State PQC Leaders Panel: National Perspectives on Improving Perinatal Care

State PQC Leaders

IL PQC
Illinois Perinatal Quality Collaborative

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


PN
QIN
PERINATAL-NEONATAL
QUALITY IMPROVEMENT NETWORK


MPQC
Massachusetts Perinatal Quality Collaborative


neoQIC

Goals

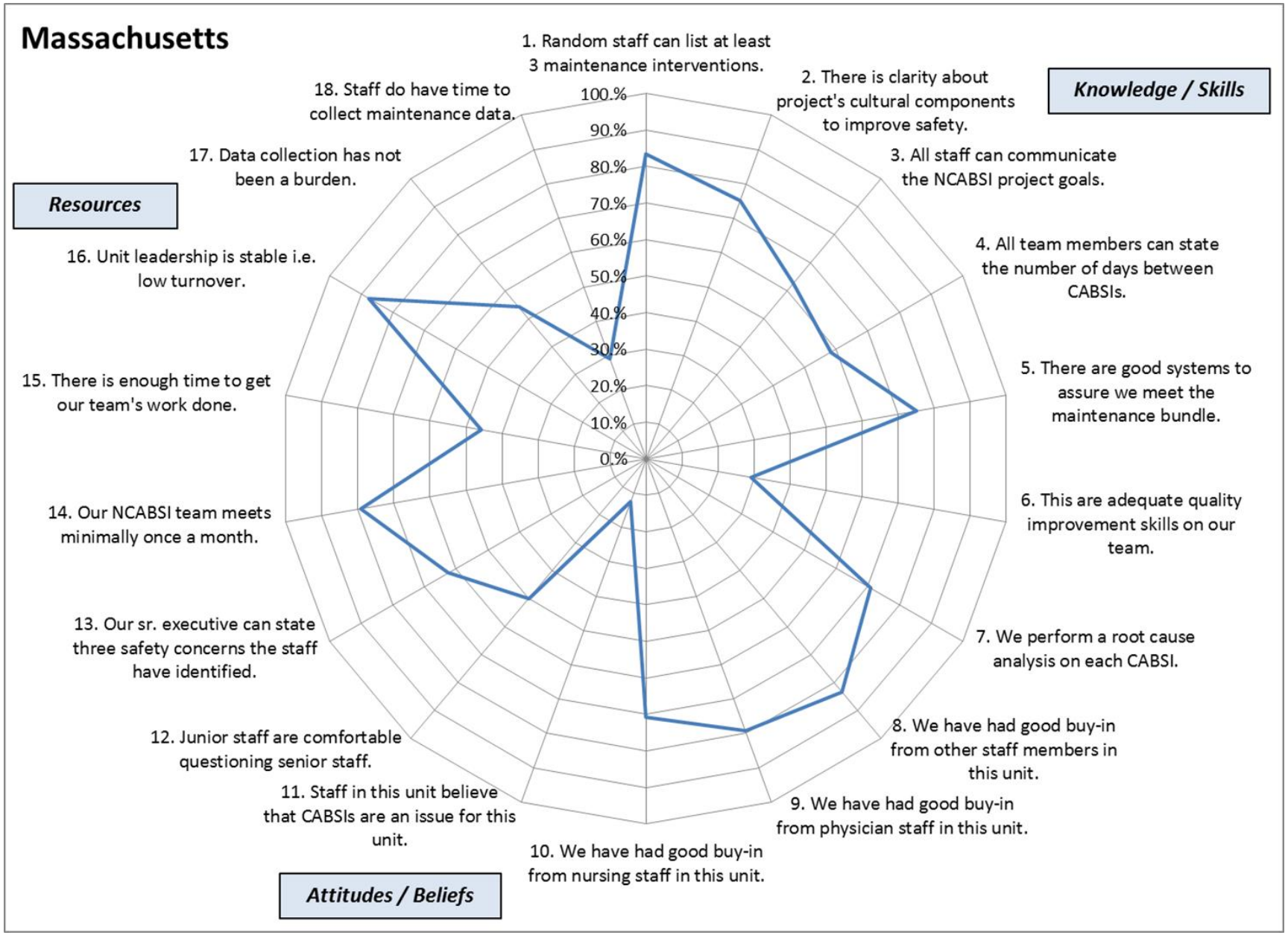
- A really quick overview of some of our neonatal projects in Massachusetts
- Highlights of what was good and not-so-good with each project

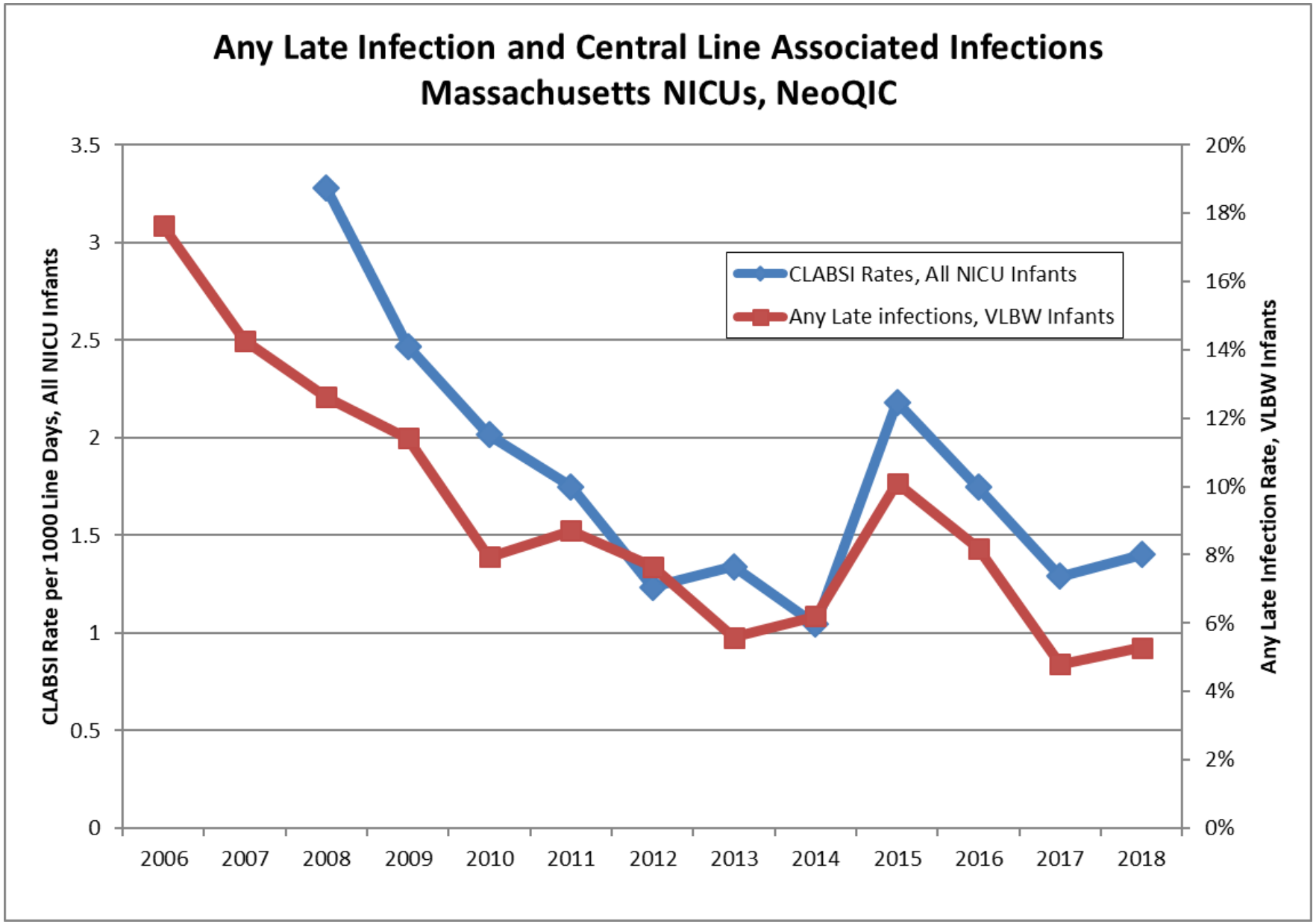
Projects

- 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


Massachusetts
1. Random staff can list at least 3 maintenance interventions.
2. There is clarity about project's cultural components to improve safety.
3. All staff can communicate the NCABSI project goals.
4. All team members can state the number of days between CABSIs.
5. There are good systems to assure we meet the maintenance bundle.
6. This are adequate quality improvement skills on our team.
7. We perform a root cause analysis on each CABSI.
8. We have had good buy-in from other staff members in this unit.
9. We have had good buy-in from physician staff in this unit.
10. We have had good buy-in from nursing staff in this unit.
11. Staff in this unit believe that CABSIs are an issue for this unit.
12. Junior staff are comfortable questioning senior staff.
13. Our sr. executive can state three safety concerns the staff have identified.
14. Our NCABSI team meets minimally once a month.
15. There is enough time to get our team's work done.
16. Unit leadership is stable i.e. low turnover.
17. Data collection has not been a burden.
18. Staff do have time to collect maintenance data.
100.%
90.%
80.%
70.%
60.%
50.%
40.%
30.%
20.%
10.%
0.%
Knowledge / Skills
Resources
Attitudes / Beliefs

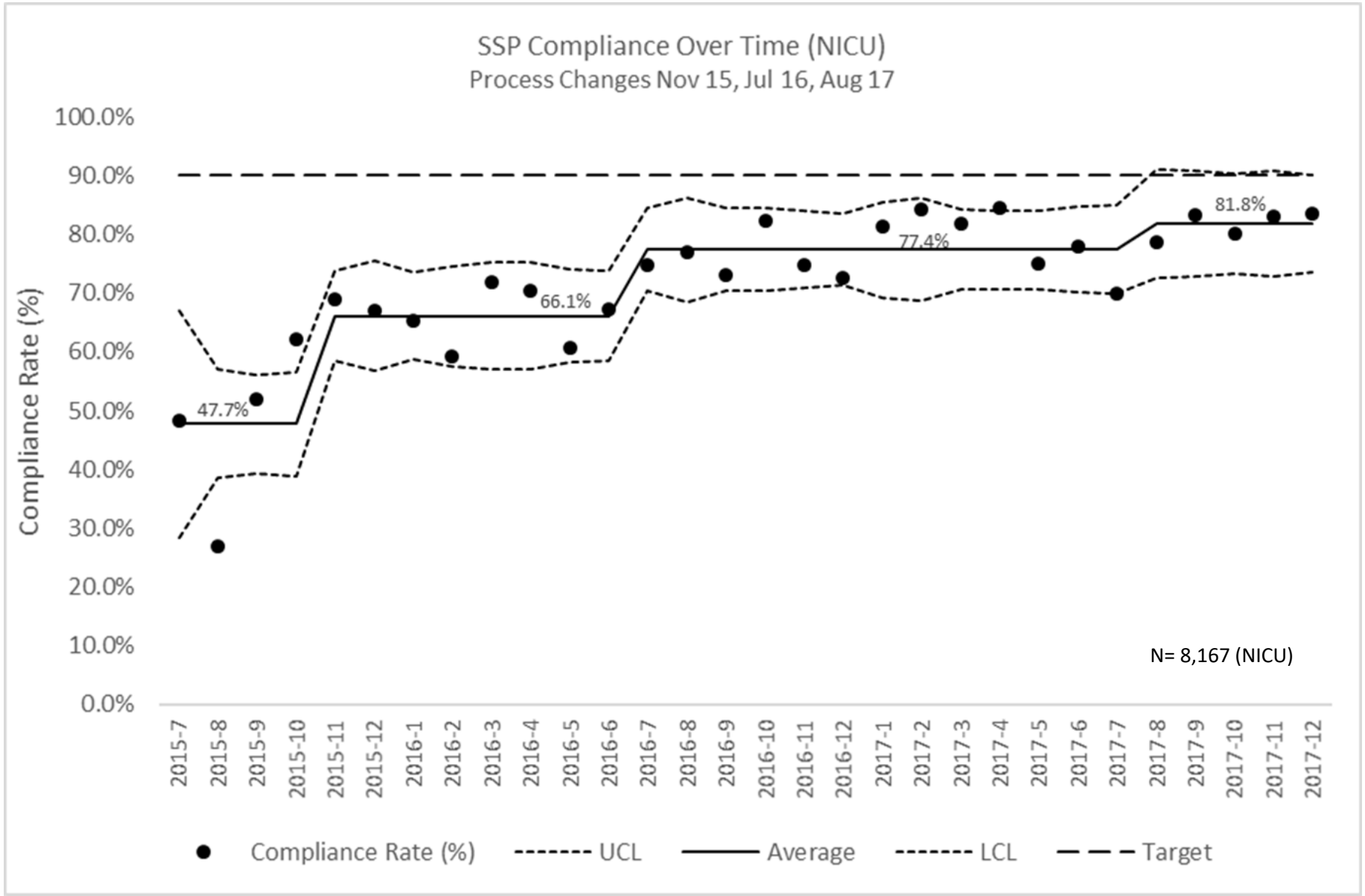

Any Late Infection and Central Line Associated Infections
Massachusetts NICUs, NeoQIC
CLABSI Rate per 1000 Line Days, All NICU Infants
Any Late Infection Rate, VLBW Infants
CLABSI Rates, All NICU Infants
Any Late infections, VLBW Infants
3.5
3
2.5
2
1.5
1
0.5
0
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018

Projects

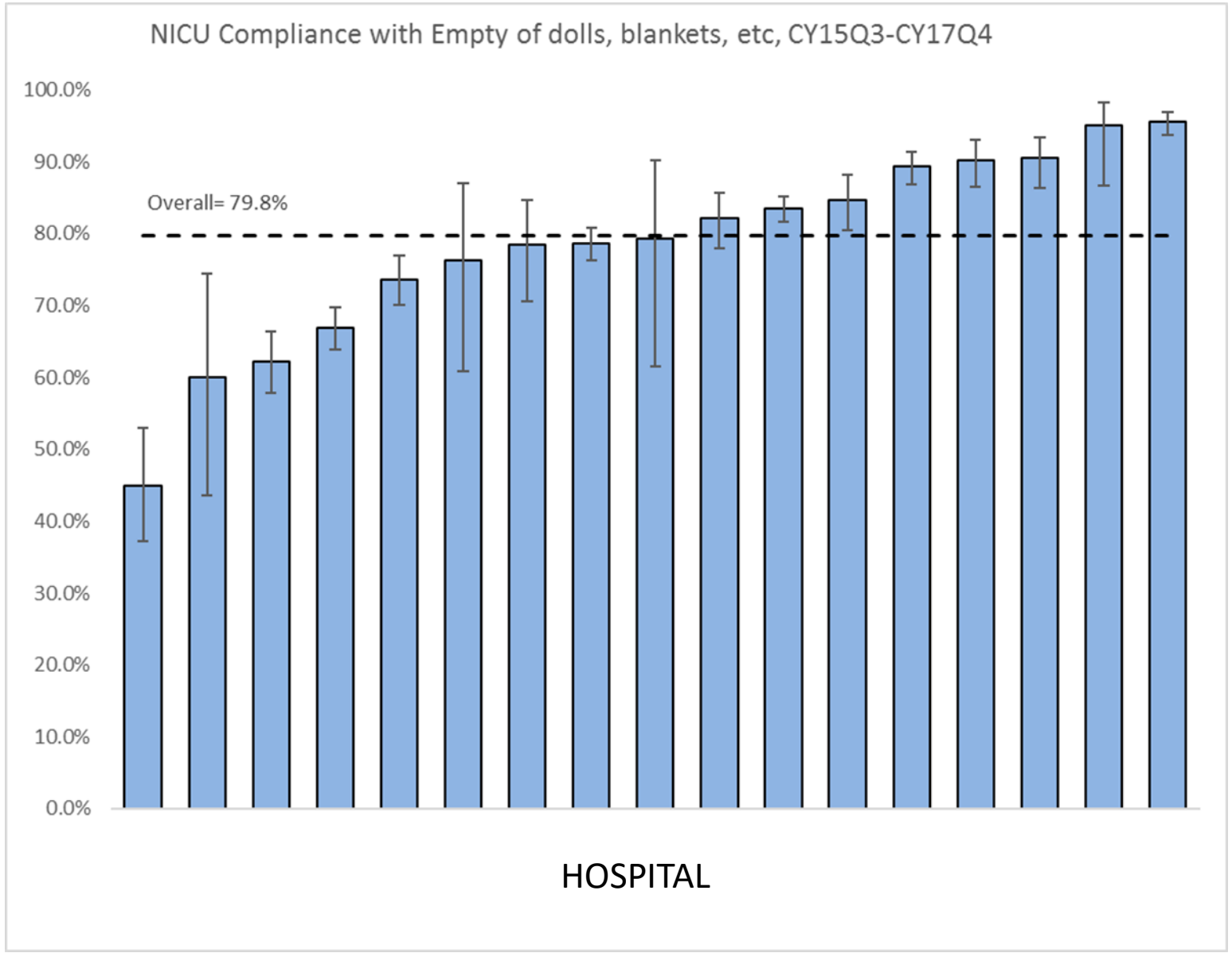
- CLABSIs (Alan Picarillo)
- Safe sleep (Susan Hwang)

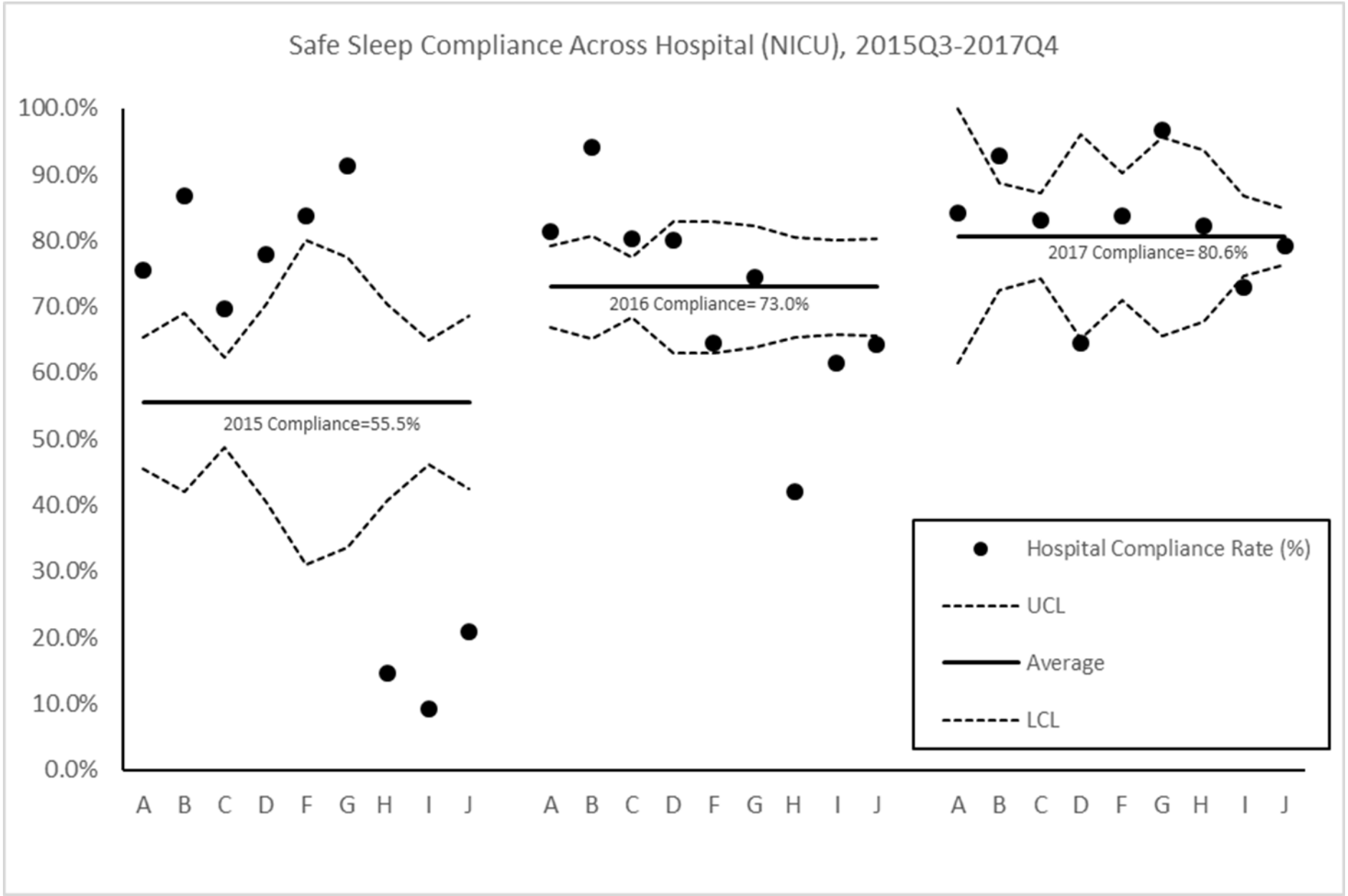
Safe Sleep in High Risk Newborns

- 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 CoIIN work
- Selection for national NAPPSS-IIN
- Difficult to link to outcome measures!
- Improvements in practice seemed ‘hard-wired’



