Welcome!

- Please use this time before we begin to:
  - Set up your storyboard in your network area
  - Help yourself to continental breakfast in the corridor
  - Restrooms are past the lobby then down the hall to the left
  - If you have team members here, please try to sit together

ILPQC
Illinois Perinatal Quality Collaborative

Birth Certificate Accuracy Initiative

Face-to-Face Collaborative Learning Session

May 18, 2015

10:00 am – 3:30 pm

BC Accuracy Initiative Partnership

The “Birth Certificate” is more than just a piece of paper…

- The electronic birth certificate:
  - Collects over 300 pieces of information on Illinois mothers and babies
  - Is a data information system used by local, state, and national partners
  - Is the only consistent source of health information on **ALL** Illinois babies and new mothers
  - Is the foundation for surveillance, monitoring and public health research in perinatal health
  - Reflects your hospital’s performance and adherence to best practices in perinatal care

IDPH
Illinois Department of Public Health

Today's Participants

- 252 participants registered
- 100 hospitals registered
- Roll call: physicians, nurses, abstractors, quality, public health

Agenda

- Welcome and Overview
- Applying the IHI Model for Improvement and PDSA Cycles
- Team Storyboard Viewing
- Working Lunch
- Small Group Breakout Discussion and Debrief
- Key Birth Certificate Variables Overview
- Monthly Quality Improvement Cycle Support Recap

Today's Presenters

- Ann Borders, ILPQC OB Lead & Executive Director
- Patti Lee King, ILPQC State Project Director
- Kate Finnegan, ILPQC Project Coordinator
- Susan Ford, BEACON Quality Improvement Coordinator, Ohio Perinatal Quality Collaborative
- Cindy Mitchell, Birth Certificate Accuracy Initiative Perinatal Network Administrator Lead, South Central IL
- Vickie Williams, Vital Records, Illinois Department of Public Health

Agenda

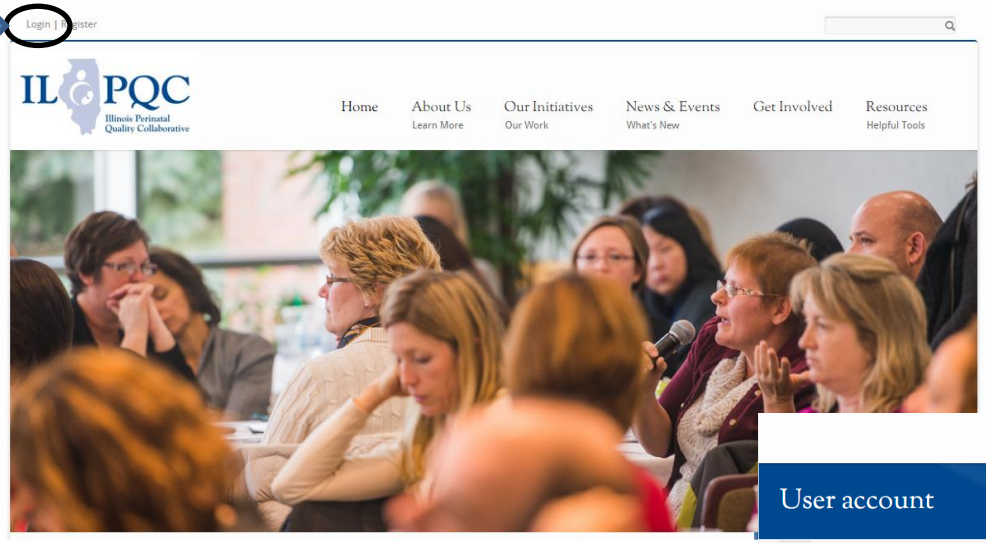
10:00 – 10: 15 am	Welcome & Overview of Baseline Data (Ann Borders)
10:15 – 11:15 am	Applying the IHI Model for Improvement and PDSA Cycles (Susan Ford and Patti Lee King)
11:15 am – 12:00 pm	Team story board presentations / viewing (All participants)
12:00 – 12:45 pm	Working Lunch – Teams / Table discussion of lessons learned from Story boards / Process Flow diagrams
12:45 – 1:45 pm	Small group breakouts with PNAs – PDSA worksheets
1:45 – 2:00 pm	Debrief from small groups to large group (All participants)
2:00 – 3:00 pm	Key Birth Certificate Variables Overview (Cindy Mitchell and Vickie Williams)
3:00 –3:10 pm	Monthly Quality Improvement Cycle Support Recap (Ann Borders)
3:10 – 3:30 pm	Questions & Wrap-up Panel (Ann Borders, Patti Lee King, Susan Ford, Cindy Mitchell, Vickie Williams)

