ILPQC BE Monthly Data Collection Form		
REDCAP Study Identifiers		
1. REDCap Record ID	REDCap Record ID: _____	
2. Hospital ID Number	Hospital ID Number: _____	
3. Please select the time period for this monthly data:	☐ Baseline (Oct - Dec 2020) ☐ August 2021 ☐ September 2021 ☐ October 2021 ☐ November 2021 ☐ December 2021 ☐ January 2022 ☐ February 2022	☐ March 2022 ☐ April 2022 ☐ May 2022 ☐ June 2022 ☐ July 2022 ☐ August 2022 ☐ September 2022 ☐ October 2022 ☐ November 2022 ☐ December 2022
4. Total Deliveries:		
5. Deliveries with Severe Maternal Morbidity: (defined by CDC) https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm		
6. Of your deliveries with Severe Maternal Morbidity please share the number of patients who self-reported/identified as:	#_____ White #_____ Black #_____ Hispanic #_____ Asian #_____Other	
7. Of your deliveries with Severe Maternal Morbidity please share the number of patients by insurance status	#_____Private Insurance #_____Public Insurance #_____Uninsured/Self-pay	
Structure Measures		
8. Hospital has implemented standardized social determinants of health screening tools for screening all pregnant women during delivery admission in order to link patients to needed resources and services	☐ Haven't started ☐ Working on it ☐ In place	

9. Hospital has provided affiliated prenatal care sites options for standardized social determinants of health screening in order to screen pregnant patients early in pregnancy and link to needed resources and services	☐ Haven't started ☐ Working on it ☐ In place
10. Hospital has completed ILPQC social determinants of health community resources mapping tool to assist linking patients to needed resources and services and share with affiliated outpatient prenatal care sites and hospital OB units	☐ Haven't started ☐ Working on it ☐ In place
11. Hospital has strategy for incorporating discussion of social determinants of health and discrimination as potential factors in hospital maternal morbidity reviews	☐ Haven't started ☐ Working on it ☐ In place
12. Hospital has implemented a protocol for improving the collection and accuracy of patient-reported race/ethnicity data	☐ Haven't started ☐ Working on it ☐ In place
13. Hospital has developed a process to review maternal health quality data stratified by race/ethnicity and Medicaid status	☐ Haven't started ☐ Working on it ☐ In place
14. Hospital has engaged patients and/or community members to provide input on quality improvement efforts	☐ Haven't started ☐ Working on it ☐ In place
15. Hospital has a strategy for sharing expected respectful care practices with delivery staff and patients (i.e. posting in L&D) including appropriately engaging support partners and/or doulas	☐ Haven't started ☐ Working on it ☐ In place
16. Hospital has implemented a Patient Reported Experience Measure (PREM) patient survey to obtain feedback from postpartum patients on respectful care practices and a process to review and share results	☐ Haven't started ☐ Working on it ☐ In place
17. Hospital has standardized system to provide all patients the recommended postpartum safety patient education materials prior to hospital discharge including urgent maternal warning signs and where patients call for immediate help with concerns as well as scheduling early postpartum follow-up	☐ Haven't started ☐ Working on it ☐ In place
Process Measures	
18. Percentage of providers completing education on the importance of listening to patients, providing respectful care, and addressing implicit bias	☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%
19. Percentage of nurses completing education on the importance of listening to patients, providing respectful care, and addressing implicit bias	☐ 0% ☐ 10% ☐ 20%

	☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%
20. Percentage other staff completing education on the importance of listening to patients, providing respectful care, and addressing implicit bias. Should consider all staff who have contact with patients during the delivery admission.	☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Outcome Measures

The goal is to review a sample of **10 records patients delivered from the specified race/ ethnicity categories or on Medicaid/ uninsured per month.**

- Example 1: If your hospital has **102 patients delivered from the specified race/ethnicity categories in a month**, then divide 102 by 10=10.2 and you will select every 10th birth for that month.

- Example 2: If your hospital has **28 patients delivered from the specified race/ ethnicity categories in a month**, then 28 divided by 10 is 2.8 and you will select every 2nd birth for that month.

If you have **less than 10 deliveries of the specified race/ ethnicity categories per month include all of them and select additional deliveries with Medicaid/ uninsured,** to complete sample of 10 total charts.

1. Begin by systematically selecting **10 records per month** from deliveries to patients of the specified race/ ethnicity categories. a. Patients of these race/ ethnicity categories: i. Black or African American ii. Hispanic or Latino iii. Native American or Alaskan Native iv. Asian/Pacific Islander v. Multiracial or Biracial 2. Divide the total number of deliveries to patients of the specified race/ ethnicity categories occurring at your facility in a given month by 10 and then select every nth chart where 'n' is the result of that division a. Step 1: develop a process to identify deliveries to patients of the specified race/ ethnicity categories	A) #___of patients in monthly sample race/ethnicity documented and completed B) # of sample patient charts with social determinants of health (SDoH) screening documented using a SDoH screening tool (prenatal and L&D) i. ___prenatally ii. ___during delivery admission C) # of sample patient charts screen positive for social determinants of health (SDoH) (answer yes to any question on SDoH screening tool) i. ___prenatally ii. ___during delivery admission

b. Step 2: use the ILPQC direction to establish a sampling protocol c. Step 3: once a sampling protocol is determined you can use every month	a. # of sample patient charts screen positive for social determinants of health that have documentation of patient linkage to needed resources/services (prenatal and L&D) i. ____prenatally ii. ____during delivery admission E) # of patients in monthly sample with documentation of receiving postpartum safety education materials prior to hospital discharge including urgent maternal warning signs and where patients call for immediate help with concerns as well as scheduling early postpartum follow-up i. _____urgent maternal warning signs ii. _____ where patients call for immediate help with concerns iii. _____ scheduling early postpartum follow-up