Hwang et al, J Perinatology, 2018


NICU Compliance with Empty of dolls, blankets, etc, CY15Q3-CY17Q4
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Overall= 79.8%
HOSPITAL



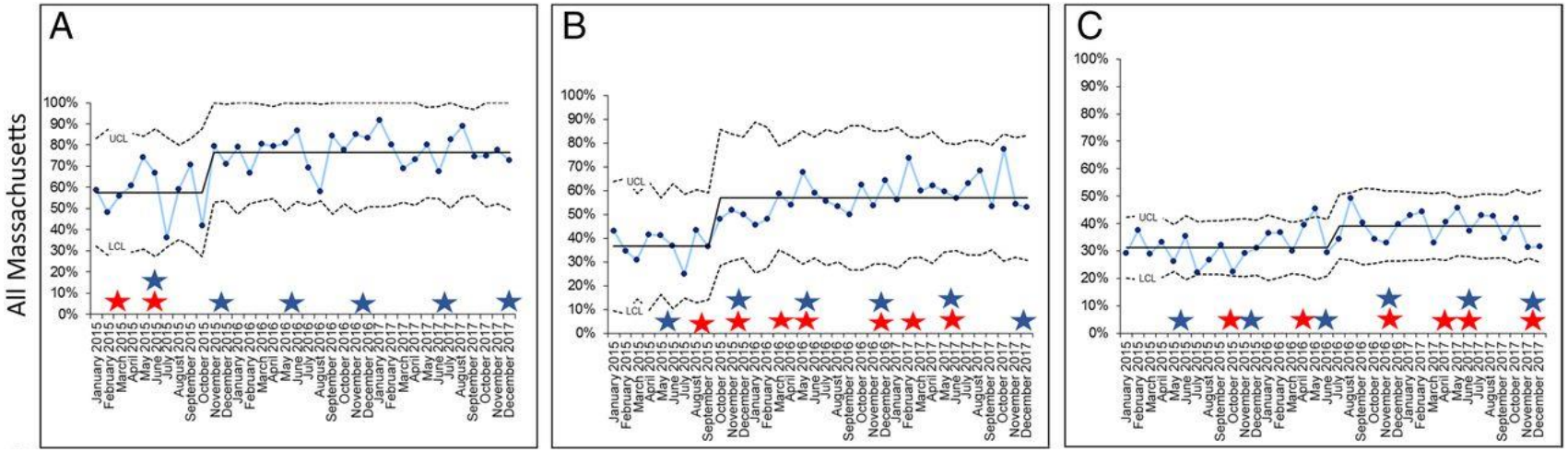
Hwang et al, J Perinatology, 2018

Projects

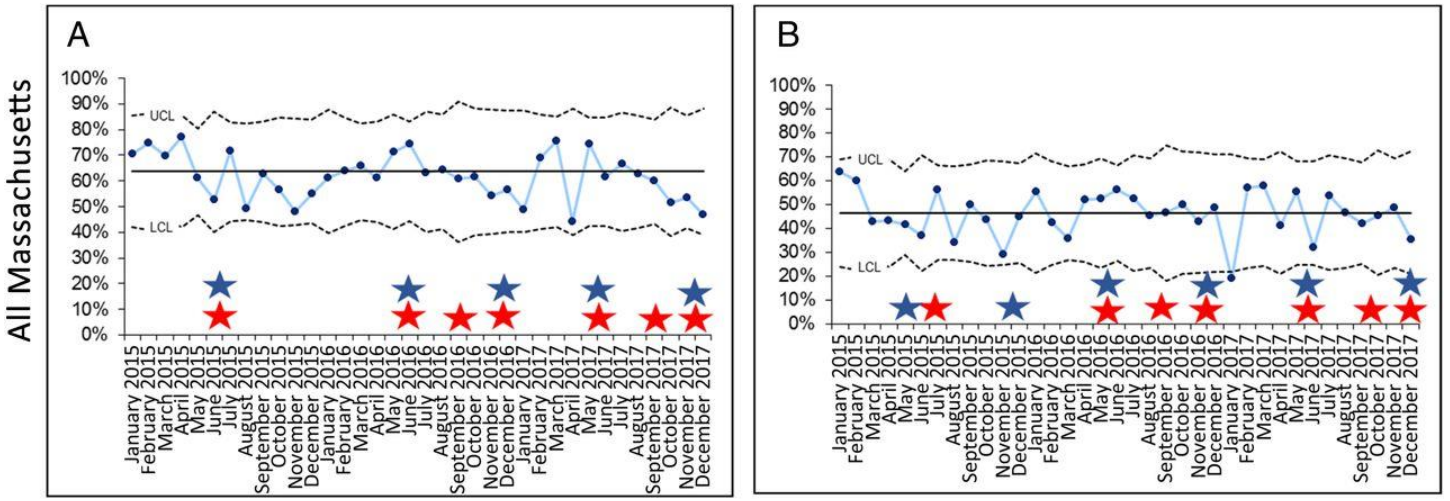
- CLABSIs (Alan Picarillo)
- Safe sleep (Susan Hwang)
- Mother's milk (Meg Parker)

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

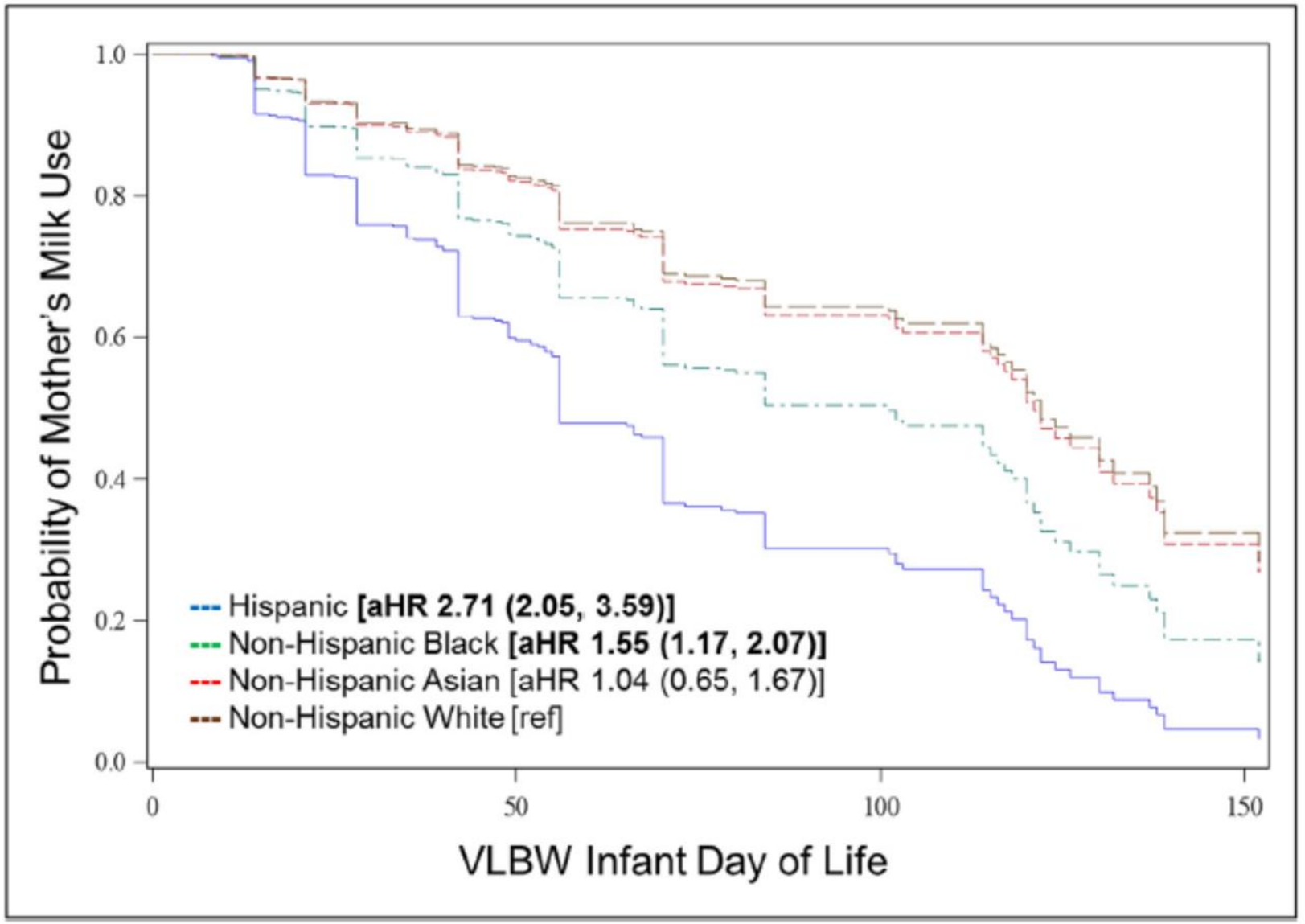


Prenatal education | Early milk expression | Skin-to-skin care

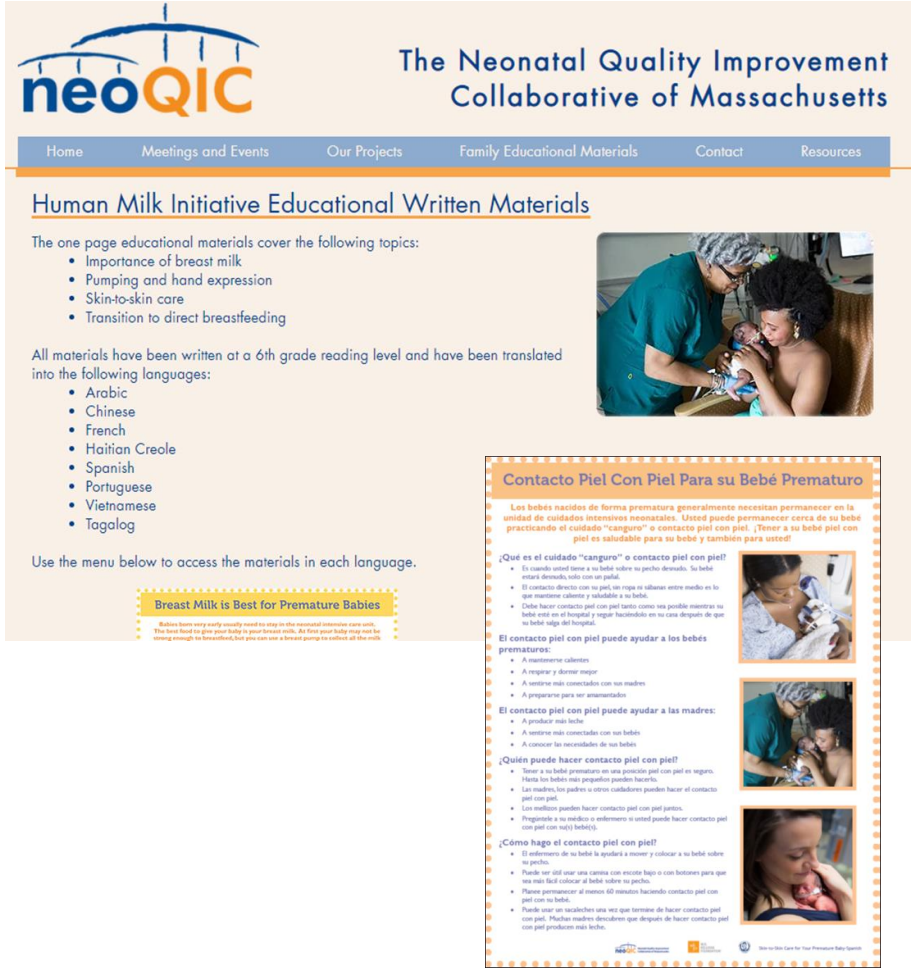


Any mother's milk at discharge | Exclusive mother's milk at discharge

Parker et al, Pediatrics, 2019



Parker et al, J. Pediatrics, 2019



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

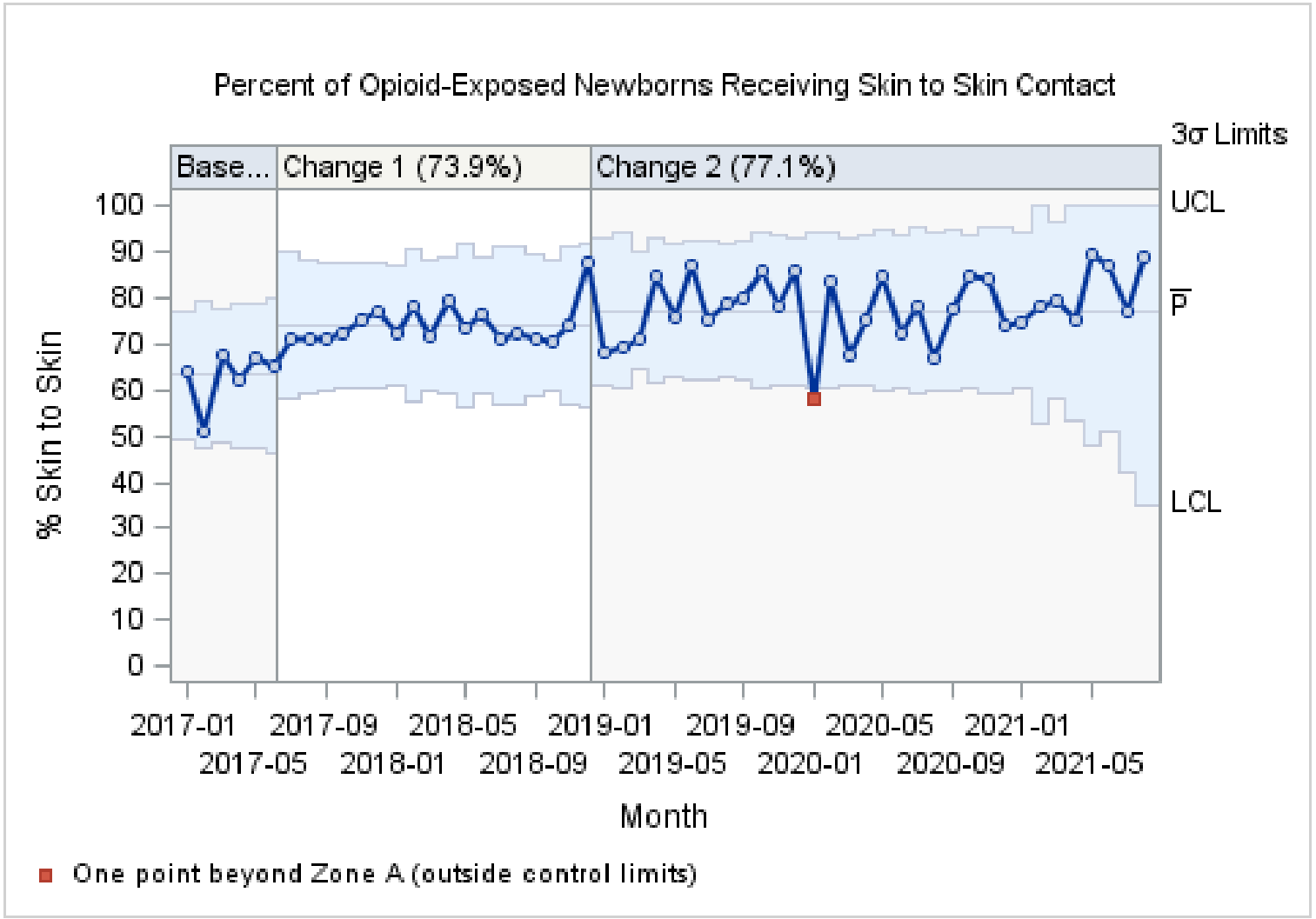
https://www.neoqicma.org/human-milk-educational-videos

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


Percent of Opioid-Exposed Newborns Receiving Skin to Skin Contact
3σ Limits
Base...
Change 1 (73.9%)
Change 2 (77.1%)
UCL
P̄
LCL
% Skin to Skin
100
90
80
70
60
50
40
30
20
10
0
2017-01
2017-05
2017-09
2018-01
2018-05
2018-09
2019-01
2019-05
2019-09
2020-01
2020-05
2020-09
2021-01
2021-05
Month
One point beyond Zone A (outside control limits)