Storyboard & Group Discussion Organization

- Teams view storyboards from 11:15 – 12:00 pm
- Discuss storyboards and complete worksheets during lunch with team and/or table 12:00 – 12:45 pm
- Small Group Breakout by Perinatal Network (1 – 2 pm)
  - 12:45 – 1:05 pm: Each Perinatal Network group brainstorms barriers to accuracy and opportunities for change
  - 1:05 – 1:35 pm: Group breaks down into hospital teams to discuss 30-60-90 day plan and PDSA worksheet
  - 1:35 – 1:45 pm: PNAs facilitate discussion with all hospital teams to identify key areas to share with large group
- Debrief from small groups to large group 1:45 – 2:00 pm

Sign Up for Member's Only Area on *ilpqc.org*

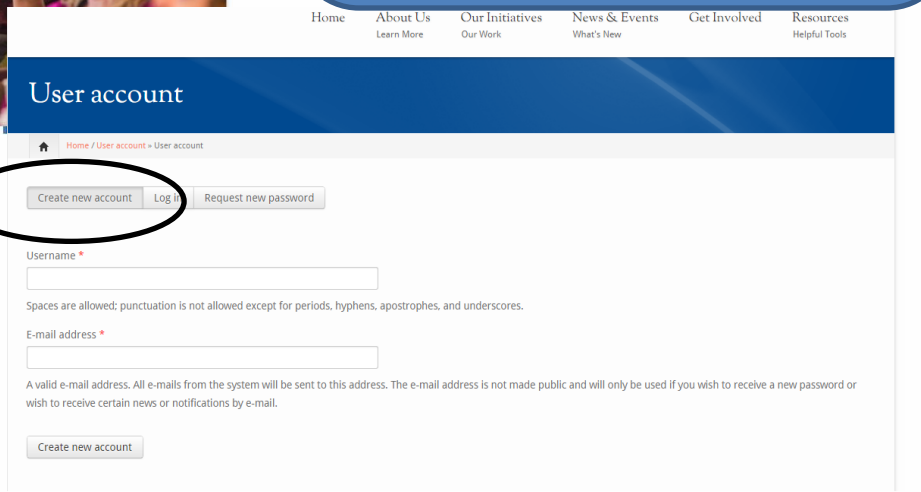
Click



Create your user account today to have access to everything you need online!

