<td><strong>Complications</strong> □ Obstetric Hemorrhage □ Severe Hypertension/Pre-eclampsia □ Venous Thromboembolism □ Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mom</strong> Pregnancy Outcome □ Live Birth □ Stillbirth □ NICU</td>
</tr>
<tr>
<td><strong>Baby</strong> GA (in weeks) Birthweight Length</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery</strong> Date Type</td>
</tr>
<tr>
<td><strong>Organs removed</strong></td>
</tr>
<tr>
<td><strong>Blood Transfusion</strong> Type of Blood Products □ Red Blood Cells □ Platelets □ Plasma</td>
</tr>
<tr>
<td><strong>Number of units</strong> __ Red Blood Cells __ Platelets __ Plasma</td>
</tr>
<tr>
<td><strong>Imaging Tests</strong> □ Yes □ No Date Type Result</td>
</tr>
<tr>
<td><strong>Interventional Radiology</strong> □ Yes □ No Date Type Result</td>
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<table>
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</table>

<table>
<thead>
<tr>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinician Name</strong> Phone</td>
</tr>
<tr>
<td><strong>Appointment Date</strong> Phone</td>
</tr>
</tbody>
</table>

For further information, please contact the Hospital Medical Record Office to request your complete medical record.

| Medical Records Phone |

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

Reference: [CMS Patients Clinical Summary Guidelines](#)
1. Urgent Maternal Warning Signs: Use this tool at Prenatal Care Visits.

**Responsible Persons - OB Physician, Clinic Nurse, Clinic Staff**

- Engage patients and support persons by educating on Urgent Maternal Warning Signs and how to seek care.
  - Strongly reinforce your desire for the patient to seek care if they have questions/concerns – invited vs. excluded. Give permission for them to seek care.
  - Explain to the patient why you would rather them seek care than blow something off. “I want you to ask questions.” “Do you have questions?” “If you ever have questions, please contact me in this way...”
  - When should the patient go to hospital? Give examples and let them know what hospital your clinic prefers them to go to.

- Place Urgent Maternal Warning Signs posters in clinic exam rooms and waiting areas. Give patients and support persons written materials to keep as a reference. Provide explanations and review with patient and support persons.
  - Reinforce the Urgent Maternal Warning Signs with clinic posters in waiting areas, restrooms, clinic exam rooms, etc.
  - Ensure all patients are provided a hard copy of the Urgent Maternal Warning Signs. Use the Print Cards, Educational Flyers, or Info Graphic Handout.
  - Train staff using CDC Maternal Healthcare Provider Practice Tools.

- Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document these conversations.
  - Ensure there is a number or other method to contact a person and speak to them in real time for emergency/urgent needs. Give it to the patient in writing.
  - What should patients do after hours if they have questions or concerns?
  - Provide instructions for specific scenarios, i.e. 1st trimester spotting. What is specific to your clinic and your hospital?
  - Remember that Women may avoid seeking care if their only option is to go to hospital ED.
  - Reduce the patients hassle factor by giving options for seeking care when they have concerns.
THANK YOU!

barbara-obrien@ouhsc.edu