Massachusetts: ESC & Pharm Therapy

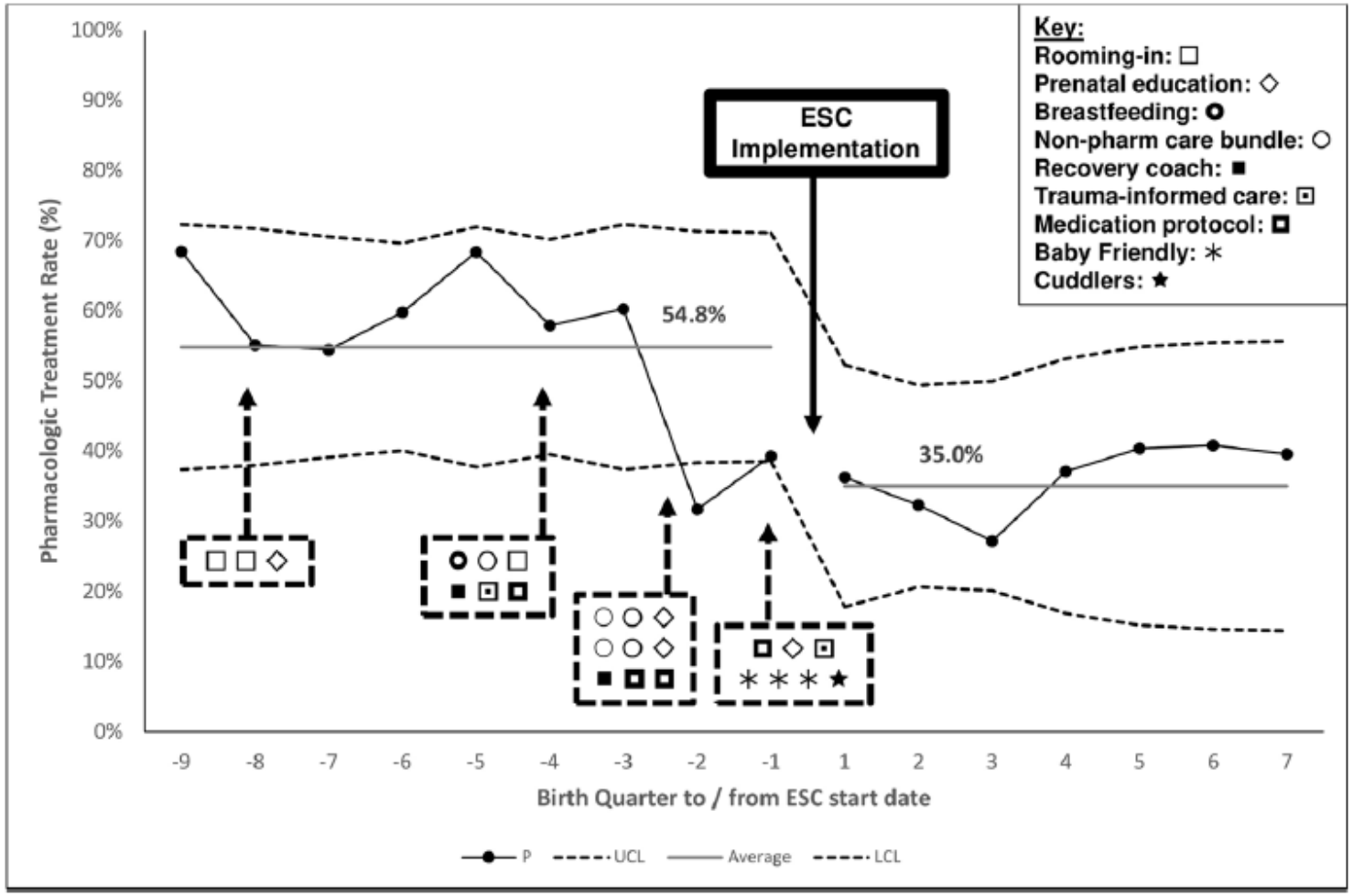
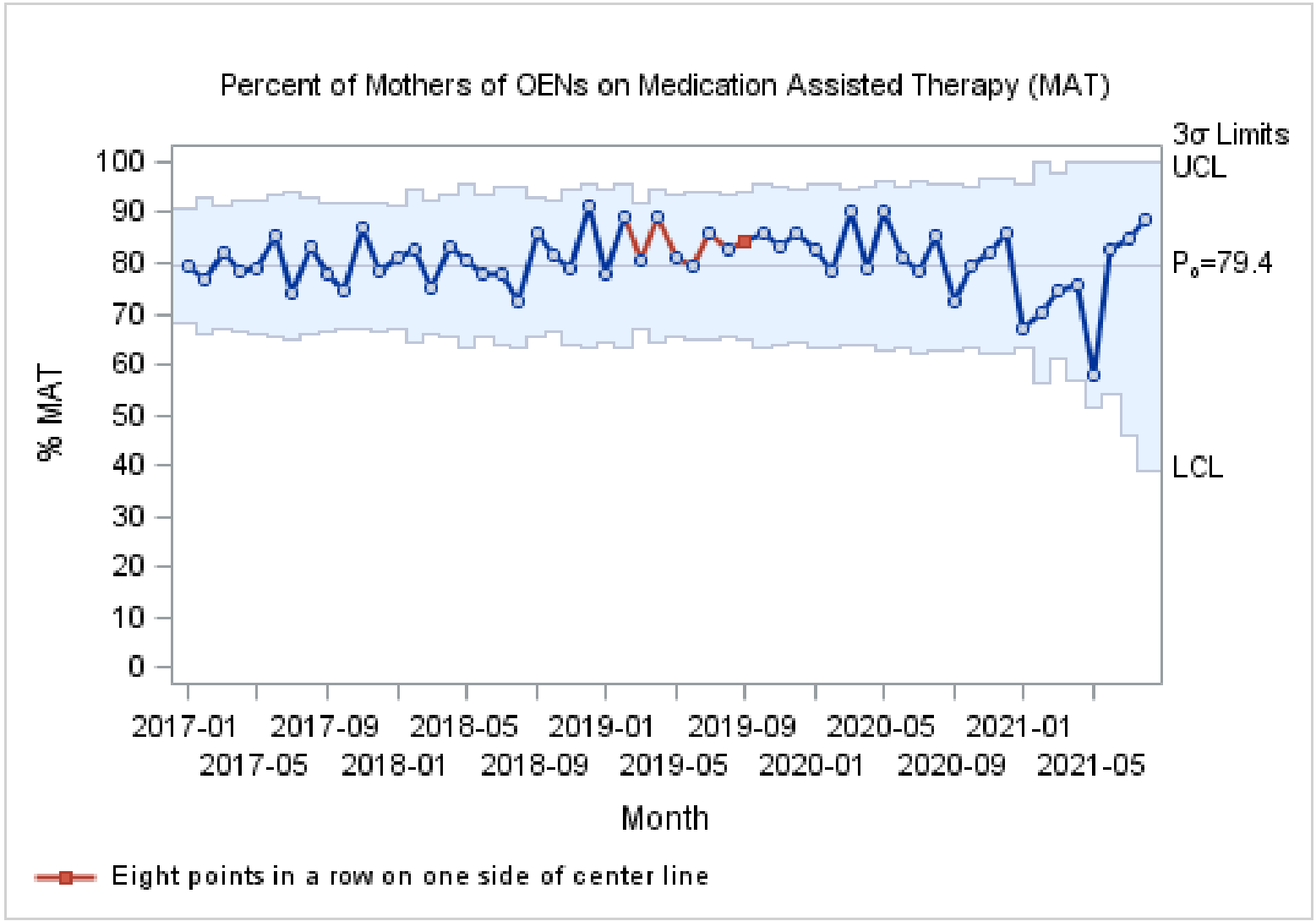
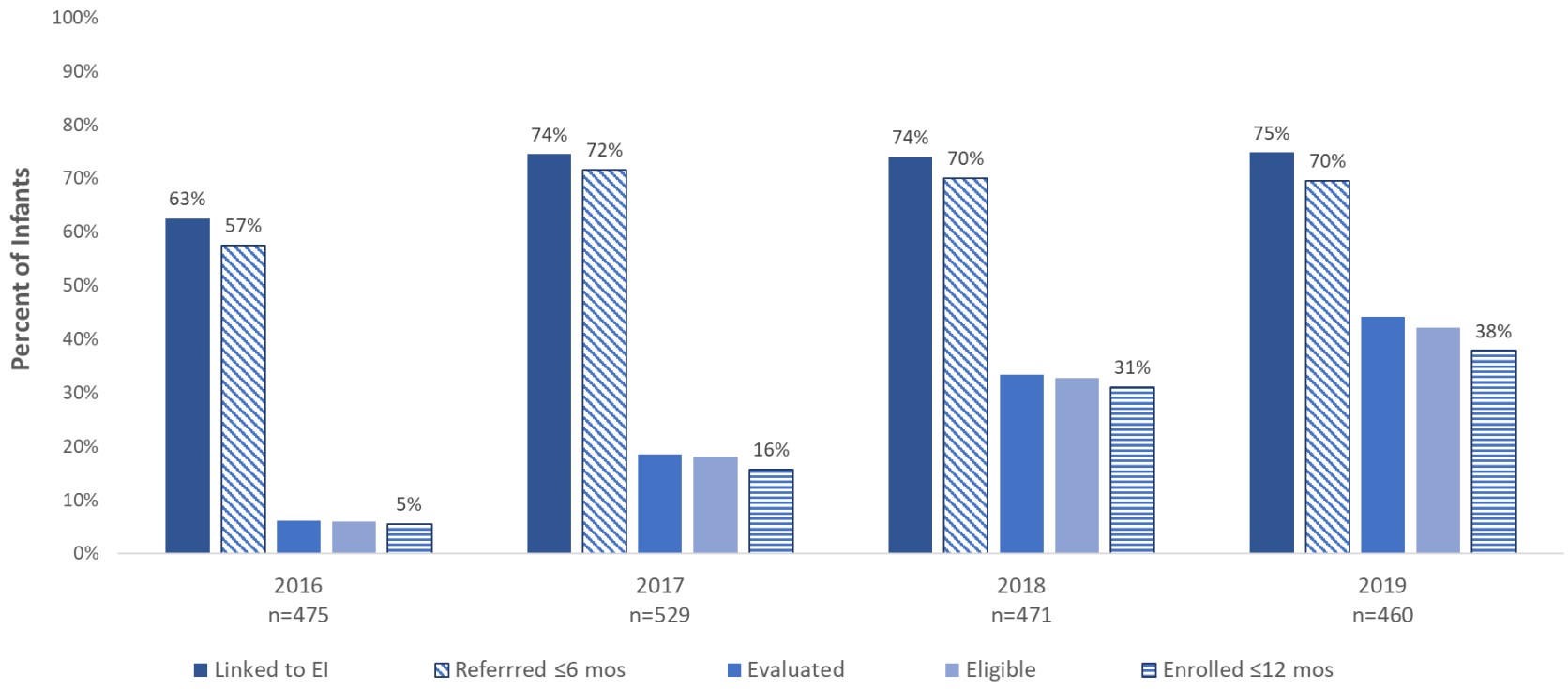


Figure 1: Pharmacotherapy among OENs, pre- and post- ESC implementation

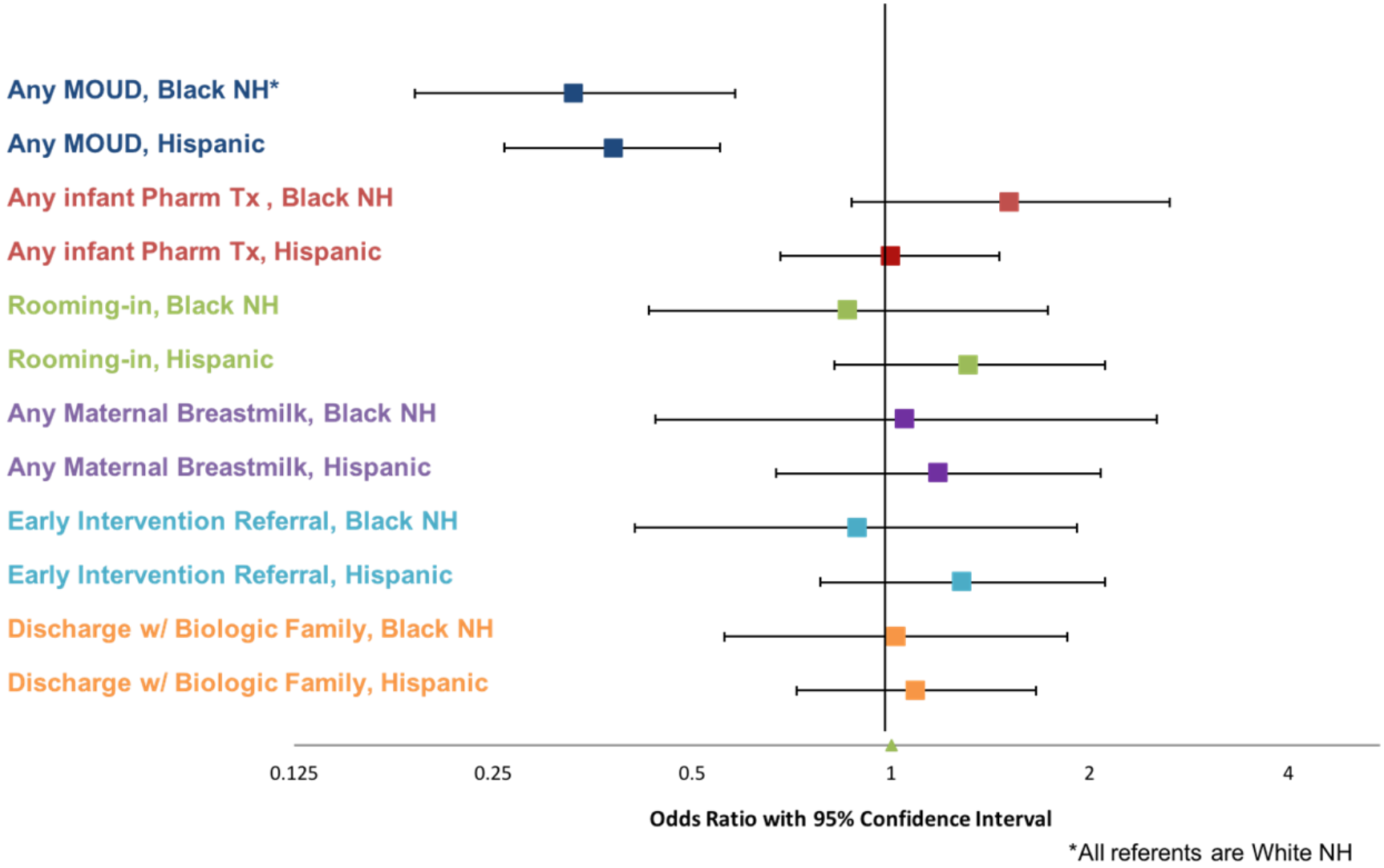
Wachman et al, J Perinatology, 2020


Percent of Mothers of OENs on Medication Assisted Therapy (MAT)
3σ Limits
UCL
P_0=79.4
LCL
% MAT
100
90
80
70
60
50
40
30
20
10
0
2017-01
2017-05
2017-09
2018-01
2018-05
2018-09
2019-01
2019-05
2019-09
2020-01
2020-05
2020-09
2021-01
2021-05
Month
Eight points in a row on one side of center line

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



*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.

New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

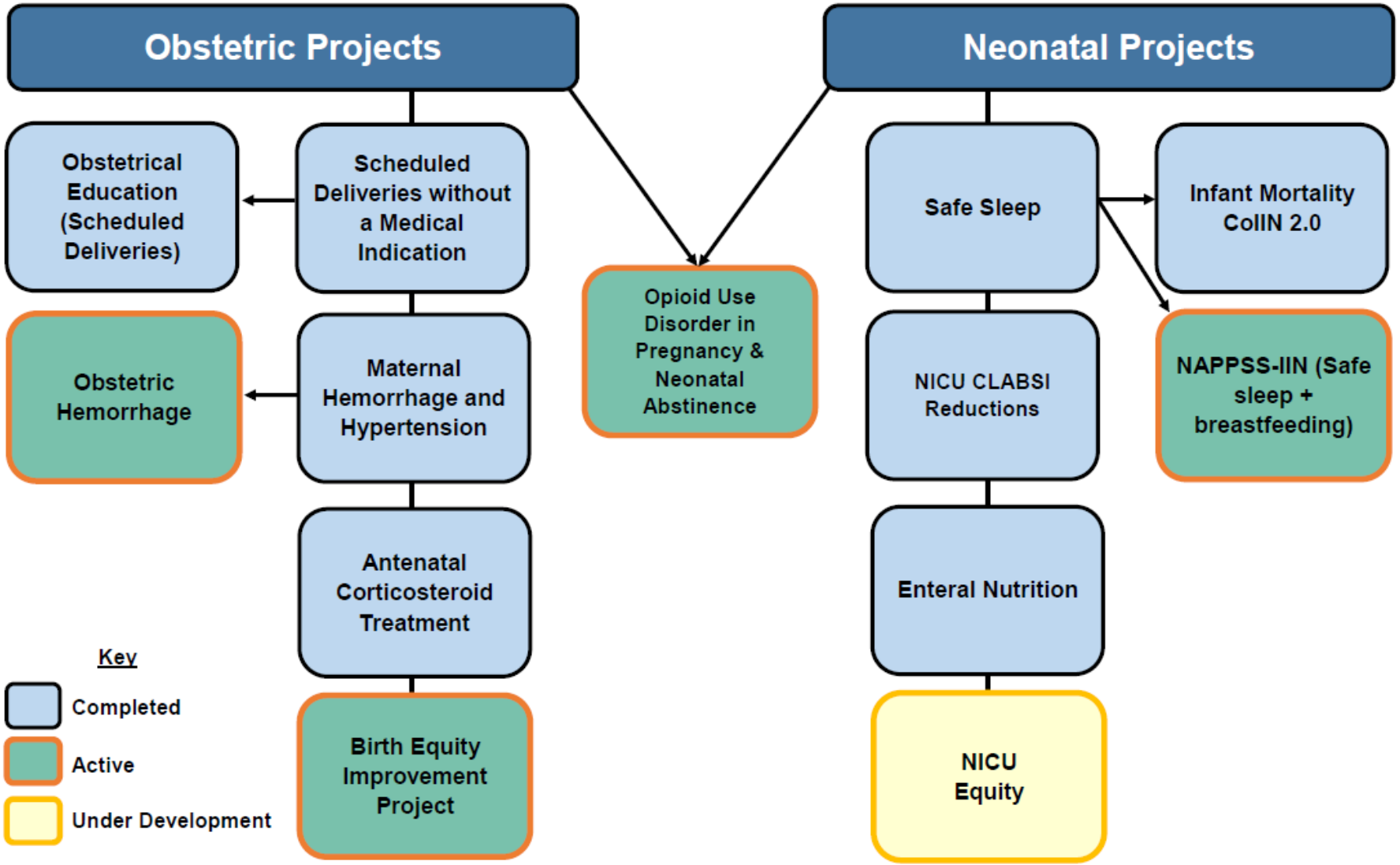
Engagement with Stakeholders

- **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.

New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

NYSPQC Focus Areas



Department of Health

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.

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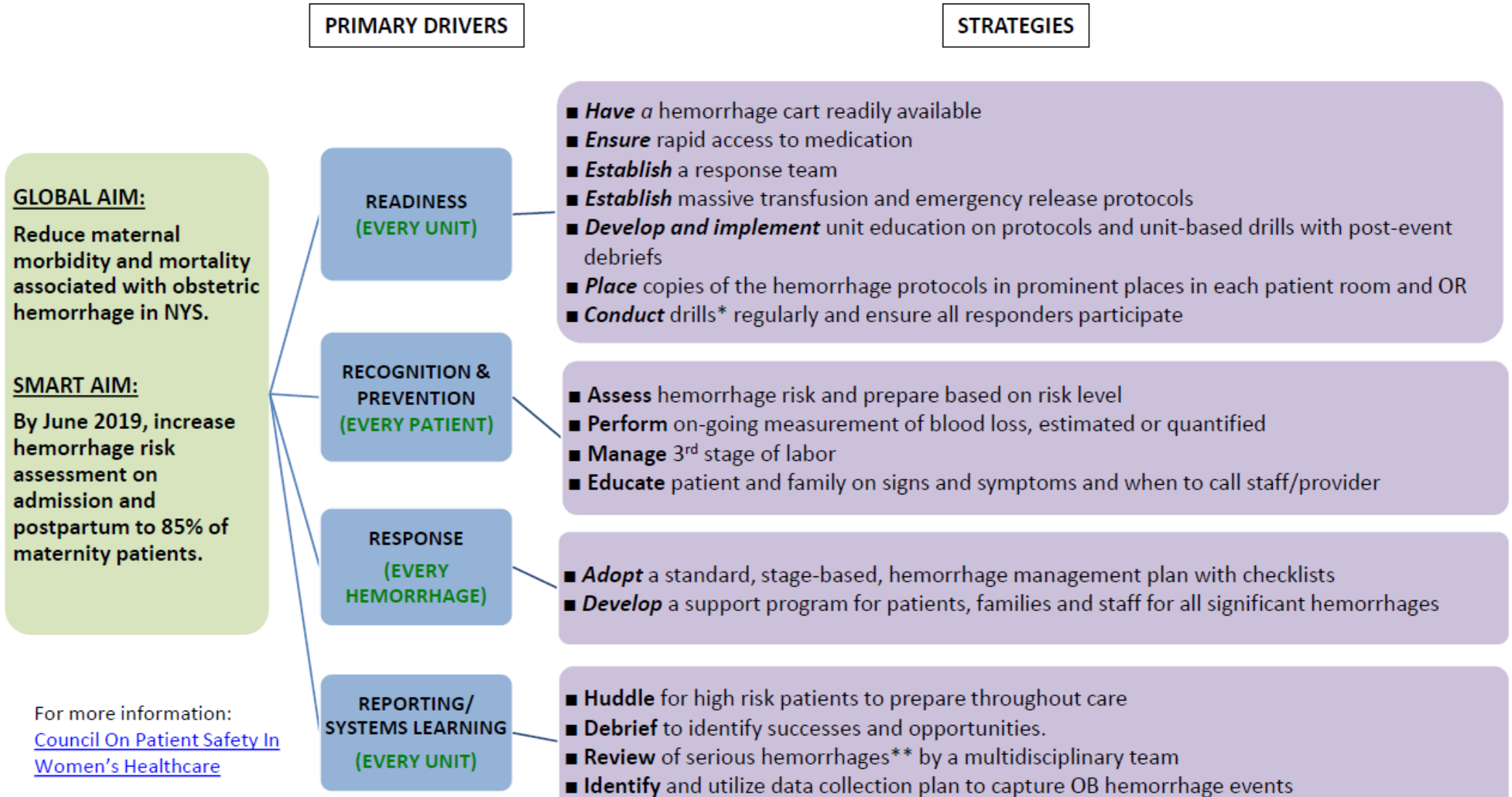
NEW YORK STATE Department of Health