Click

Fill in info



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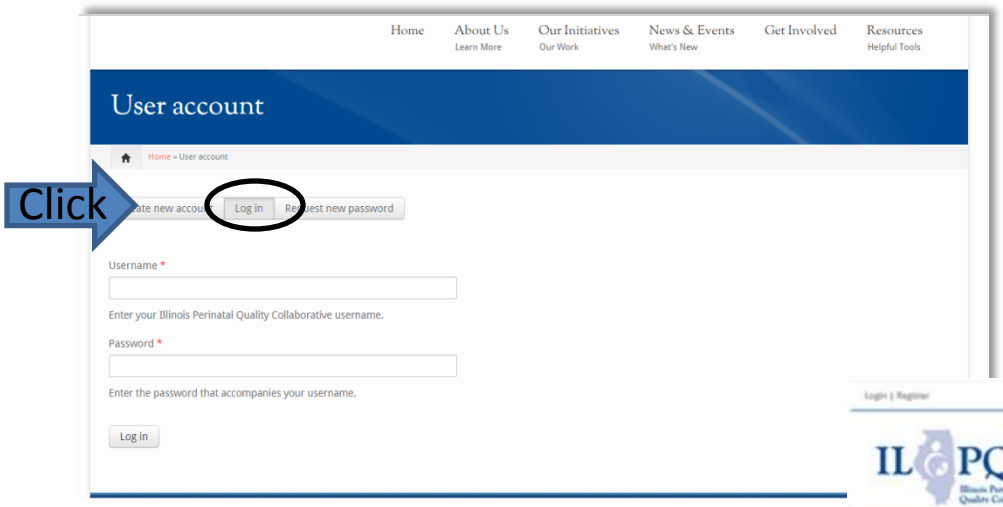
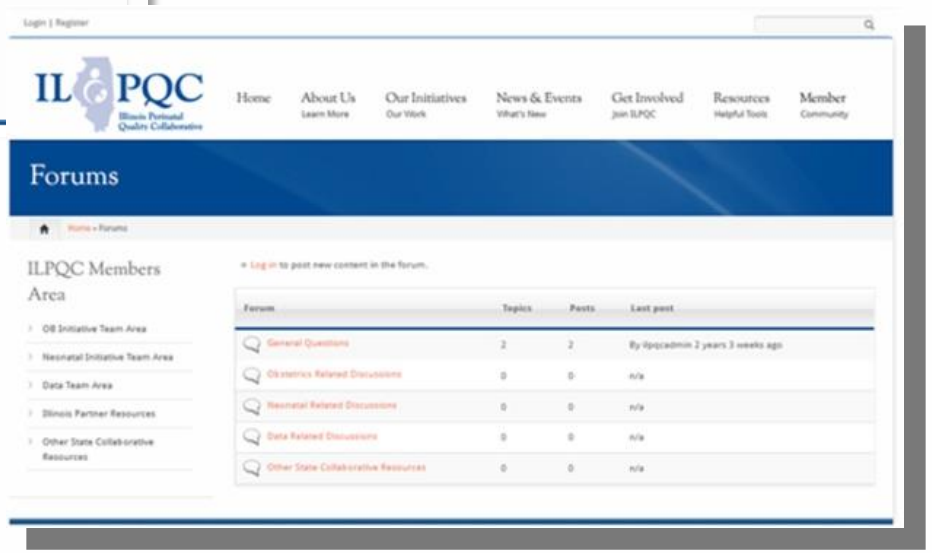