NEW YORK STATE OBSTETRIC HEMORRHAGE PROJECT – KEY DRIVER DIAGRAM



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

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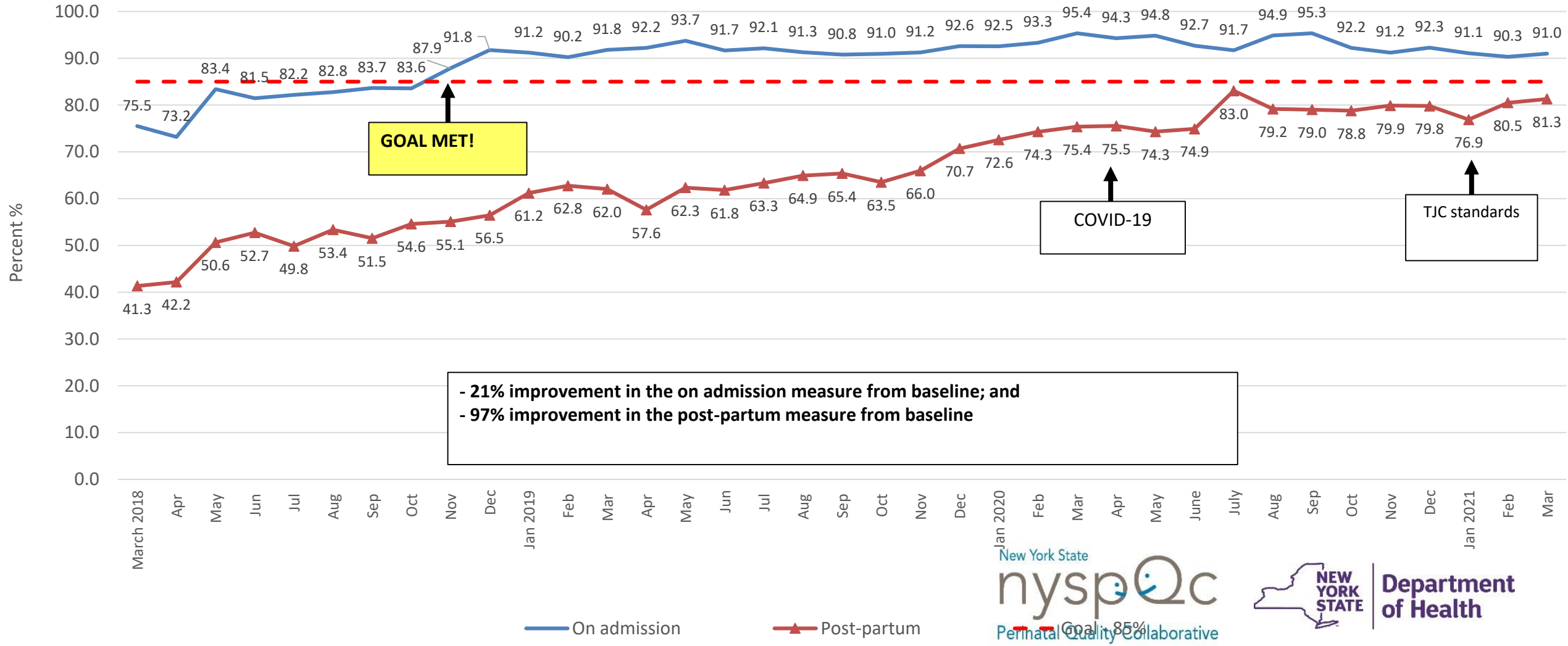
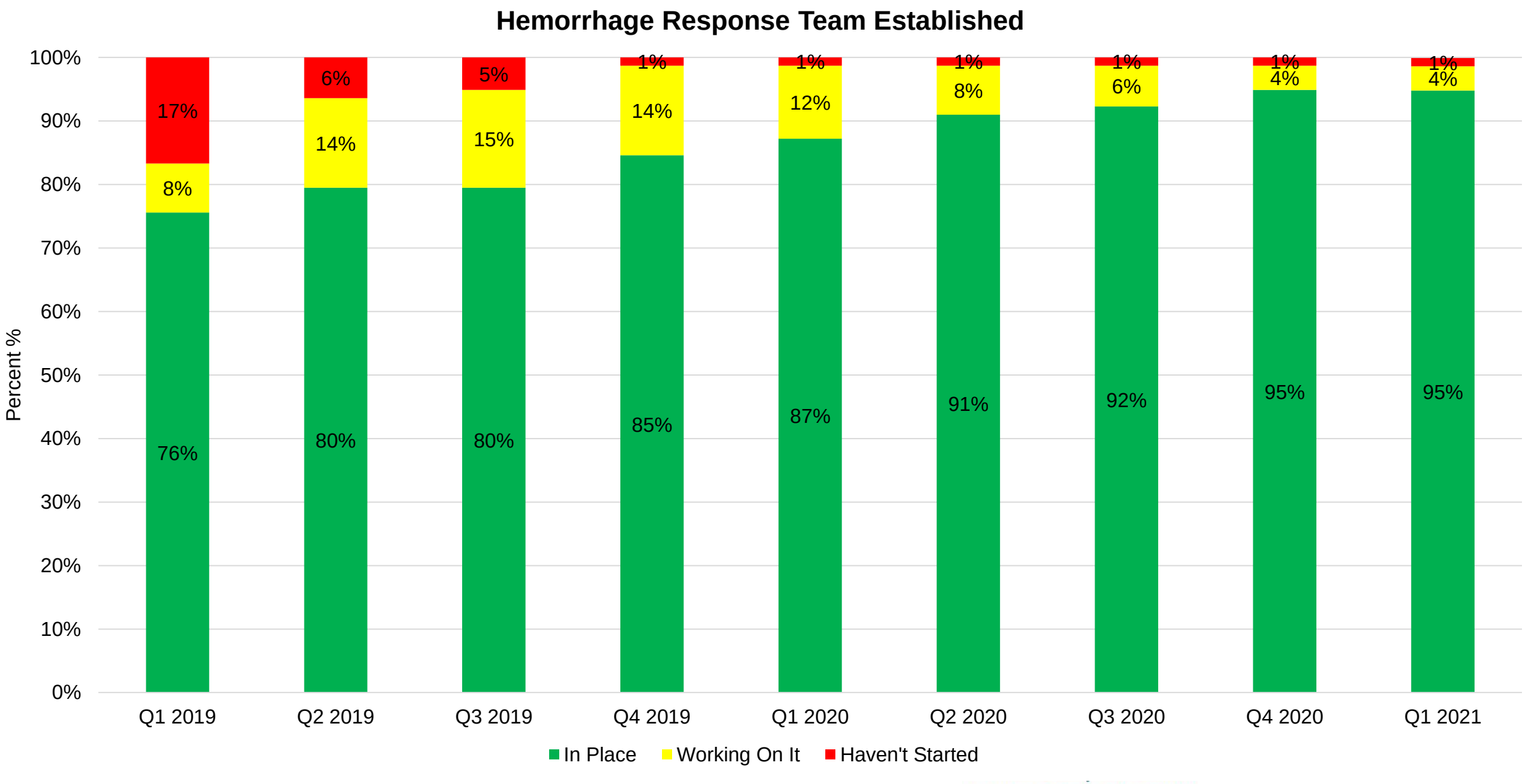
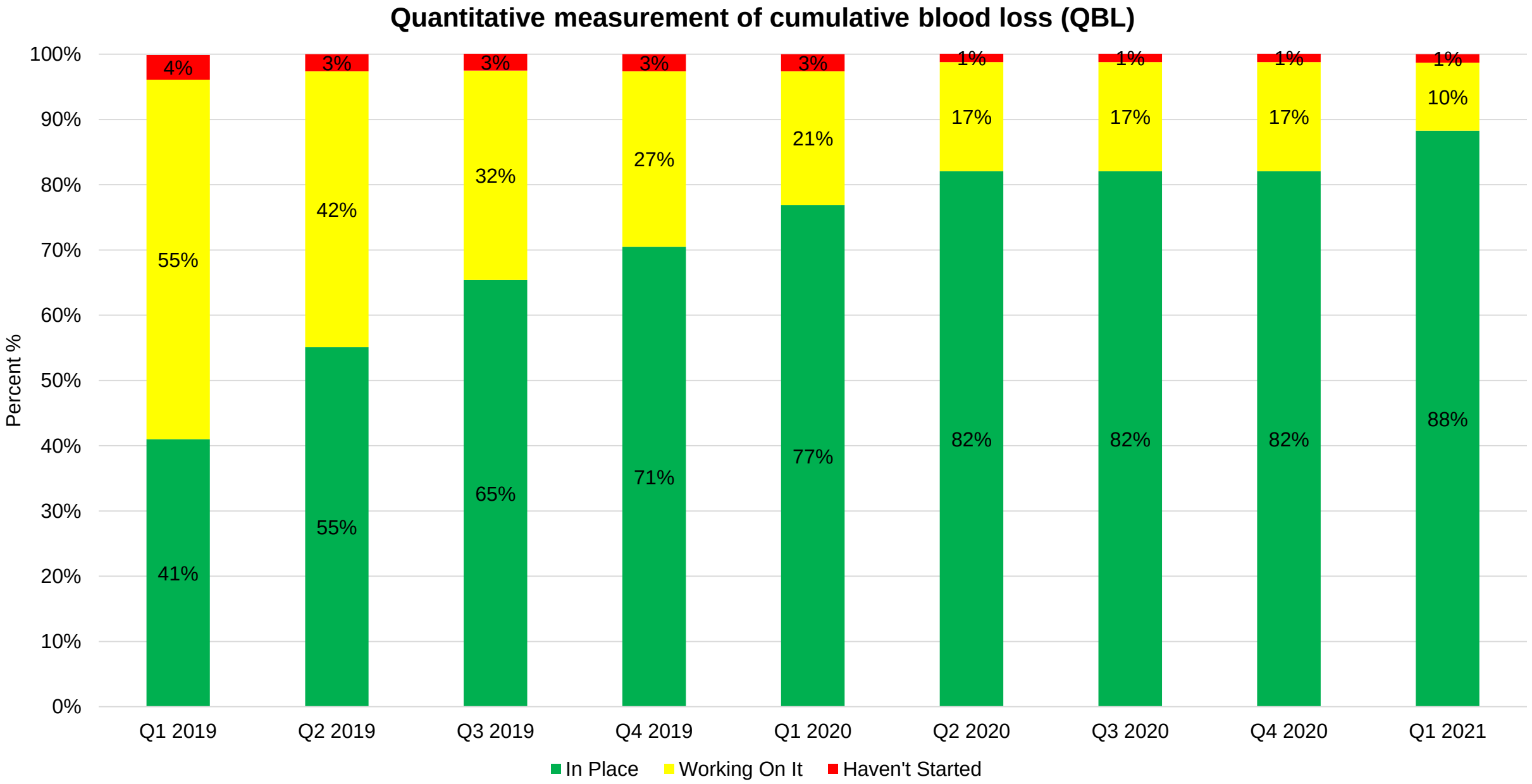
Percent of Patients Receiving a Hemorrhage Risk Assessment on Admission and Postpartum



New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health


Hemorrhage Response Team Established
Percent %
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
17%
8%
76%
6%
14%
80%
5%
15%
80%
1%
14%
85%
1%
12%
87%
1%
8%
91%
1%
6%
92%
1%
4%
95%
1%
4%
95%
Q1 2019
Q2 2019
Q3 2019
Q4 2019
Q1 2020
Q2 2020
Q3 2020
Q4 2020
Q1 2021
In Place
Working On It
Haven't Started


Quantitative measurement of cumulative blood loss (QBL)
Percent %
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
4%
55%
41%
3%
42%
55%
3%
32%
65%
3%
27%
71%
3%
21%
77%
1%
17%
82%
1%
17%
82%
1%
17%
82%
1%
10%
88%
Q1 2019
Q2 2019
Q3 2019
Q4 2019
Q1 2020
Q2 2020
Q3 2020
Q4 2020
Q1 2021
In Place
Working On It
Haven't Started

Obstetric Hemorrhage Drills

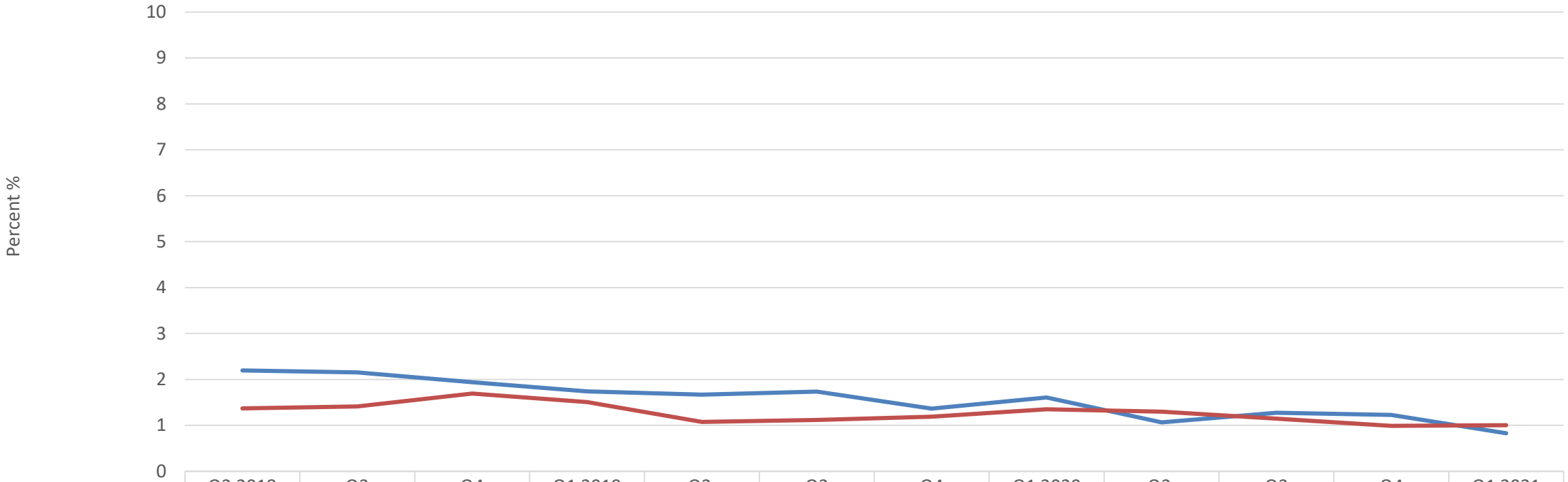
- 78% (61/78) of hospitals reported completing at least one drill in the past year

- 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



	Q2 2018	Q3	Q4	Q1 2019	Q2	Q3	Q4	Q1 2020	Q2	Q3	Q4	Q1 2021
Transfer to higher care*	2.2	2.2	1.9	1.7	1.7	1.7	1.4	1.6	1.1	1.3	1.2	0.8
Hysterectomy	1.4	1.4	1.7	1.5	1.1	1.1	1.2	1.3	1.3	1.1	1.0	1.0

*Transfer to higher care includes to the hospital's ICU or to a higher-level hospital (e.g., the Regional Perinatal Center).

New York State nyspQc Perinatal Quality Collaborative

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NYS OUD in Pregnancy & NAS Project

- 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 nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

New York State (NYS) Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project
OUD in Pregnancy Driver Diagram

OB
8/23/2020

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%.

Key Drivers	Key Changes

Patient & Family Education	• 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

Provider Education	• 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

Identification of Pregnant People with Opioid Use Disorder	• Implement universal prenatal screening
	  ○ Select a verbal screening tool
	  ○ Train staff to use verbal screening tool
	  ○ Screen all pregnant people for SUD using a verbal screening tool

Optimize Medical Care of Pregnant People with OUD	• Ensure coordination of care among providers during pregnancy, postpartum and the inter-conception period
	  ○ Identify local resources
	  ○ Identify partners to receive referrals
	  ○ Establish protocols for referral
	  ○ Encourage all patients with OUD to enroll in an OUD treatment program and link to resources/services
	• Adopt prescribing protocols for pain management for patients with OUD
	• Implement evidence based guidelines to reduce opioid over prescribing to pregnant and postpartum people
	• Educate providers on the risk of overdose / use of naloxone
	• Consider providing at risk patients with OUD naloxone education and a prescription for naloxone

Create a Multidisciplinary Coordinated Discharge Plan	• Engage the multidisciplinary team with mother and identified care partner(s) in discharge planning
	  ○ Refer to follow up and treatment appointments (MAT, etc.)
	  ○ 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.
	  ○ Engage families in safety planning and consider home safety assessment referral
	• Ongoing communication between obstetric and pediatric teams

New York State (NYS) Opioid Use Disorder in Pregnancy & Neonatal Abstinence Syndrome Project
Neonatal Abstinence Syndrome (NAS) Driver Diagram

Key Changes*

PEDS
10/2020

Global AIM
Improve the care of infants with NAS.

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

Key Drivers

Parent and family education

- Standardize parent and family education regarding mother/dyad 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

Provider education

- 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 toxicology 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
  - Pharmacological and non-pharmacological care strategies of infants with signs of NAS
- Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective

Early and accurate identification of newborns with signs of NAS

- 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

Management of newborns using standardized NAS treatment protocol

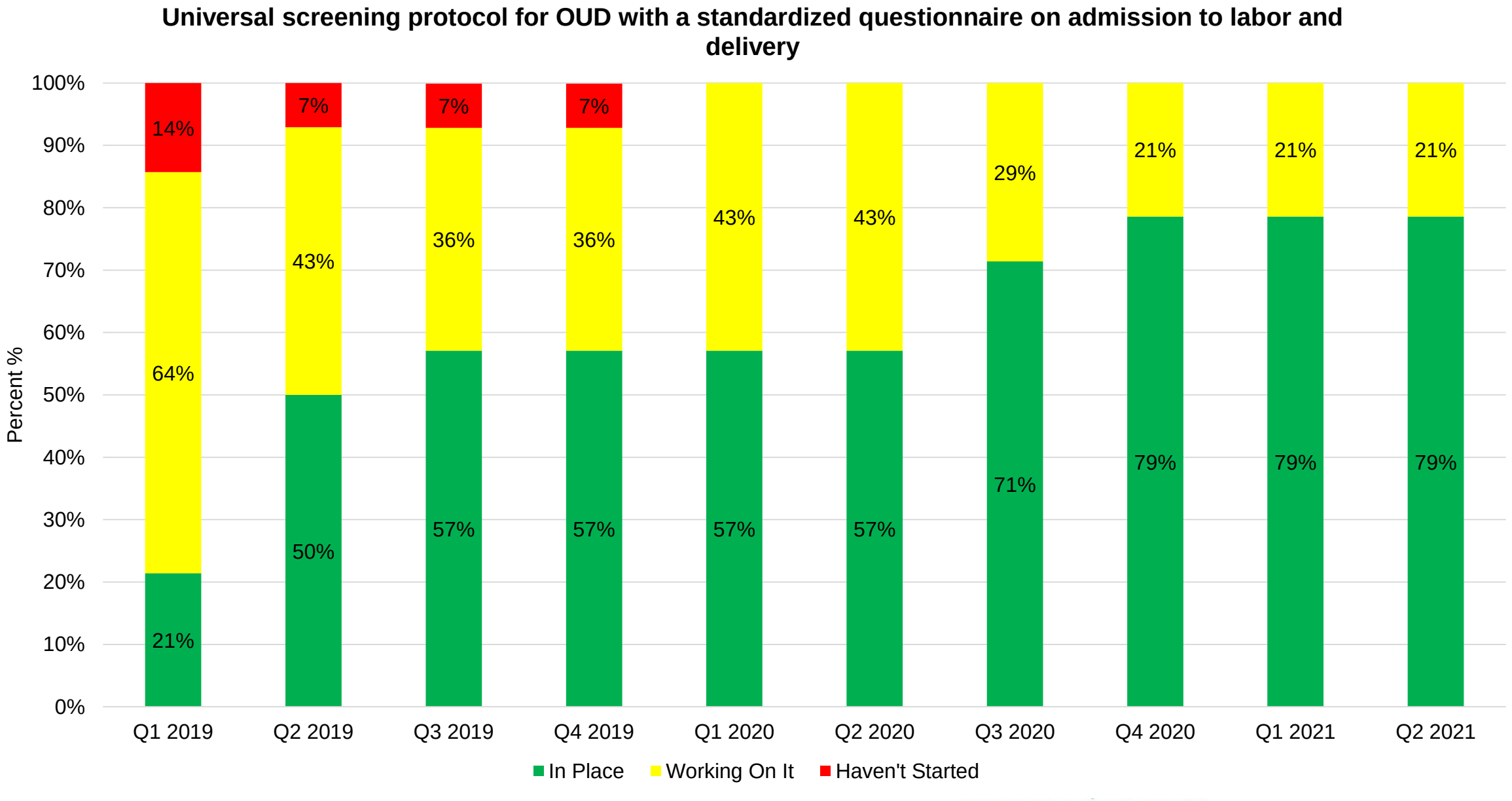
Non-pharmacologic care
- Utilize function-based assessments consisting of symptom prioritization for the assessment and management of NAS (Eat, Sleep, Console)
- Establish and implement standardized protocols for non-pharmacological management including:
  - Low lighting / Quiet environment
  - Encourage kangaroo care / skin-to-skin contact
  - Allow rooming-in 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

Create a Multidisciplinary Coordinated Discharge Plan

- 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

*** Refer to project Change Package for additional detail.**


Universal screening protocol for OUD with a standardized questionnaire on admission to labor and delivery
Percent %
100%
90%
80%
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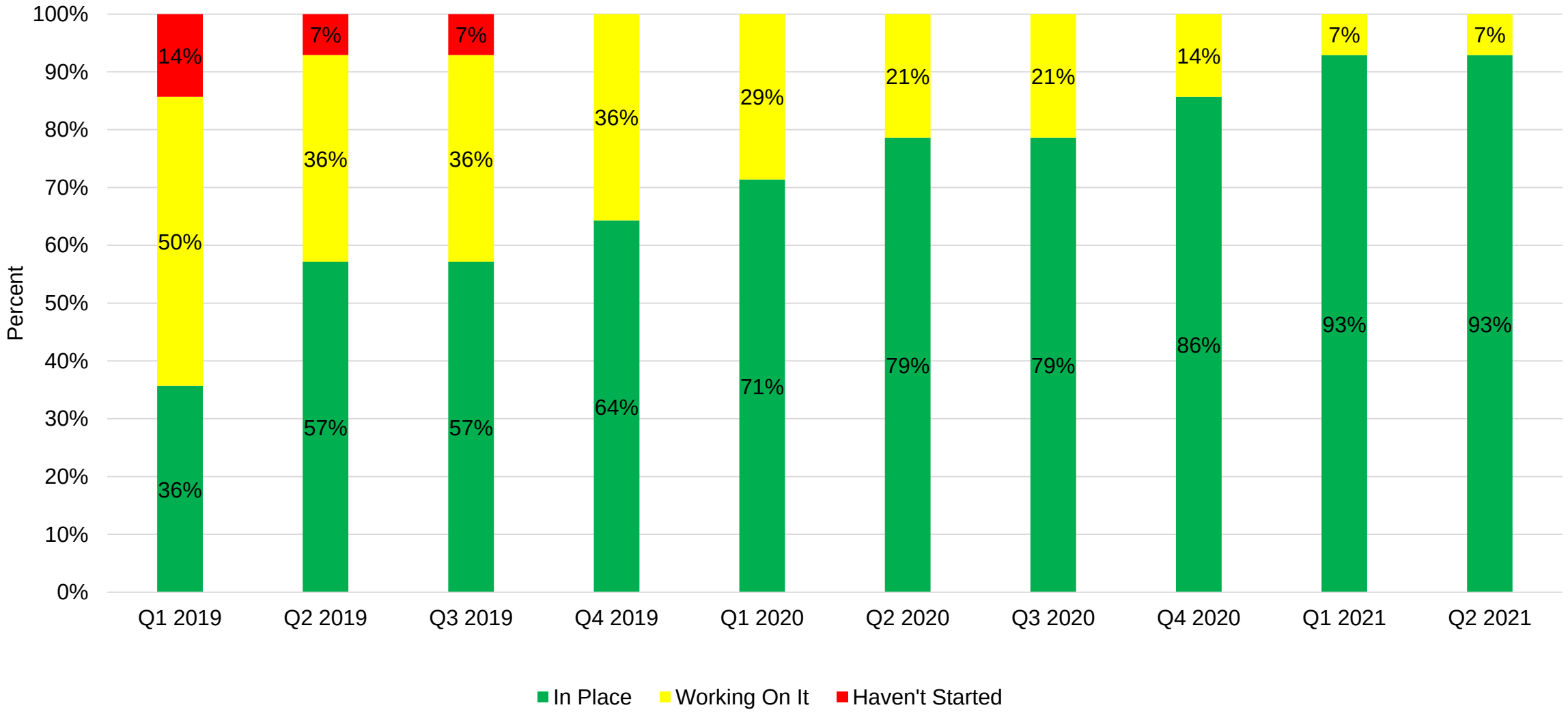
Q1 2019
Q2 2019
Q3 2019
Q4 2019
Q1 2020
Q2 2020
Q3 2020
Q4 2020
Q1 2021
Q2 2021
In Place
Working On It
Haven't Started

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

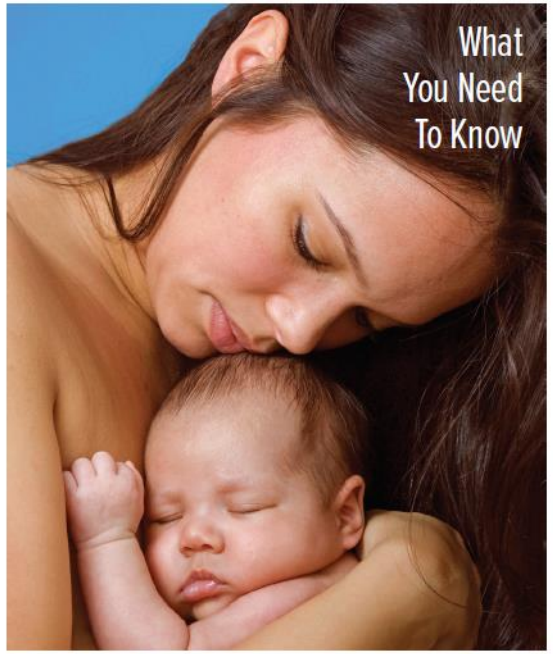


Neonatal Measures

- 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)



Be with your baby.
You are the treatment!