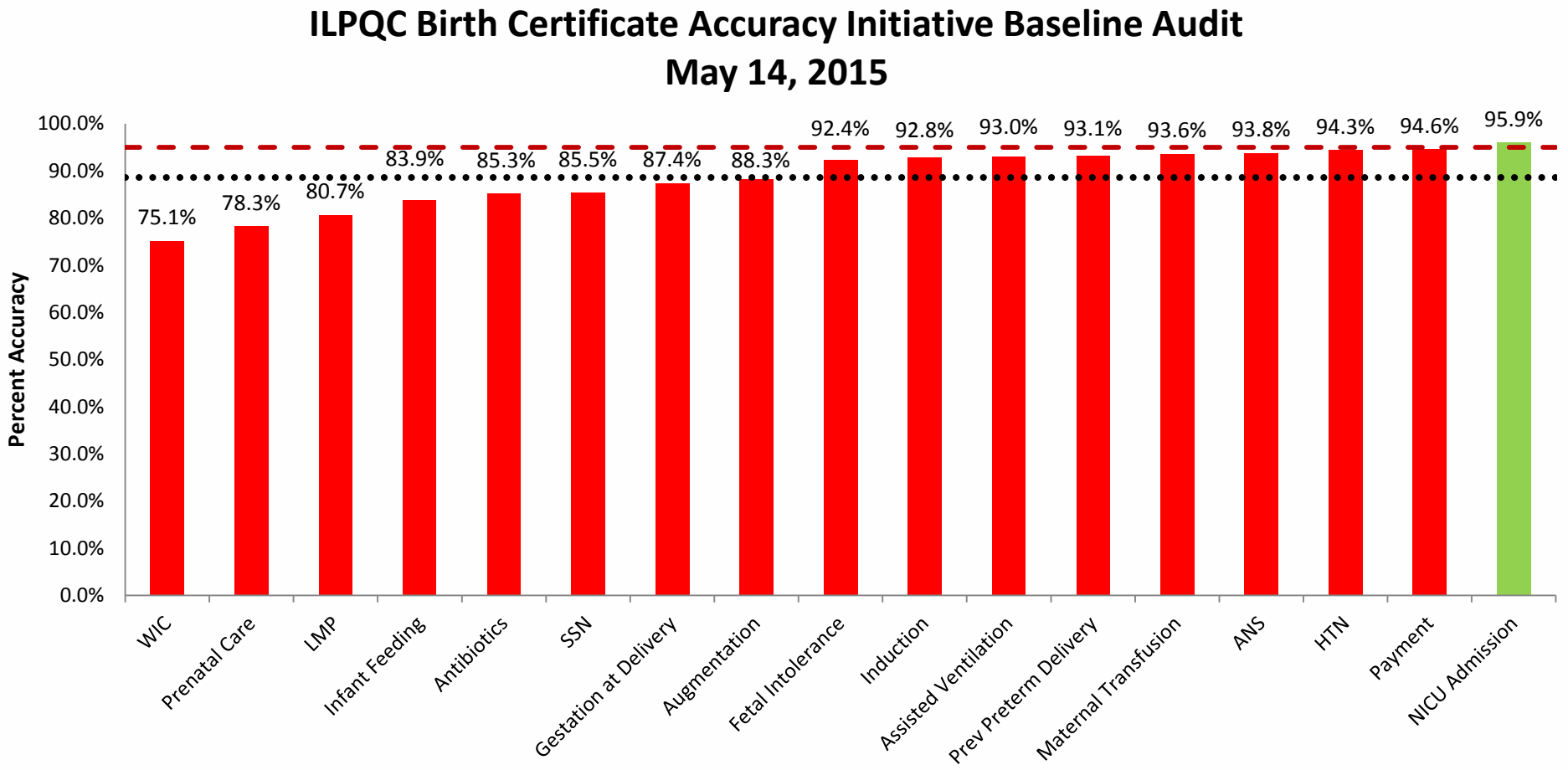


- Share initiative specific resources
- Collaborate and communicate via online ILPQC initiative forums/discussion boards

BC Accuracy Baseline Data

- 103 team rosters submitted for initiative (44 wave 1, 59 wave 2)
- Baseline data completion as of May 14
  - 89 teams completed data entry (**86% of teams!!**)
  - 5 teams with partial data entered
- Make sure you received your baseline data report at registration if you submitted your data by May 11
- Reports are available online via REDCap login at any time (demo later today)

BC Accuracy Baseline: All Variables



Overall accuracy for all 17 variables = **88.6%**

Total Hospitals Reporting Data = 94

***Total Hospitals Reporting Transfusion = 60**

Applying the IHI Model for Improvement and PDSA Cycles to Improve Your Hospital's Birth Certificate Accuracy

Patti Lee King and Susan Ford
with Kate Finnegan

Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

The Model for Improvement

AIM
What are we trying to accomplish?

MEASURES
How will we know that a change is an improvement?

CHANGES
What changes can we make that will result in improvement?