NEW YORK STATE Department of Health | nyspQc Perinatal Quality Collaborative | Illinois Department of Public Health | ILPQC

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 nurses to show you how to swaddle your baby.
   - Offer a pacifier.
   - Try shushing.
   - 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 ILPQC gratefully acknowledge Boston Medical Center for its contributions to this brochure.

Newborn Care Journal

Baby's Name: _____ Today's Date: _____

FEEDING				DIAPERING		SLEEPING			COMFORT	
Time of baby's feeding (start to finish)	Breastfeeding (total # minutes)	Bottle feeding (total # mL)	Did baby feed well? (if no, describe)	Check box for pee	Check box for poop	Time when baby fell asleep	Time when baby woke up	Did baby sleep for an hour or more? (if no, describe)	Did baby calm in 10 min? (if no, describe)	Extra Comments / Care Provided
Example Below										
6:15 am - 6:45 am	*L – 20 min R – 10 min*	*mL*	*Yes*	✓	✓ *(black, sticky)*	*8:00 am*	*10:00 am*	*Yes*	*No, woke hungry, hard to calm until able to get latched on.*	*Mom and baby had skin-to-skin time. Will try to shorten length of time between feedings.*

NEW YORK STATE Department of Health | nyspQc Perinatal Quality Collaborative

New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

NYSPQC Resources

Perinatal Substance Use

5 ways you can improve care during pregnancy and beyond

Pregnancy presents unique opportunities for patients to make positive changes in their substance use. When you become an informed provider, you empower patients to make those changes.

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 everyone'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 buprenorphine@health.ny.gov to become an MAT provider. Make naloxone available to all your patients who use opioids.

End the Stigma

Embrace people who use substances. Meet them where they are. Abide by your medical ethics. Practice beneficence. Promote public health.

Academy of Perinatal Harm Reduction www.perinatalharmreduction.org | National Perinatal Association www.nationalperinatal.org | nyspQc New York State Perinatal Quality Collaborative www.nyspqc.org

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!

Academy of Perinatal Harm Reduction www.perinatalharmreduction.org | National Perinatal Association www.nationalperinatal.org | nyspQc New York State Perinatal Quality Collaborative www.nyspqc.org

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 theirs 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.

Academy of Perinatal Harm Reduction www.perinatalharmreduction.org | National Perinatal Association www.nationalperinatal.org | nyspQc New York State Perinatal Quality Collaborative www.nyspqc.org

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 (1-877-846-7369)
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.org/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

CoIIN 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 10% 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

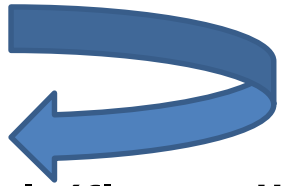
NYSPQC AIM Statement
By September 2016, we AIM to reduce infant sleep-related deaths in NYS by improving safe sleep practices for infants. To accomplish this, we will form a multidisciplinary team (with members from our OB and neonatal care units) and work to implement evidence based infant mortality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

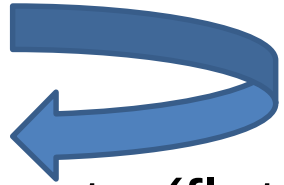
DRIVERS	CHANGES
Health care professionals understand, actively endorse and model safe sleep practices	Medical and nursing staff model safe sleep practices in hospital before discharge
	Standardized education and training for health professionals on current AAP guidelines for infant safe sleep, including promoting breastfeeding in a safe sleep environment
	Train and support healthcare professionals in using engagement techniques (e.g., motivational interviewing, teach back, etc.)
Infant caregivers have the knowledge, skills and self-efficacy to practice safe sleep for every sleep	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
Engage and activate infant caregivers, community to support 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
Policies support/facilitate safe sleep practices	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
Spread bright spots within facility and to other facilities	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

System Change: Improving Safe Sleep Practices

- Increased understanding by hospital staff members regarding safe sleep practices

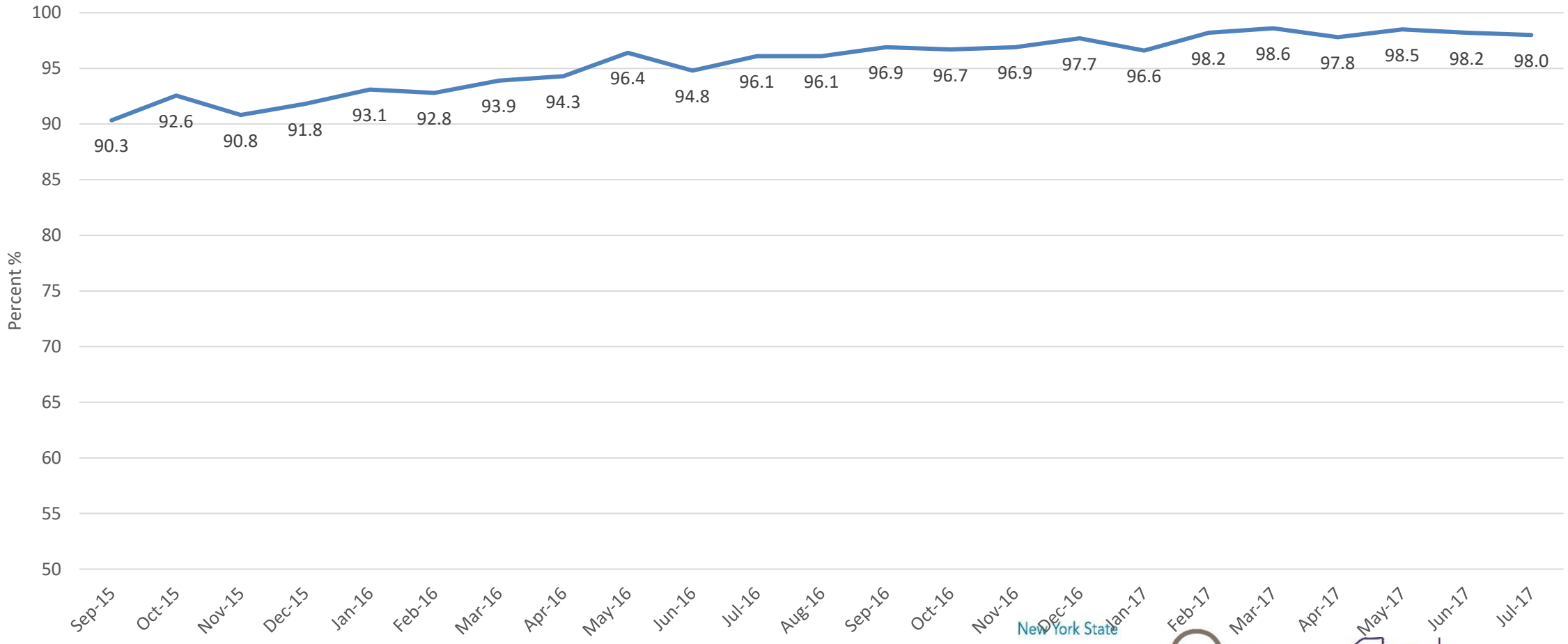


- Increased modeling of safe sleep practices in hospital (flat crib, no objects, safe sleep clothing/blankets)



- 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



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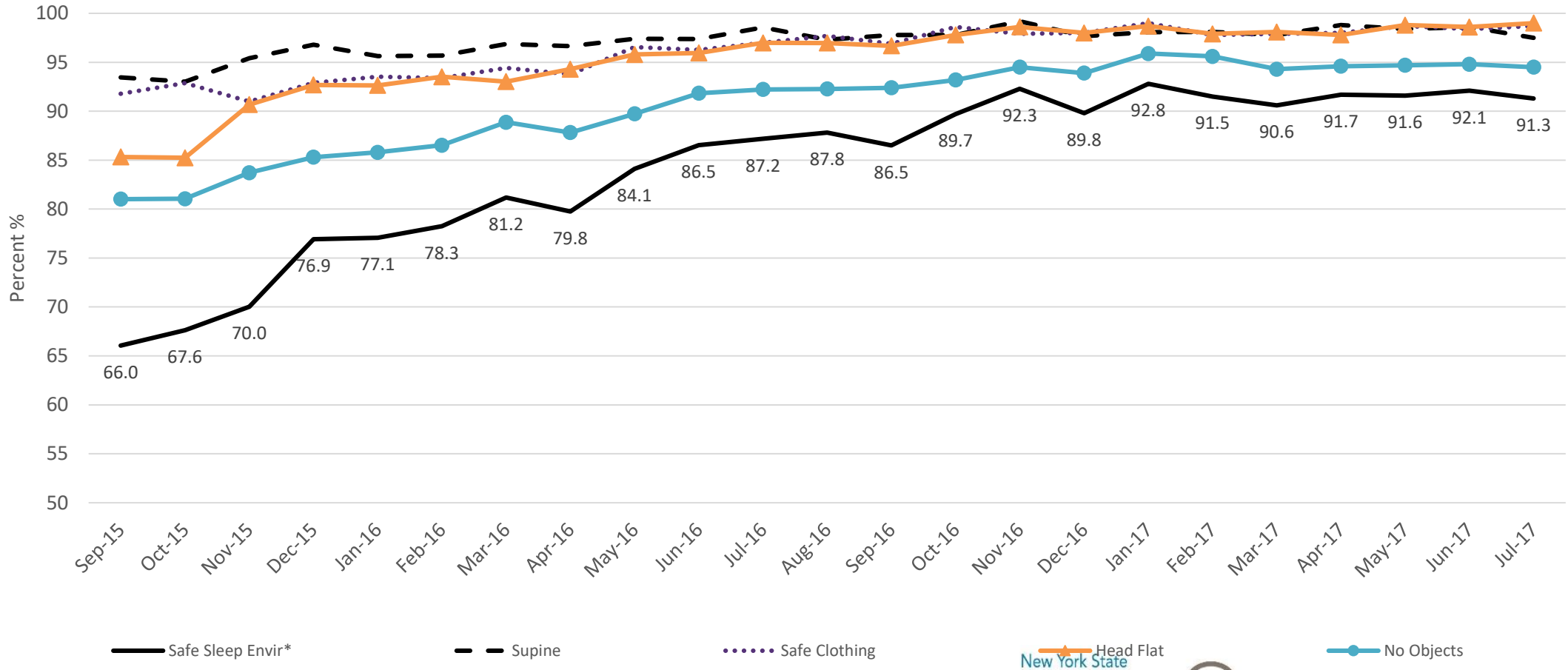
NEW YORK STATE Department of Health

Percent of Infants, Sleeping or Awake-and-unattended, in a Safe Sleep Environment

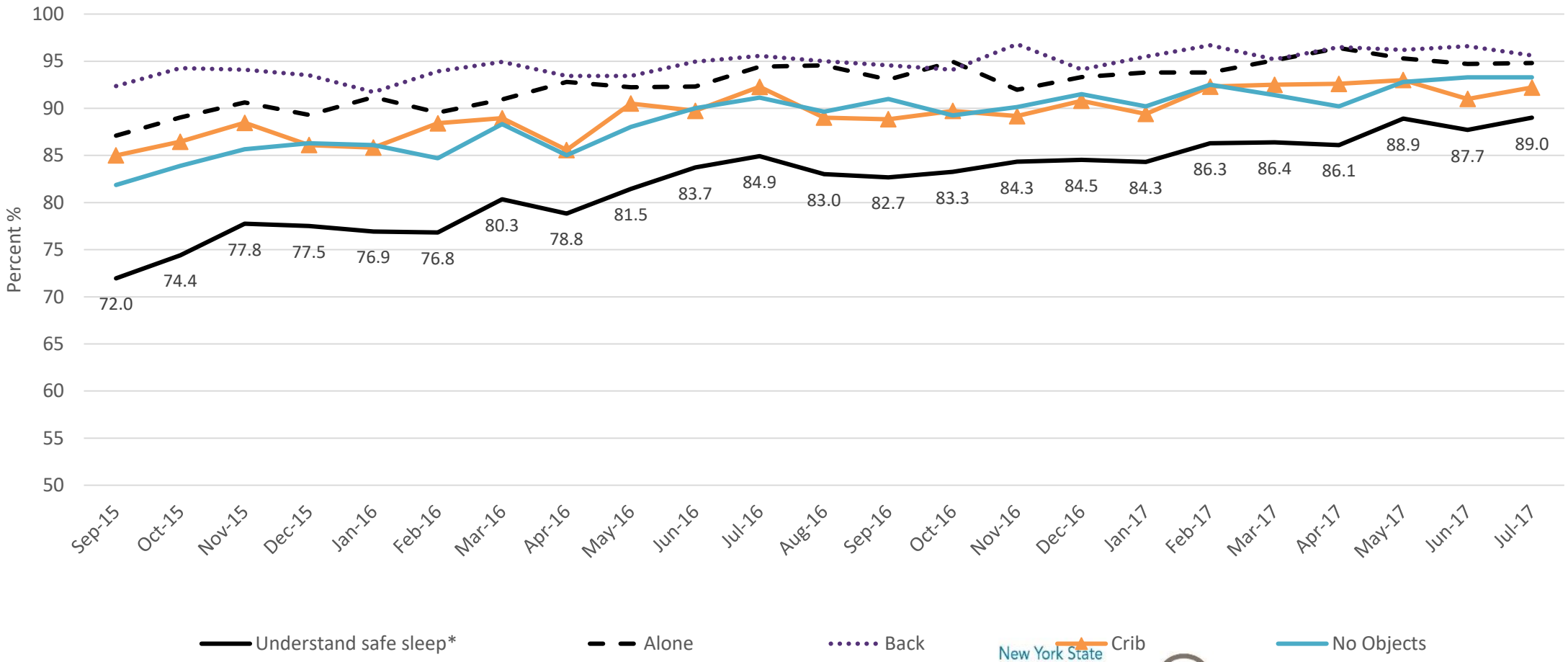


*A safe sleep environment is defined as infants who were positioned supine, in safe clothing, with head of crib flat and no objects in the crib

New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

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

New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

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.

New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

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

New York State nyspQc Perinatal Quality Collaborative

New York State nyspQc Perinatal Quality Collaborative

NEW YORK STATE Department of Health

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

OKLAHOMA State Department of Health

OPQIC
OKLAHOMA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE

Need more information?

https://opqic.org

info@opqic.org

Facebook | Twitter | YouTube | Instagram

CURRENT PRIORITIES

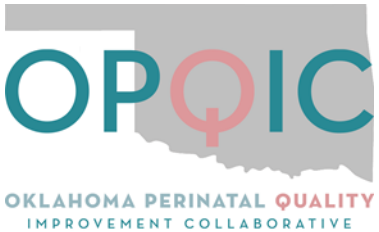
Oklahoma Mothers and Newborns Affected by Opioids

Launched with 17 pilot hospitals on March 3, 2020

Reboot September 2020

Oklahoma Perinatal Quality Improvement Collaborative

OPQIC.org

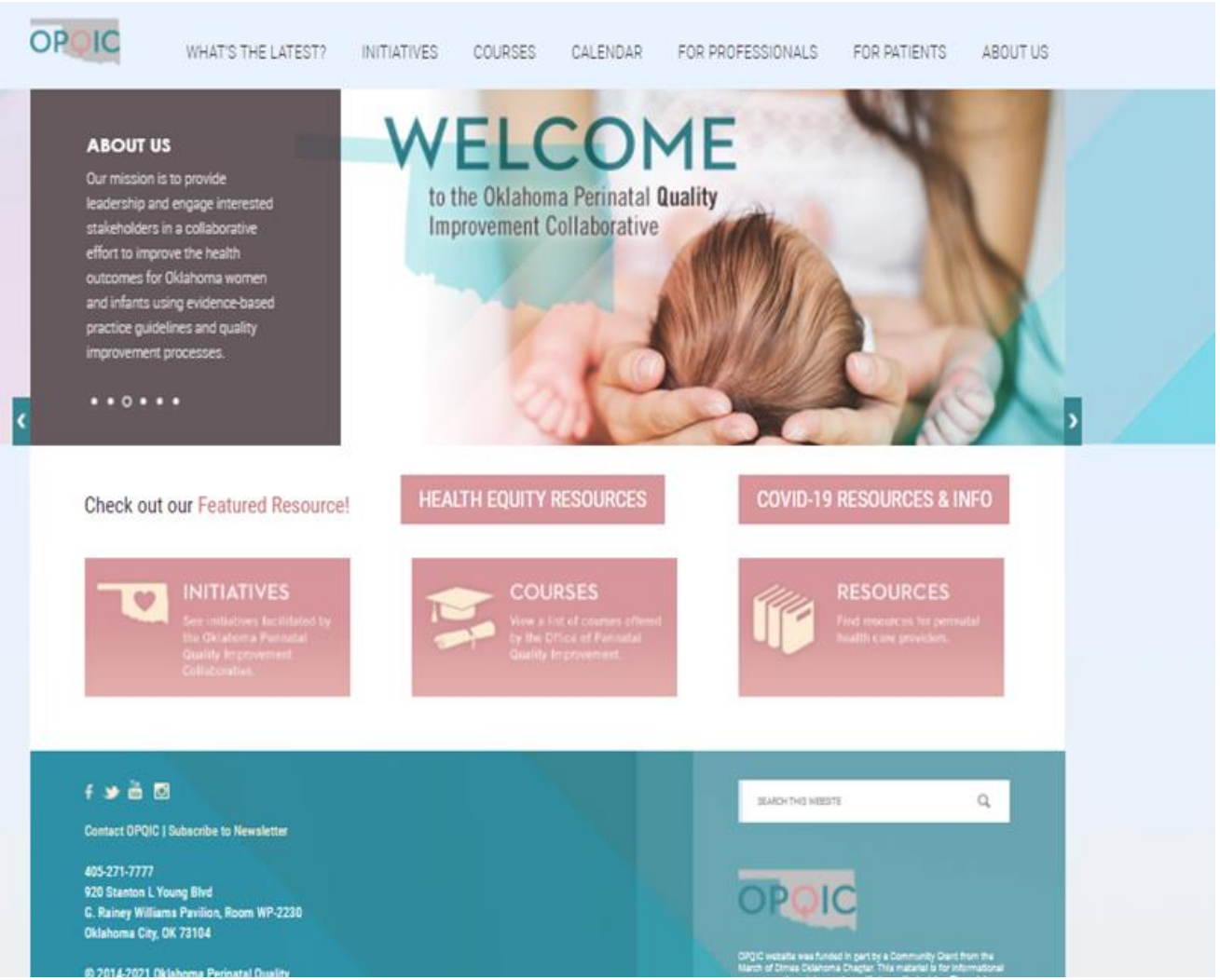


OKLAHOMA OSTEOPATHIC ASSOCIATION
ADVOCACY AND WELL BEING

OKLAHOMA PAIN PHYSICIANS
TAKE CONTROL OF YOUR PAIN

OMNO Goals

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



opqic.org

OMNO – OKLAHOMA MOTHERS AND NEWBORNS AFFECTED BY OPIOIDS

download OMNO FAQs

OMNO FILES for Pilot Hospitals

click here to REGISTER

request REDCAP ACCOUNT

OKLAHOMA OPIOID PRESCRIBING GUIDELINES

RISKS OF OPIOIDS IN PREGNANCY: WHAT YOU NEED TO KNOW

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, and mental and public health officials.[1,2,3,4] Although the recommendations do not include language on Oklahoma's opioid-related laws, it is imperative

ce suggests that opioids do not differ from nonopioid medication
often better tolerated, with greater improvements in physical function.

ment of pain in women of childbearing age:

PREGNANCY AND OPIOID PAIN MEDICATIONS

Women who take opioid pain medications should be aware of the possible risks during pregnancy.

What are opioid pain medications?

Opioid pain medications are prescribed by doctors to treat moderate to severe pain. Common types are codeine, oxycodone, hydrocodone, and morphine.

Before starting or stopping any med
choices for you and your pregnancy

Are opioid pain medi
are pregnant or plan

Possible risks to your pregnancy include[1,2]:

- **Neonatal abstinence syndrome (NAS):** withdrawal symptoms (irritability, seizures, vomiting, diarrhea, fever, and poor feeding) in newborns[3]
  - Opioid-related NAS is also known as neonatal opioid withdrawal syndrome (
- **Neural tube defects:** serious problems in development (or formation) of the fetus' bra

Learn

OK SBIRT Pocket Guide

211 For treatment referrals, call 211

Learn more: opqic.org/omno

PROJECT ECHO®: A TELEHEALTH MODEL FOR RURAL HEALTH CARE

Project ECHO® (Extension for Community Health Care Outcomes) expands access to preventive and specialty care for rural and underserved urban populations by building the capacity of primary care physicians and community health workers to provide safe and effective care for complex and chronic conditions. Through telementoring and guided practice, the ECHO model™ is a cost efficient solution to reduce disparities in health outcomes.

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LOCAL PRIMARY CARE

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OKLAHOMA OPIOID PRESCRIBING GUIDELINES

TREATING PREGNANT PATIENTS WITH OPIOID USE DISORDER

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, and mental and public health officials.[1,2,3,4] Although the recommendations do not include language on Oklahoma's opioid-related laws, it is imperative that providers maintain compliance.

PREGNANCY: METHADONE AND BUPRENORPHINE

Some women are surprised to learn they got pregnant while using heroin, OxyContin, Percocet, or other opioid pain medications that can be misused (known as opioid drugs). You, along with family and friends, may worry about your drug use and if it could affect your baby. Some women may want to "detox" as a way to stop using heroin or pain medications. Unfortunately, studies have shown that 8 out of 10 women return to drug use within a month after "detox." Therefore, most doctors treat opioid misuse in pregnant women with either methadone or buprenorphine. These are long-acting opioid medications that are associated with improved outcomes in pregnancy.

How safe is it to take methadone or buprenorphine (Subutex®) during pregnancy?

- In the right doses, both methadone and buprenorphine stop withdrawal, reduce cravings, and block effects of other opioids.
- Treatment with either methadone or buprenorphine makes it more likely that the baby will grow normally and not come too early.
- Based on many years of research studies, neither medicine has been associated with birth defects.
- Babies born to women who are addicted to drugs can have temporary withdrawal or abstinence symptoms (neonatal abstinence syndrome or NAS). Opioid-related NAS is known as neonatal opioid withdrawal syndrome (NOWS). These withdrawal symptoms can occur in babies whose mothers take methadone or buprenorphine.
- Talk with your doctor about the benefits versus the risks of medication-assisted treatment.

Is methadone or buprenorphine a better medication for me in pregnancy?

- You and your doctor should discuss both methadone and buprenorphine. The choice may be limited by which medication is available in your community.
- If a woman is already stable on methadone or buprenorphine and she becomes pregnant, doctors usually advise her to stay on the same medication.

How can I get started on methadone or buprenorphine?

- Depending on where you live, there may be a special program that offers care to pregnant women who need methadone or buprenorphine. These programs can offer prenatal care and substance use counseling along with your medication.
- Methadone may only be given out by specialized clinics while buprenorphine may be available from your primary care physician or obstetrician if they have received special training.
- Some women prefer or benefit from starting these medications while in a residential (inpatient) treatment facility.

What is the best dose of methadone or buprenorphine during and after pregnancy?

There is no "best" dose of either medication in pregnancy. Every woman should take the dose of methadone or buprenorphine that is right for her.

- The right dose will prevent withdrawal symptoms without making you too tired.
- The right dose depends on how your body processes the medications.
- The dose of methadone usually needs to increase with pregnancy – especially in the third trimester and you may need to take methadone more than once a day.
- There is less known about buprenorphine dose changes in pregnancy, but increases may be necessary.
- The dose does not seem to determine how much NAS/NOWS a baby will have.
- After delivery, the methadone or buprenorphine dose may remain the same or may decrease as your body returns to its non-pregnant state. This can take up to a few months after delivery.

Your dose should be reduced if it begins to cause sedation. Be sure to discuss with your doctors, nurses, and counselors whether you are feeling too sleepy.

Learn more: opqic.org/omno

SCREENING FOR SUBSTANCE USE DURING PREGNANCY: USING AN SBIRT FRAMEWORK

Developing a Screening, Brief Intervention, and Referral to Treatme process in the maternity care context

Note: While some medical tests may be used for both screening and diagnostic purposes, the terms are not interchangeable. Screening may occur in a setting to identify health risk behaviors, including substance use.

SBIRT implementation requires modification of existing clinic workflows. Each context is different. SBIRT sho incorporated into the existing intake process for new OB patients, which includes screening for other medici

Brief description of a typical SBIRT implementation process

1 SBIRT Preparation

- Review institutional policies and update as needed to include use of the SBIRT framework for prenatal patients
- Develop a plan for modifying workflow to incorporate screening
- Train appropriate staff on screening process
- Train appropriate staff in brief intervention techniques
- Identify follow-up plan and key personnel for when screening is positive
- Create a list of resources to support women in need of referrals for substance use
- Identify billing requirements and opportunities
- Develop patient information script or written materials about substance use screening and institutional policies on substance use

2 Implementation

- Implement workflow modification to include confidential screening and response
- Provide information about institutional substance use policies as part of new patient orientation
- Screen using a validated questionnaire on paper or electronically
- Ensure a warm handoff occurs from staff performing screening to staff who will address positive screening results
- Implement Brief Negotiated Interview (BNI) algorithm following positive screening
- Develop a follow-up plan when screening is positive
- Make referrals if needed

Learn more: opqic.org/omno

NEONATAL ABSTINENCE SYNDROME (NAS)

OPIOID-RELATED NAS IS ALSO KNOWN AS NEONATAL OPIOID WITHDRAWAL SYNDROME (NOWS)

WHAT YOU NEED TO KNOW

BE WITH YOUR BABY: YOU ARE THE TREATMENT!

Learn more: opqic.org/omno

Injury Prevention Service
Oklahoma State Department of Health

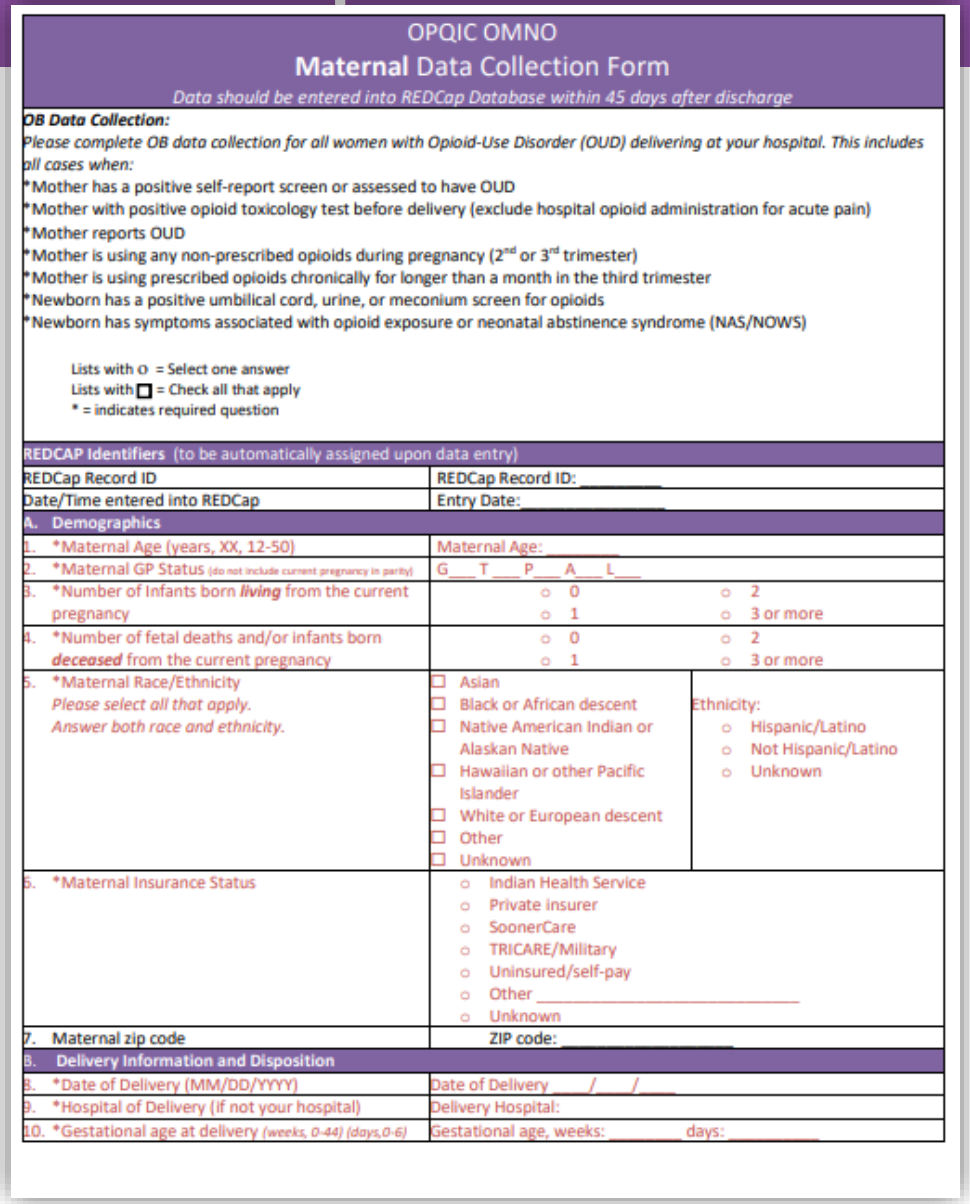
OKLAHOMA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE

Our Partnership

Digital health company focused on the lifecycle of substance use disorder (SUD), from prevention to intervention to treatment to recovery

Data Collection

OMNO Paper Data Collection Forms



OPQIC OMNO

Maternal Data Collection Form

Data should be entered into REDCap Database within 45 days after discharge

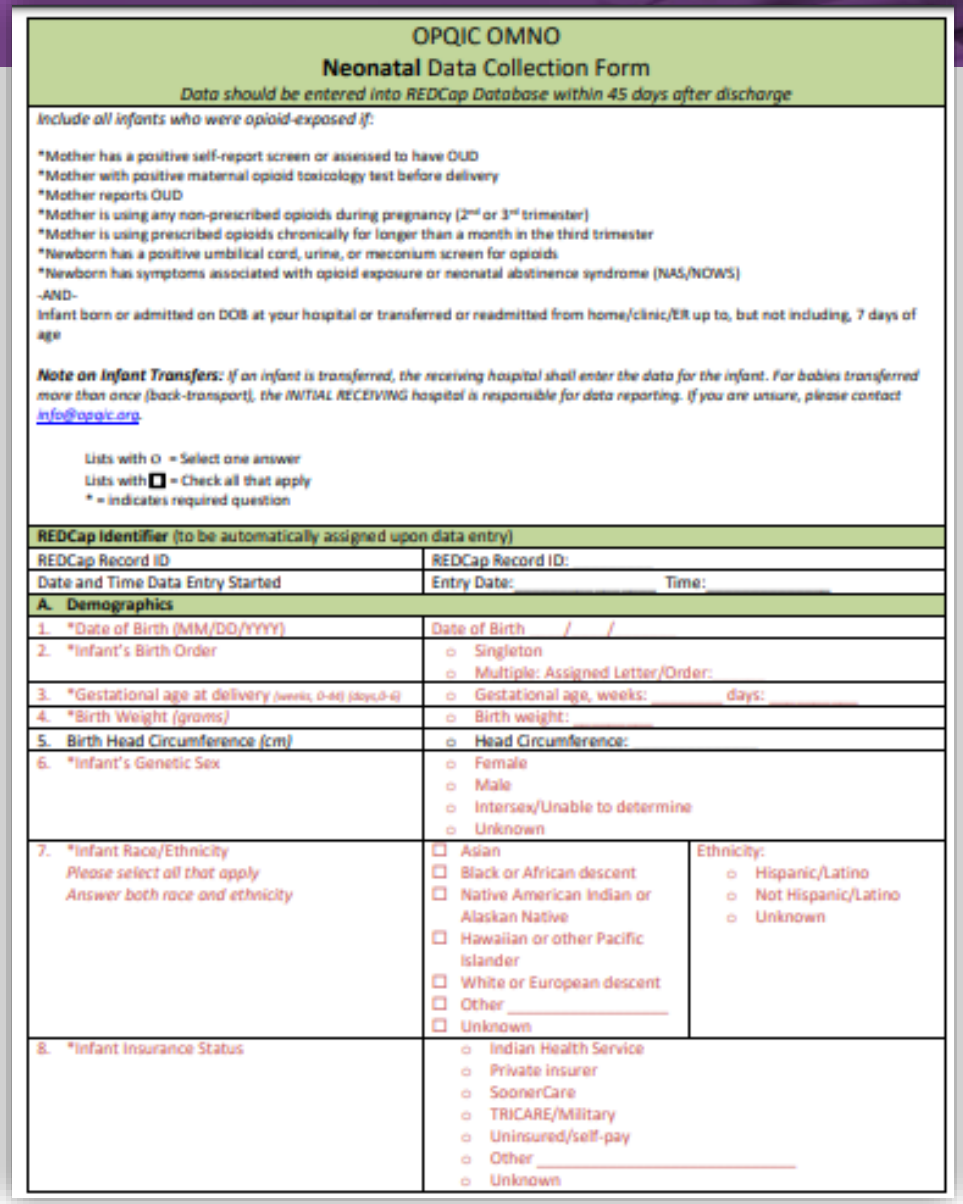
OB Data Collection:

Please complete OB 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 with positive opioid toxicology test before delivery (exclude 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 prescribed opioids chronically for longer than a month in the third trimester
*Newborn has a positive umbilical cord, urine, or meconium screen for opioids
*Newborn has symptoms associated with opioid exposure or neonatal abstinence syndrome (NAS/NOWS)

Lists with ○ = Select one answer
Lists with ☐ = Check all that apply
* = indicates required question

REDCAP Identifiers (to be automatically assigned upon data entry)	
REDCap Record ID	REDCap Record ID: _____
Date/Time entered into REDCap	Entry Date: _____
A. Demographics	
1. *Maternal Age (years, XX, 12-50)	Maternal Age: _____
2. *Maternal GP Status (do not include current pregnancy in parity)	G___ T___ P___ A___ L___
3. *Number of Infants born ***living*** from the current pregnancy	○ 0 ○ 1 ○ 2 ○ 3 or more
4. *Number of fetal deaths and/or infants born ***deceased*** from the current pregnancy	○ 0 ○ 1 ○ 2 ○ 3 or more
5. *Maternal Race/Ethnicity *Please select all that apply.* *Answer both race and ethnicity.*	☐ Asian ☐ Black or African descent ☐ Native American Indian or Alaskan Native ☐ Hawaiian or other Pacific Islander ☐ White or European descent ☐ Other ☐ Unknown Ethnicity: ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Unknown
6. *Maternal Insurance Status	○ Indian Health Service ○ Private insurer ○ SoonerCare ○ TRICARE/Military ○ Uninsured/self-pay ○ Other _____ ○ Unknown
7. Maternal zip code	ZIP code: _____
B. Delivery Information and Disposition	
8. *Date of Delivery (MM/DD/YYYY)	Date of Delivery ____/____/____
9. *Hospital of Delivery (if not your hospital)	Delivery Hospital:
10. *Gestational age at delivery *(weeks, 0-44) (days,0-6)*	Gestational age, weeks: _____ days: _____



OPQIC OMNO

Neonatal Data Collection Form

Data should be entered into REDCap Database within 45 days after discharge

Include all infants who were opioid-exposed if:

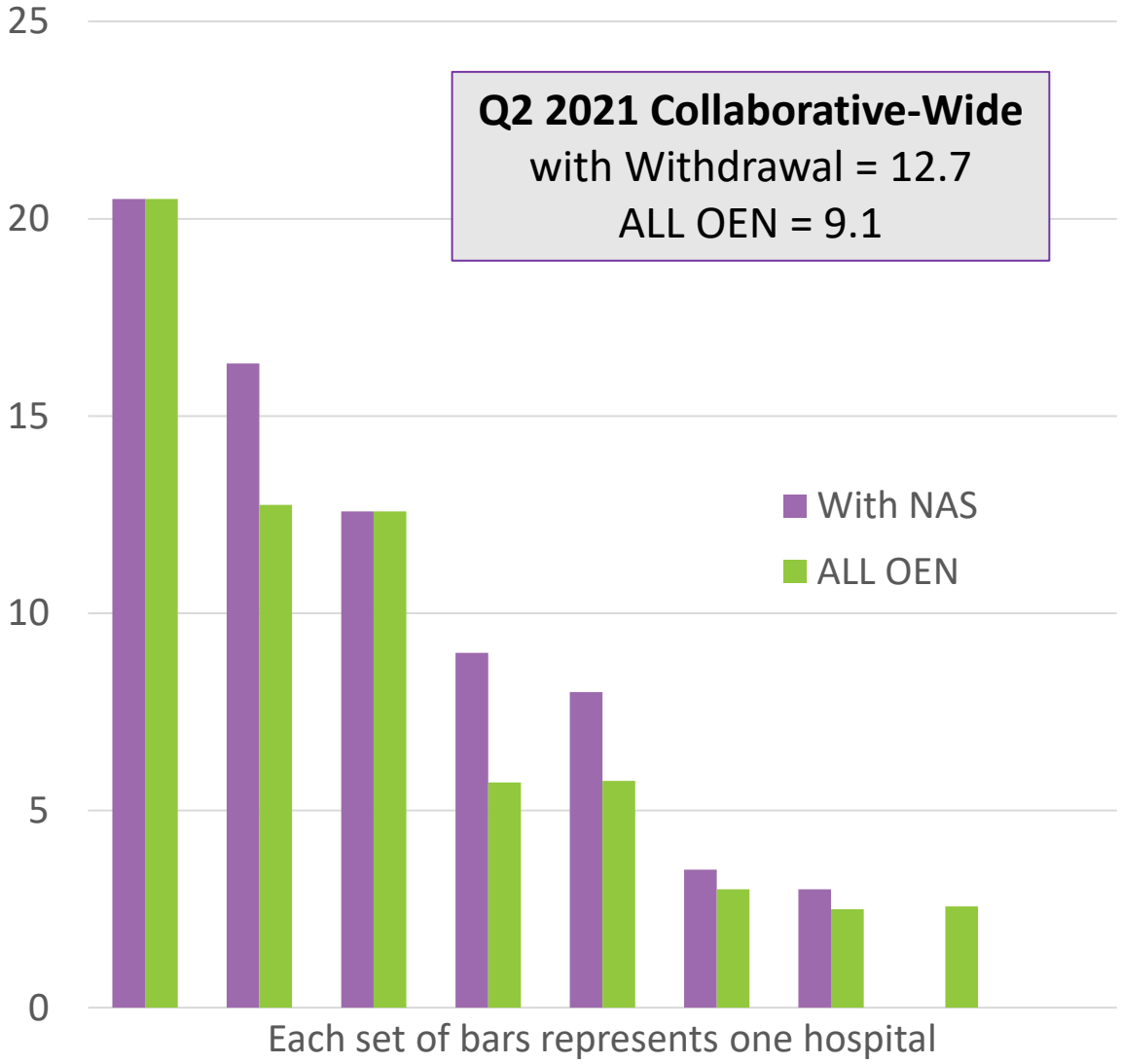
*Mother has a positive self-report screen or assessed to have OUD
*Mother with positive maternal opioid toxicology test before delivery
*Mother reports OUD
*Mother is using any non-prescribed opioids during pregnancy (2nd or 3rd trimester)
*Mother is using prescribed opioids chronically for longer than a month in the third trimester
*Newborn has a positive umbilical cord, urine, or meconium screen for opioids
*Newborn has symptoms associated with opioid exposure or neonatal abstinence syndrome (NAS/NOWS)
-AND-
Infant born or admitted on DOB at your hospital or transferred or readmitted from home/clinic/ER up to, but not including, 7 days of age