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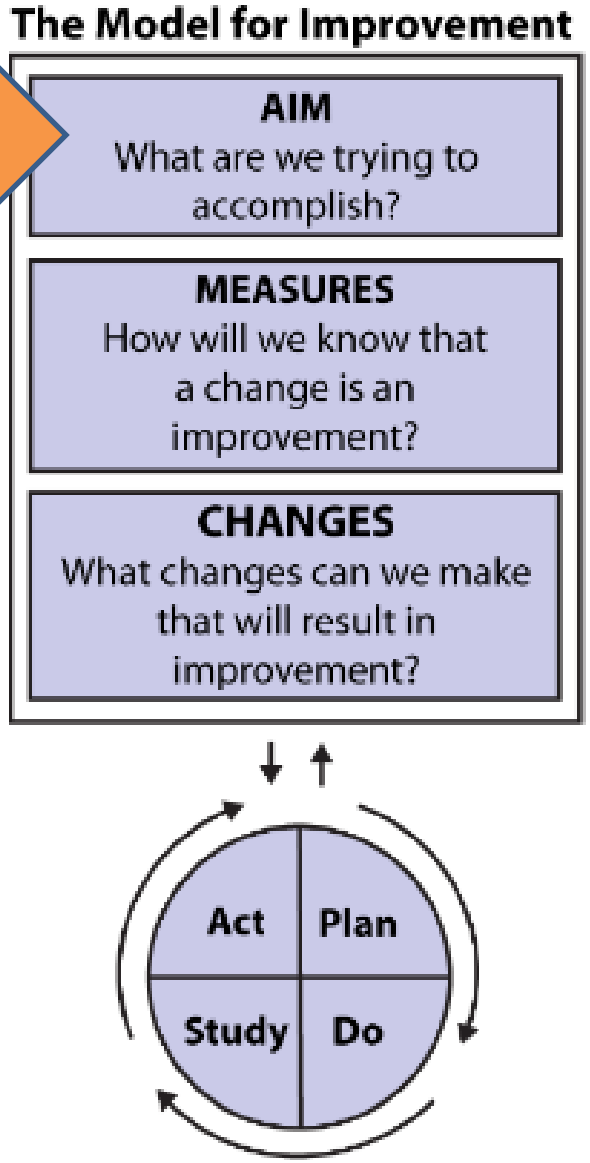
Question 1