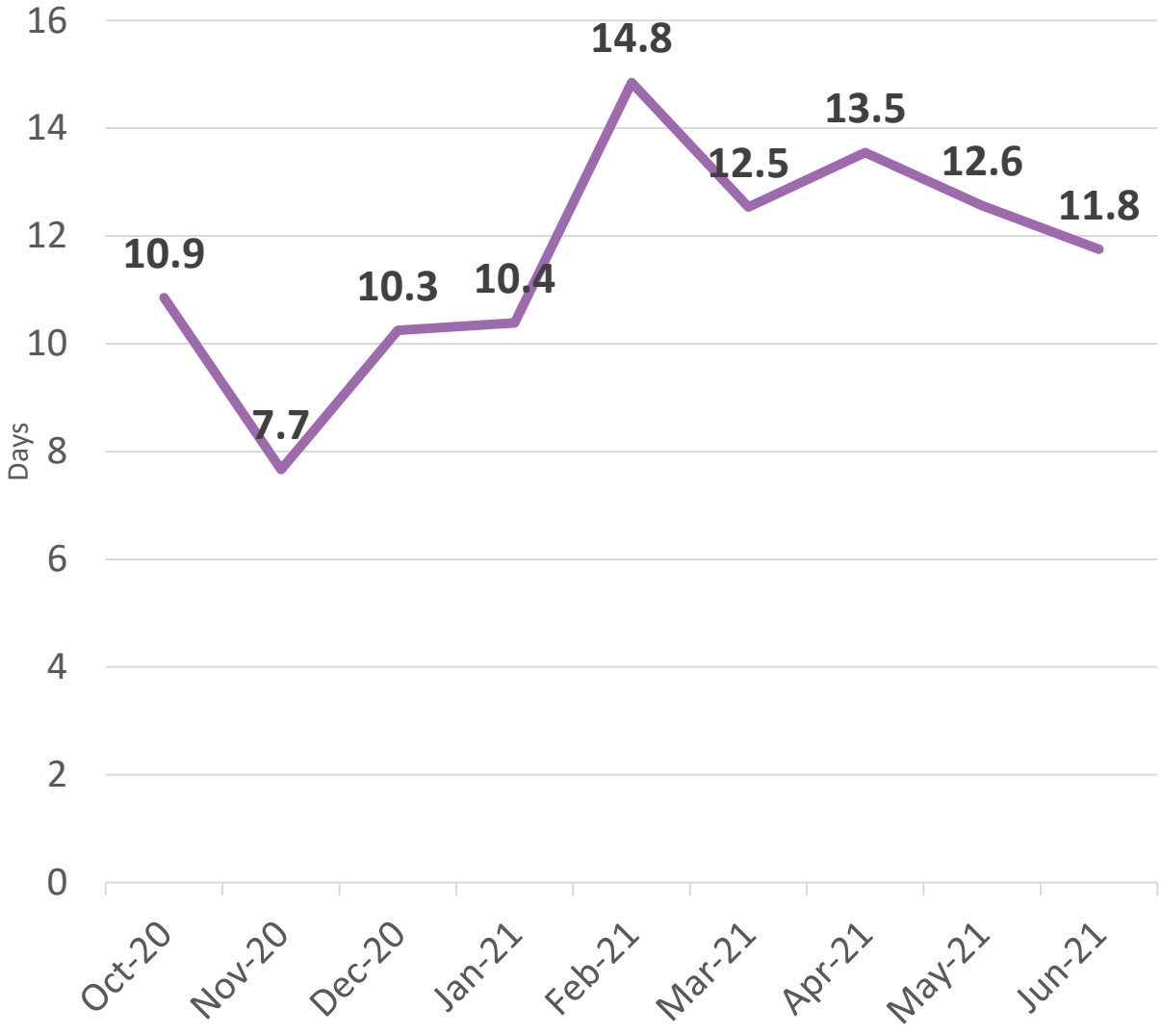
Note on Infant Transfers: *If an infant is transferred, the receiving hospital shall enter the data for the infant. For babies transferred more than once (back-transport), the INITIAL RECEIVING hospital is responsible for data reporting. If you are unsure, please contact info@opqic.org.*

Lists with ○ = Select one answer
Lists with ☐ = Check all that apply
* = indicates required question

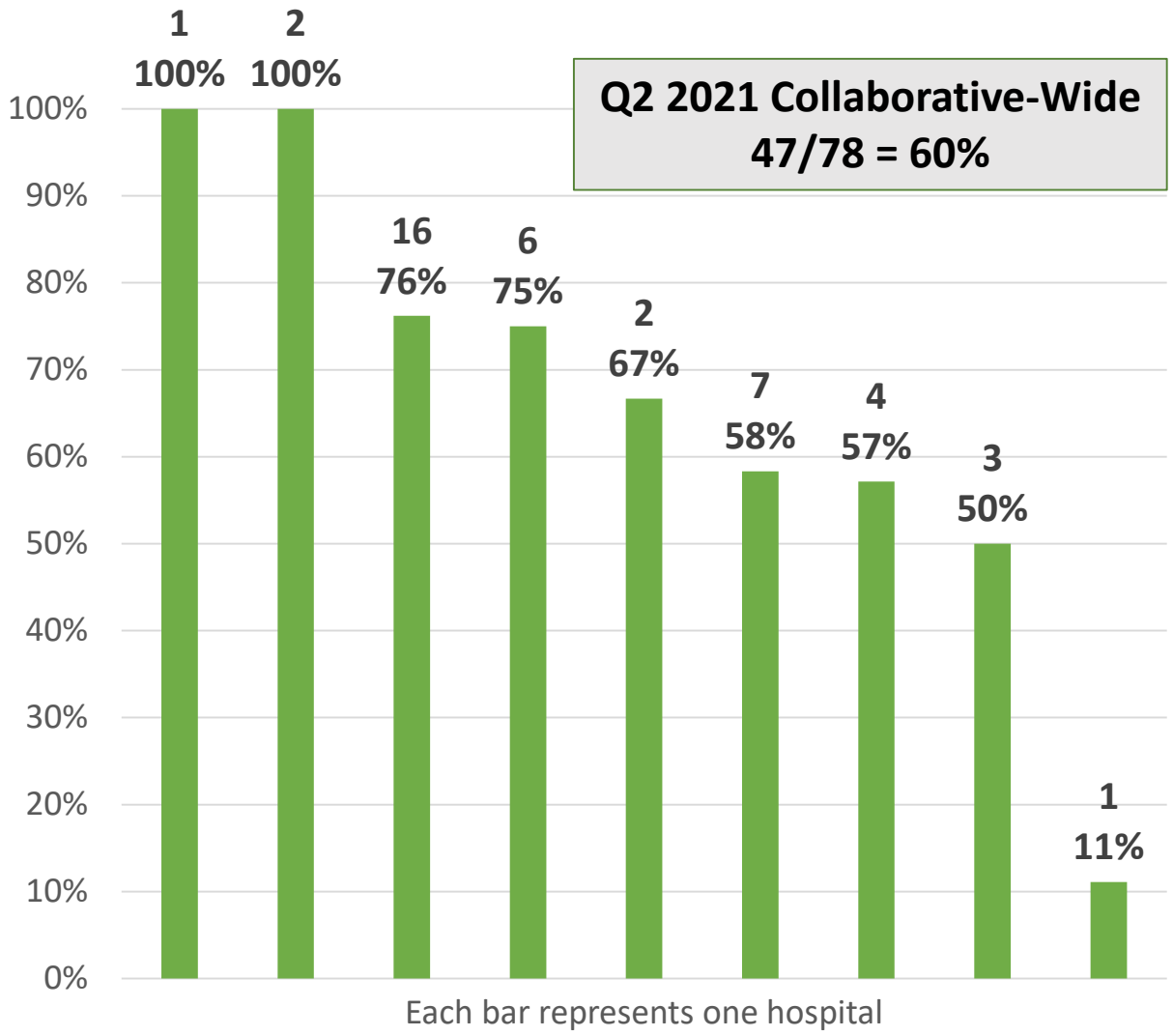
REDCap Identifier (to be automatically assigned upon data entry)	
REDCap Record ID	REDCap Record ID:
Date and Time Data Entry Started	Entry Date: _____ Time: _____
A. Demographics	
1. *Date of Birth (MM/DD/YYYY)	Date of Birth ____/____/____
2. *Infant's Birth Order	○ Singleton ○ Multiple: Assigned Letter/Order:
3. *Gestational age at delivery *(weeks, 0-44) (days,0-6)*	○ Gestational age, weeks: _____ days: _____
4. *Birth Weight *(grams)*	○ Birth weight: _____
5. Birth Head Circumference *(cm)*	○ Head Circumference: _____
6. *Infant's Genetic Sex	○ Female ○ Male ○ Intersex/Unable to determine ○ Unknown
7. *Infant Race/Ethnicity *Please select all that apply* *Answer both race and ethnicity*	☐ Asian ☐ Black or African descent ☐ Native American Indian or Alaskan Native ☐ Hawaiian or other Pacific Islander ☐ White or European descent ☐ Other _____ ☐ Unknown Ethnicity: ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Unknown
8. *Infant Insurance Status	○ Indian Health Service ○ Private insurer ○ SoonerCare ○ TRICARE/Military ○ Uninsured/self-pay ○ Other _____ ○ Unknown

Average Length of Stay for Opioid-Exposed Newborns

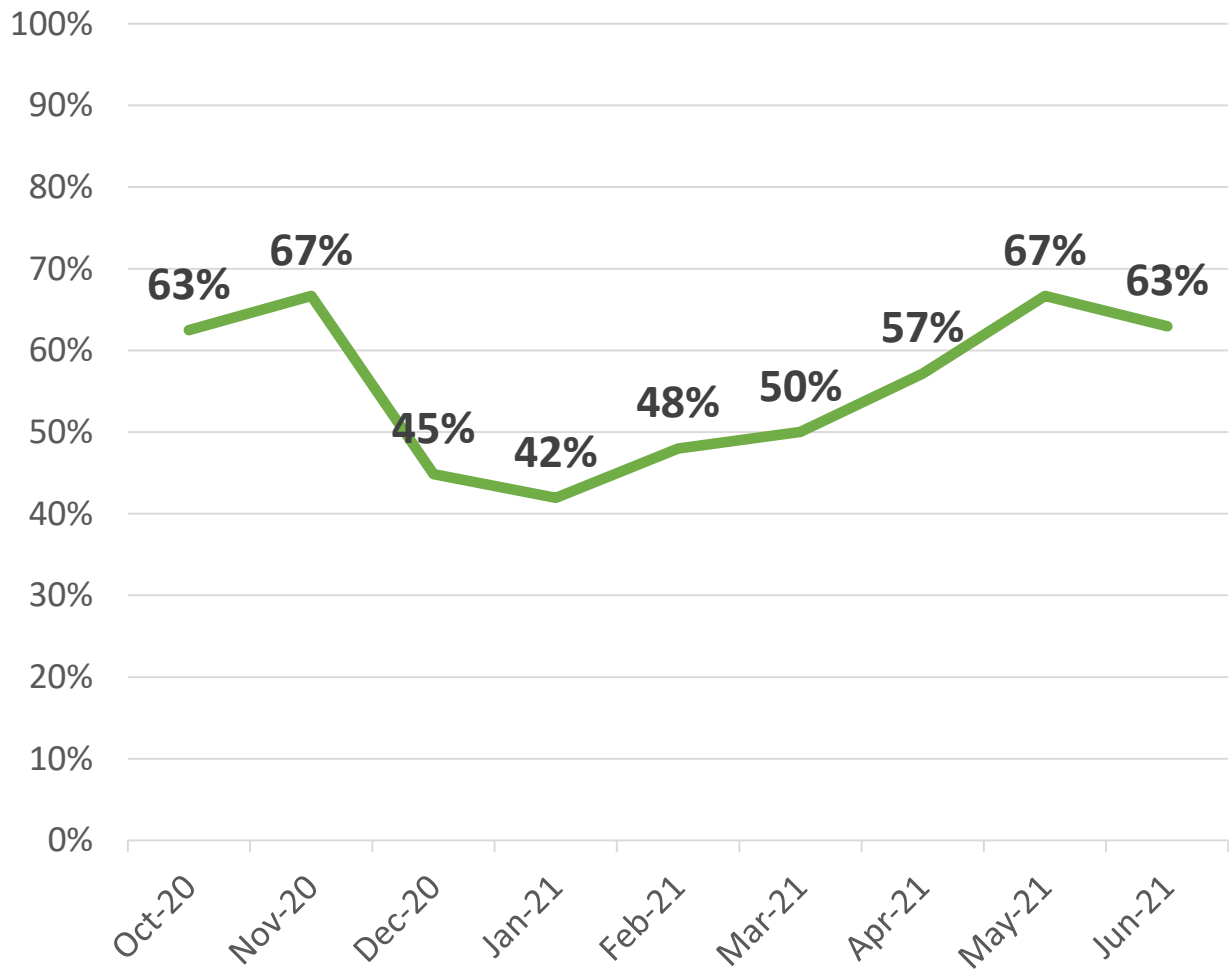




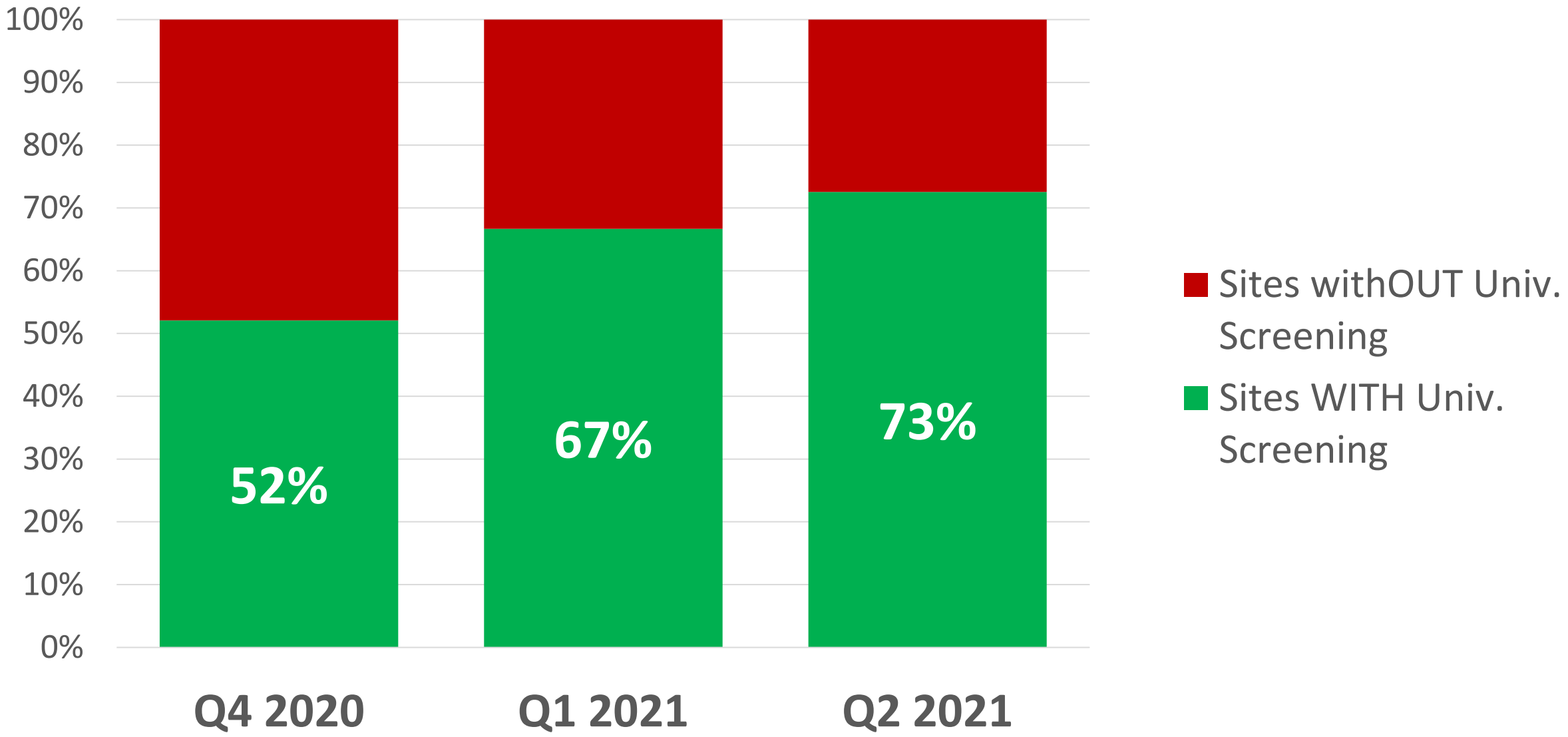
Percent of Women with OUD During Pregnancy who receive medication-assisted treatment OR behavioral health treatment



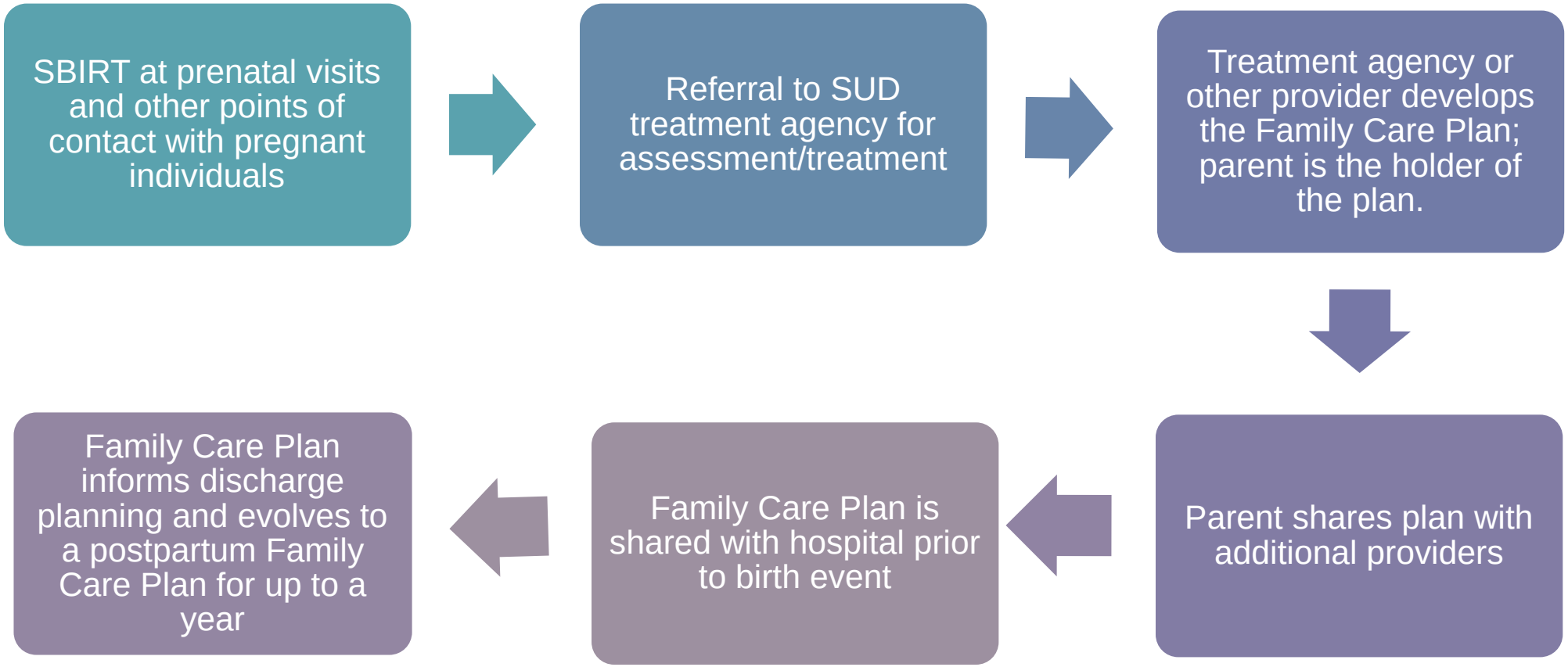
Q2 2021 Collaborative-Wide
47/78 = 60%



Prenatal Care Sites with Universal Screening Policy



Proposed Solution: Family Care Plans



TEAMBIRTH IN OKLAHOMA

TeamBirth: Process Innovation for Clinical Safety, Effective Communication, and Dignity in Childbirth

Oklahoma First Statewide Initiative

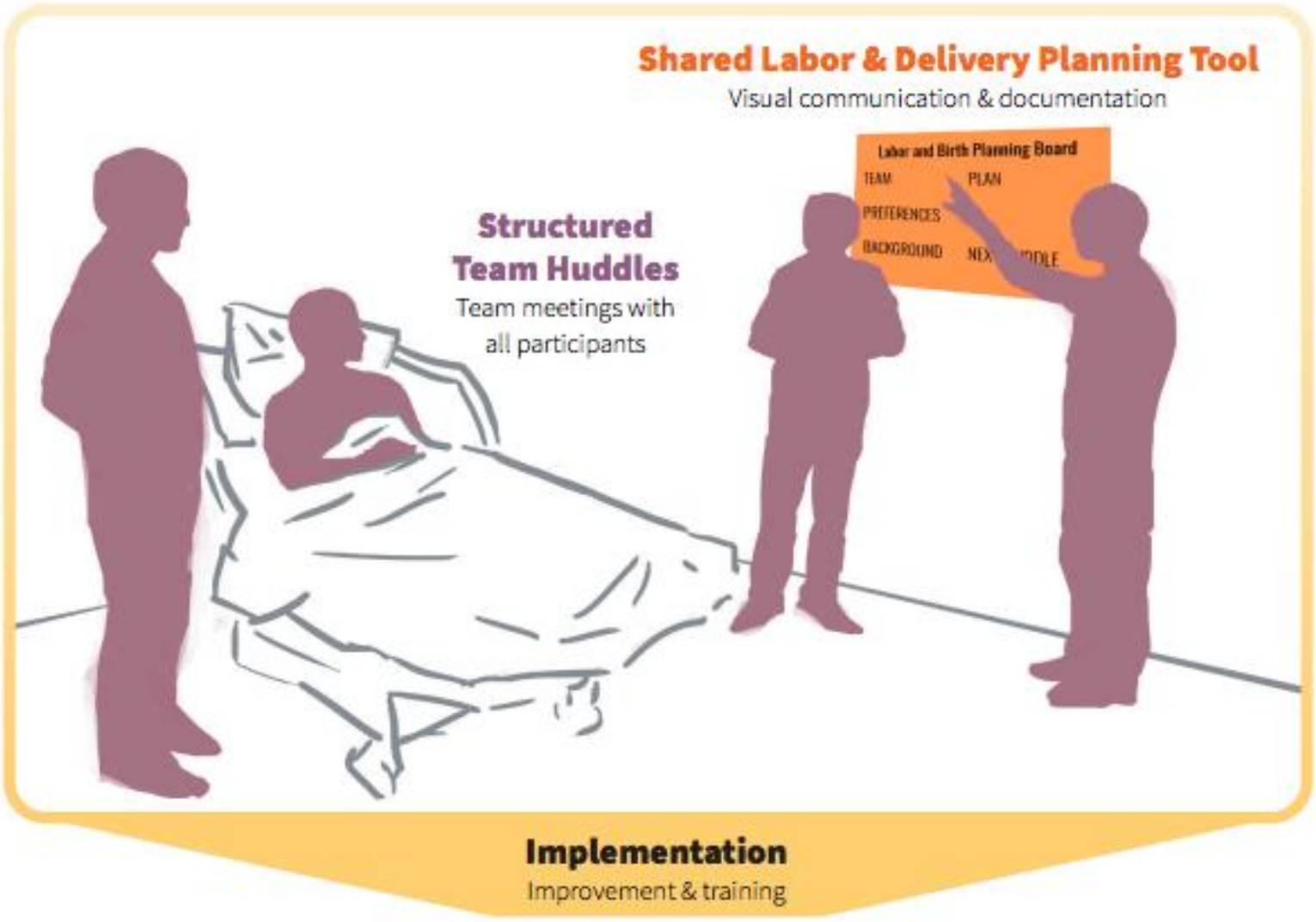
3-year Collaborative Agreement

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.