Set your aim



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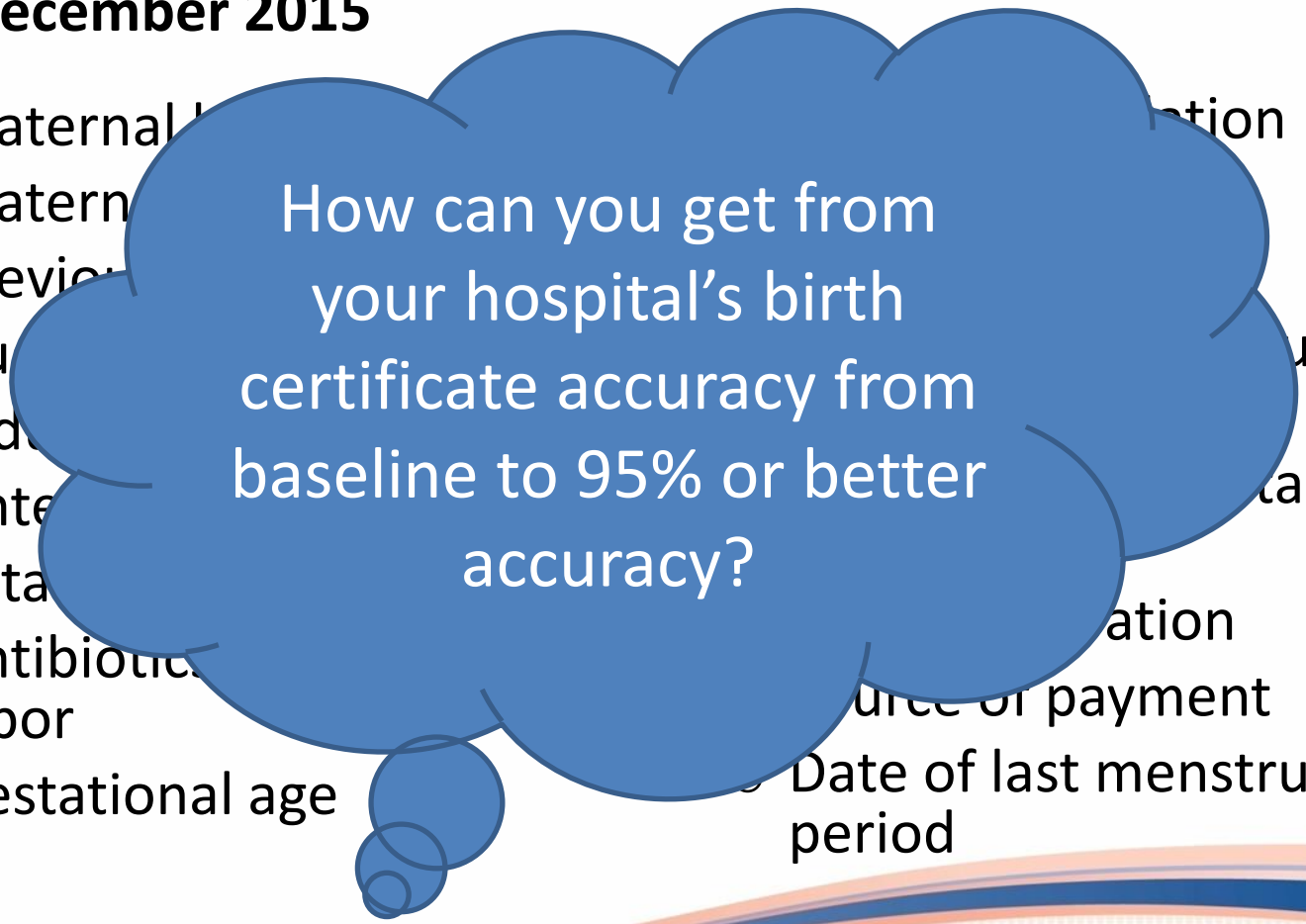
SMART AIMS

S	Specific
M	Measureable
A	Actionable
R	Relevant
T	Time bound

What is our aim?

Obtain 95% accuracy on 17 key birth certificate variables by December 2015

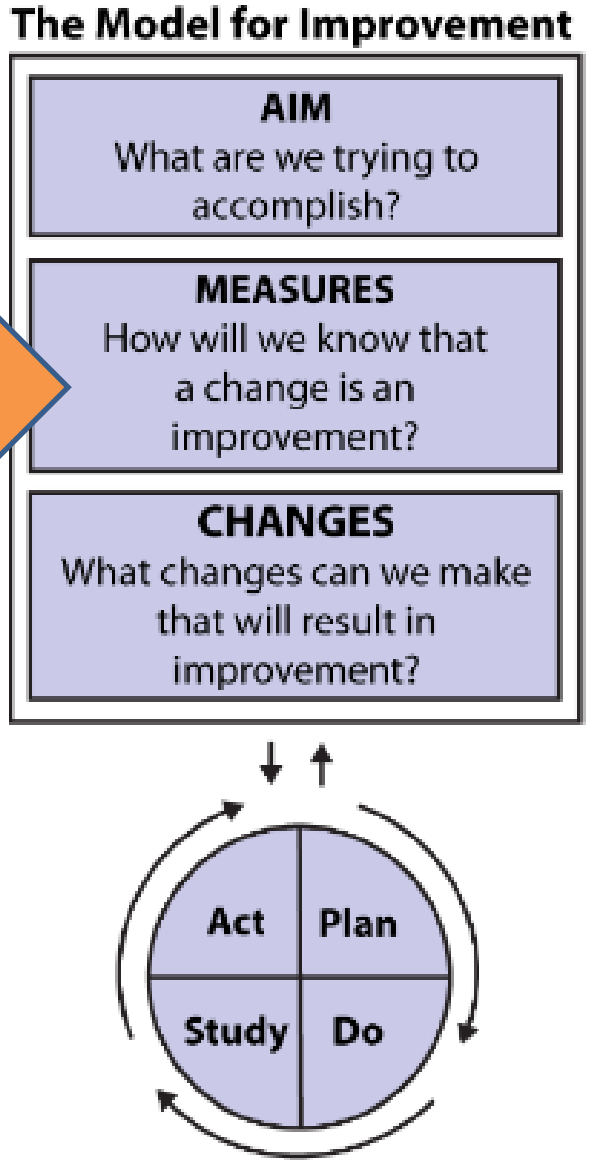
- Maternal
- Matern
- Previo
- Au
- Ind
- Ante
- Feta
- Antibiotic
  labor
- Gestational age



- tion
- urity
- tal care
- ation
- urce of payment
- Date of last menstrual period

Establish measures

Question 2



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Why Measure?

- Measures tell your team whether the changes you make lead to improvement

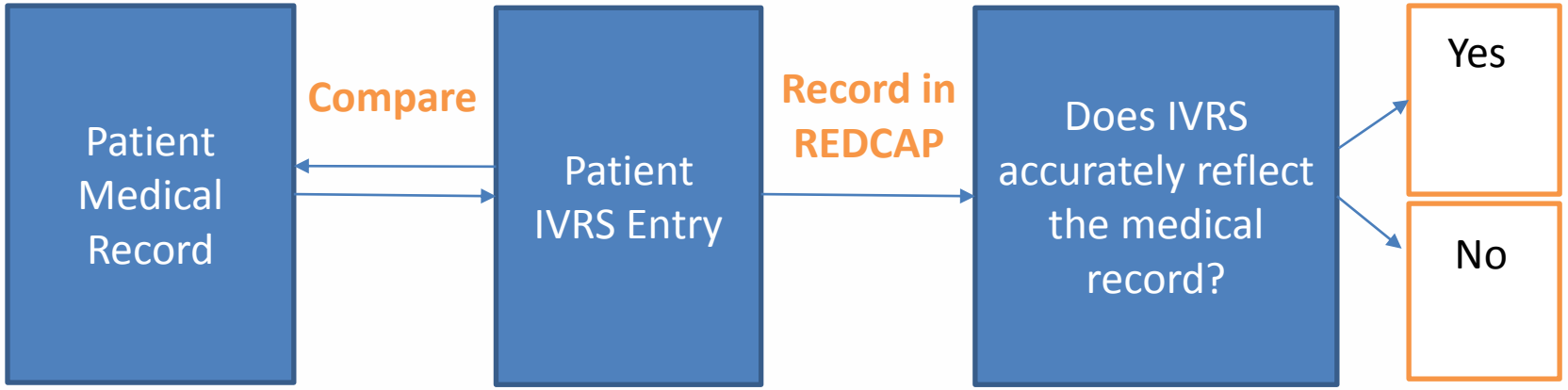
"You can't improve what you don't measure."
– Peter Drucker

Types of Measures

Outcome	Process	Balancing
• What are your results towards your aim?	• How do you achieve your aim?	• Are there unintended consequences?