Delivery Decisions Initiative

Our vision is a world in which every person can choose to grow their family with dignity.

TeamBirth Components



ARIADNE LABS

SaintFrancis Health System

Labor and Delivery Planning Board

TEAM

DATE: ROOM: LAST HUDDLE:

EARLY LABOR → ACTIVE LABOR → PUSHING

PLAN

Mom:

Baby:

Labor Progress:

PREFERENCES

Al

Voices from Oklahoma

“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)

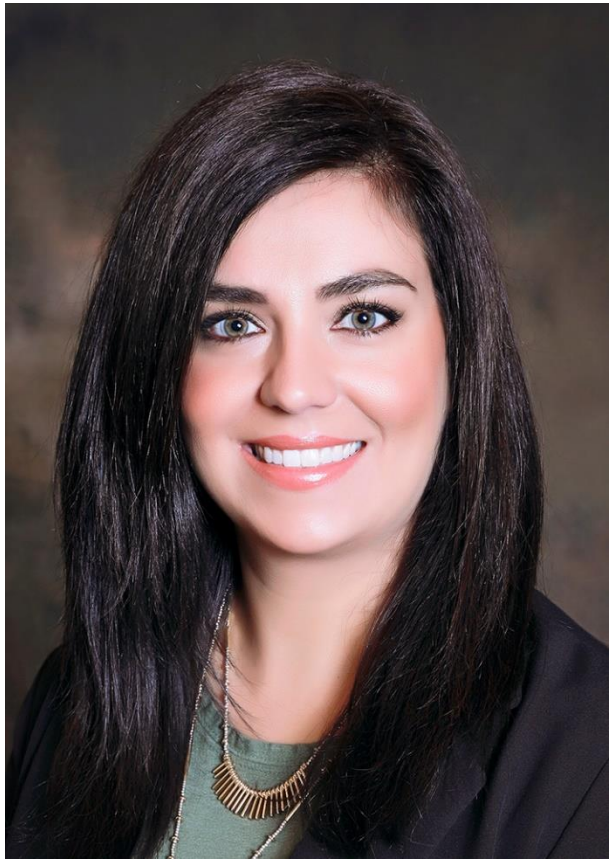
- Monthly webinars
- Coaching calls

Launch (Feb/Mar - Jun 2022)

- Monthly webinars
- Coaching calls

Sustain (Jul 2022 ->)

- Coaching calls
- Add Cohort 2 hospitals



Sarah Johnson
OPQIC Maternal Peer Navigator

OPQIC UPDATE: EMPOWERING PREGNANT AND POSTPARTUM PATIENTS

OPQIC

TOOLKIT OVERVIEW

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 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.

3 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**. 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 patient 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/

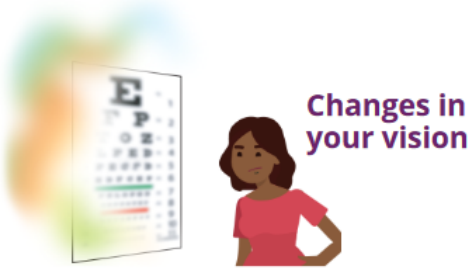
https://opqic.org/patienthandouts/

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

Council on Patient Safety in Women's Health Care

https://www.cdc.gov/hearher/index.html

https://opqic.org/patienthandouts/

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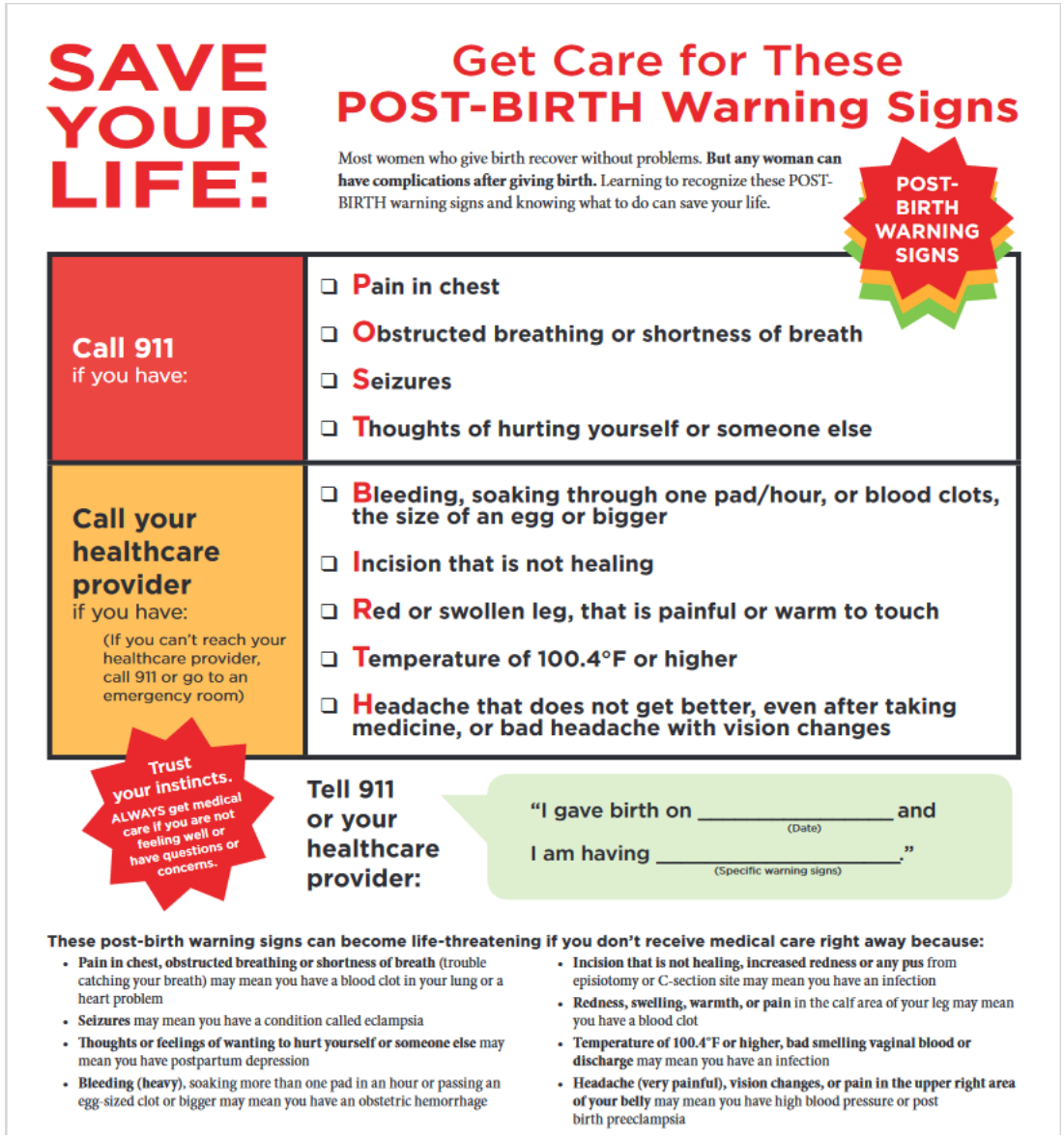
2 AWHONN POST-BIRTH Warning Signs

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 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.

POST-BIRTH WARNING SIGNS

Call 911 if you have:

- ❑ **P**ain in chest
- ❑ **O**bstructed breathing or shortness of breath
- ❑ **S**eizures
- ❑ **T**houghts 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)

- ❑ **B**leeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger
- ❑ **I**ncision that is not healing
- ❑ **R**ed or swollen leg, that is painful or warm to touch
- ❑ **T**emperature of 100.4°F or higher
- ❑ **H**eadache that does not get better, even after taking medicine, or bad headache with vision changes

Trust your instincts. ALWAYS get medical care if you are not feeling well or have questions or concerns.

Tell 911 or your healthcare provider:

"I gave birth on _____ (Date) and I am having _____ (Specific warning signs)."

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** (trouble catching your breath) may mean you have a blood clot in your lung or a heart problem
- **Seizures** may mean you have a condition called eclampsia
- **Thoughts or feelings of wanting to hurt yourself or someone else** may mean you have postpartum depression
- **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
- **Incision that is not healing, increased redness or any pus** from episiotomy or C-section site may mean you have an infection
- **Redness, swelling, warmth, or pain** in the calf area of your leg may mean you have a blood clot
- **Temperature of 100.4°F or higher, bad smelling vaginal blood or discharge** may mean you have an infection
- **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://awhonn.org/education/hospital-products/post-birth-warning-signs-education-program/

https://opgic.org/patienthandouts/

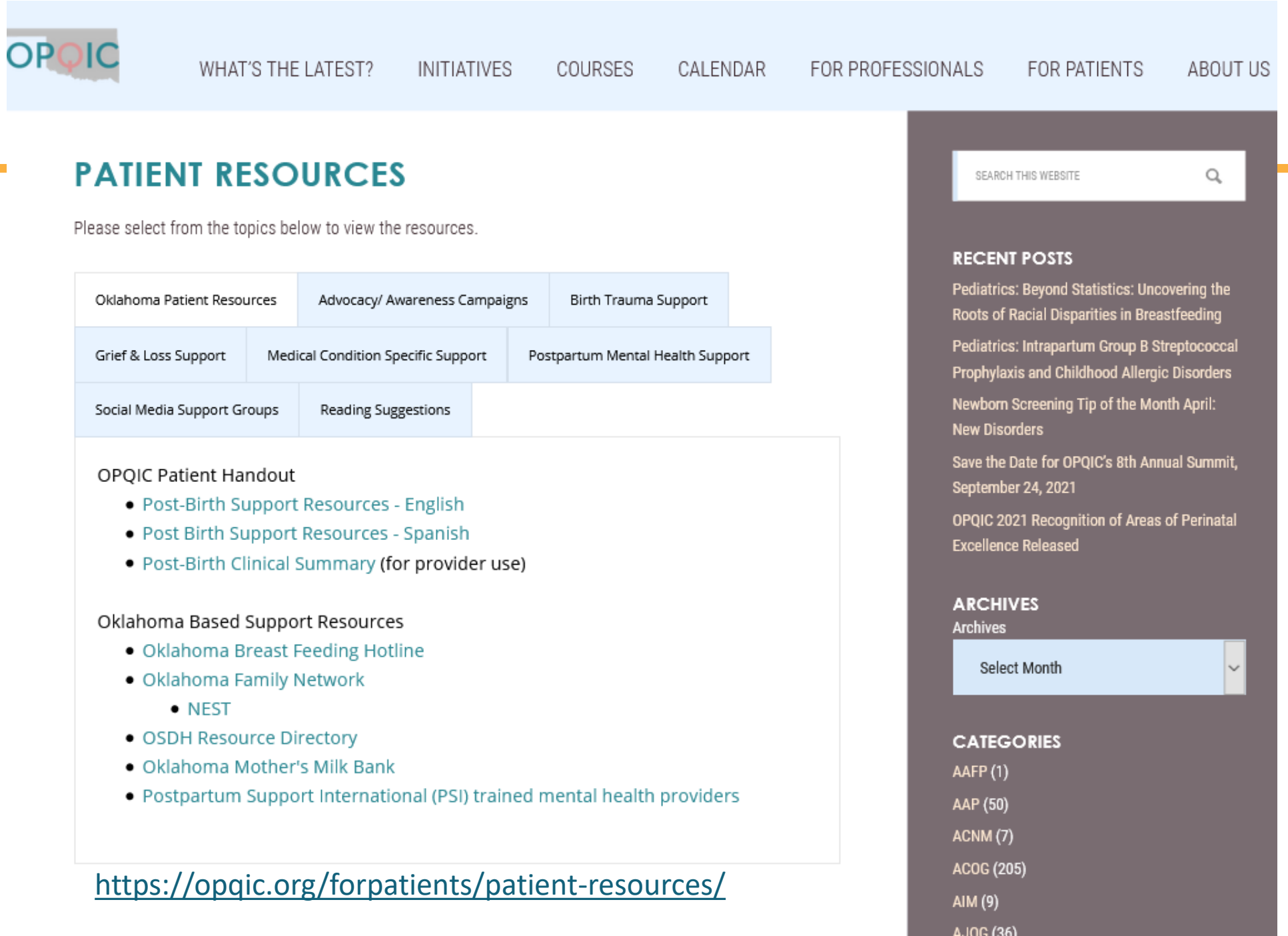
OPQIC

3 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. Document this conversation.

https://opqic.org/wp-content/uploads/2021/04/Post-Birth-Support-Resources-OPQIC-V2-FINAL.pdf



https://opqic.org/forpatients/patient-resources/

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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.

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OKLAHOMA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

Clinical Summary

Patient Name			
Date of Delivery			
Hospital		Phone	
Type of Birth	☐ Vaginal ☐ Cesarean Comments:	Blood Type	
		Postpartum Hemoglobin	

Complications

☐ Obstetric Hemorrhage ☐ Severe Hypertension/Preeclampsia
☐ Venous Thromboembolism ☐ Other:

Patient Information

Mom	Pregnancy Outcome ☐ Live Birth ☐ Stillbirth ☐ NICU		
Baby	GA (in weeks)	Birthweight	Length

Clinical Summary

Surgery	*Date*		
	Type		
	Organs removed		
Blood Transfusion	*Type of Blood Products*		☐ Red Blood Cells ☐Platelets ☐ Plasma
	Number of units		___ Red Blood Cells ___ Platelets ___ Plasma
Imaging Tests	☐ Yes ☐ No	*Date*	
		Type	
		Result	
Interventional Radiology	☐ Yes ☐ No	*Date*	
		Type	
		Result	
Medical Treatments			

Follow-up

Clinician Name		Phone	
Appointment Date		Phone	
For further information, please contact the Hospital Medical Record Office to request your complete medical record.			
Medical Records		Phone	

Notes

Reference: CMS Patient Clinical Summary Guidelines

2.18.21 V1

1. Urgent Maternal Warning Signs: Use this tool at Prenatal Care Visits.

Responsible Persons - OB Physician, Clinic Nurse, Clinic Staff

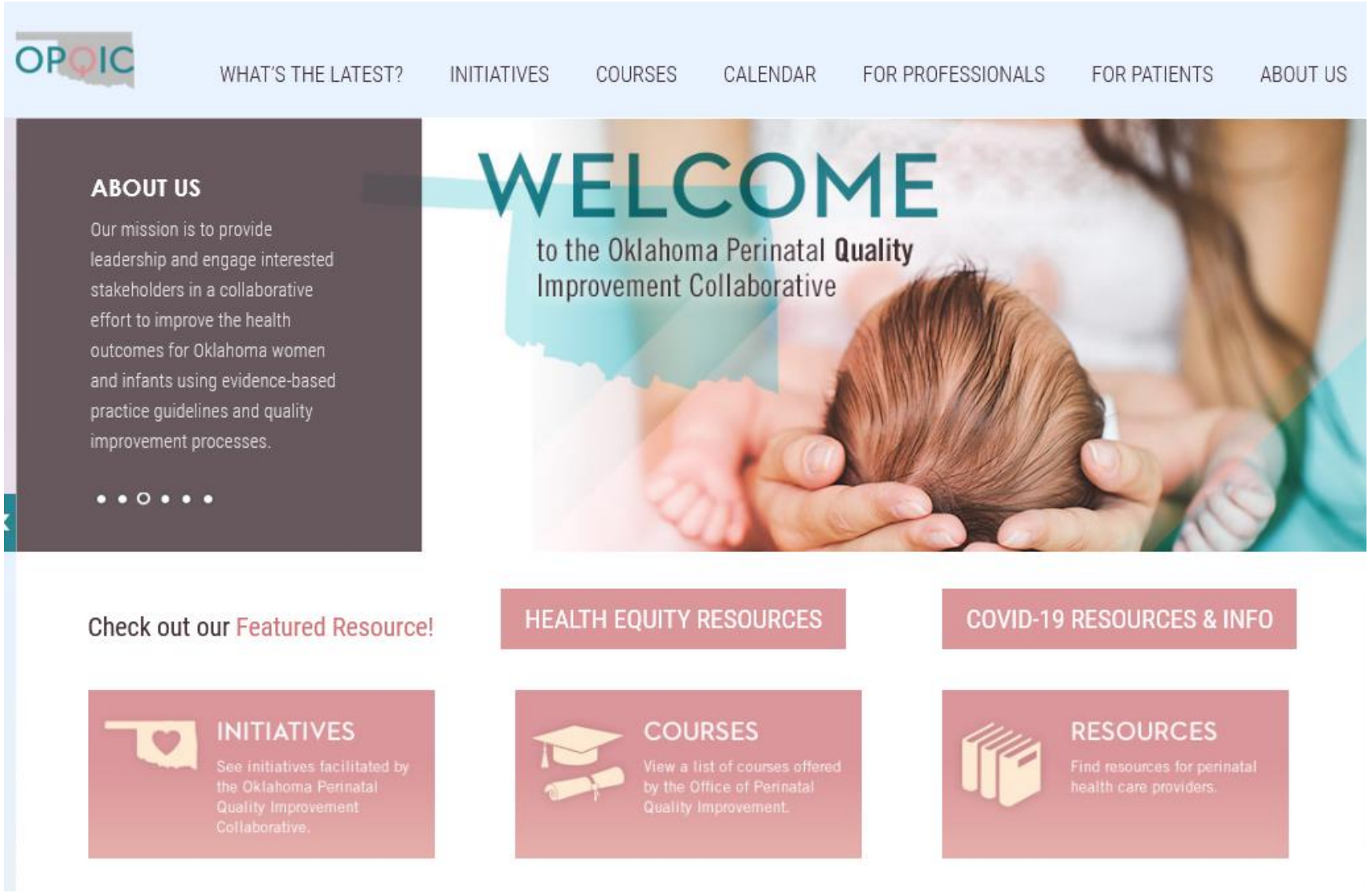
- Engage patients and support persons by educating on **Urgent Maternal Warning Signs** and how to seek care.
  - ✓ Strongly reinforce your desire for the patient to seek care if they have questions/concerns – invited vs. included. Give permission for them to seek care.
  - ✓ Explain to the patient why 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 Palm Cards, Educational Flyers, or Info Graphic Handout.
  - ✓ Train staff using CDC Hear Her 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 emergent/urgent needs. Give it to the patient in writing.
  - ✓ What should patients do afterhours 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.

Empowering Pregnant & Postpartum Patients
Toolkit Implementation Guide

Links to Urgent Maternal Warning Signs - Patient Resources
Urgent Maternal Warning Signs **Patient Education Flyer** - English
Urgent Maternal Warning Signs **Patient Education Flyer** - Spanish
Urgent Maternal Warning Signs **Patient Palm Card** - English
Urgent Maternal Warning Signs **Patient Palm Card** - Spanish
Urgent Maternal Warning Signs **Support Person Education Flyer** - English
Urgent Maternal Warning Signs **Support Person Education Flyer** - Spanish
Urgent Maternal Warning Signs - **Info Graphic** - English
Urgent Maternal Warning Signs - **Info Graphic** - Spanish
Urgent Maternal Warning Signs - **Clinic Poster** - English
Urgent Maternal Warning Signs - **Clinic Poster** - Spanish



https://opqic.org/

THANK YOU!

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https://opqic.org

info@opqic.org

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