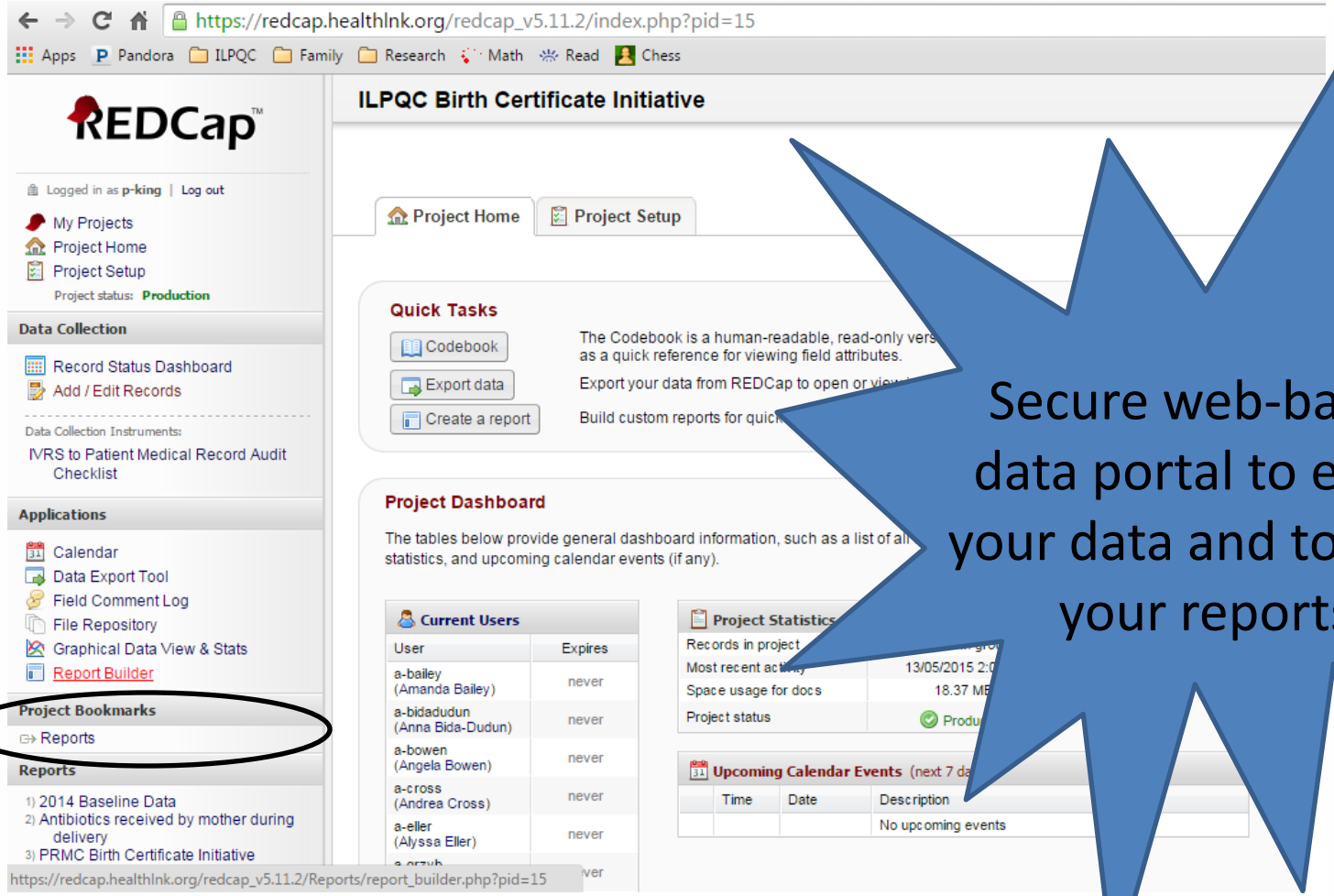
How will we measure improvement?

- Audits - You will measure your progress in increasing accuracy by comparing 10-12 patient medical records with their corresponding IVRS entries each month



- You will compare your monthly data (May-Nov., 2015) to your baseline data (avg. of Aug., Sep., Oct., 2014) using reports accessed via REDCap.

REDCap Data System



Secure web-based data portal to enter your data and to view your reports

How to Access Reports

- https://redcap.healthlnk.org/
- Login to REDCap with user name and password
- Click “My Projects” Tab
- Click “ILPQC Birth Certificates” Link
- Click “Reports” Link Under “Project Bookmarks” in left sidebar
- A new window will launch, Enter your three digit hospital id, “009”, “055” or “101”

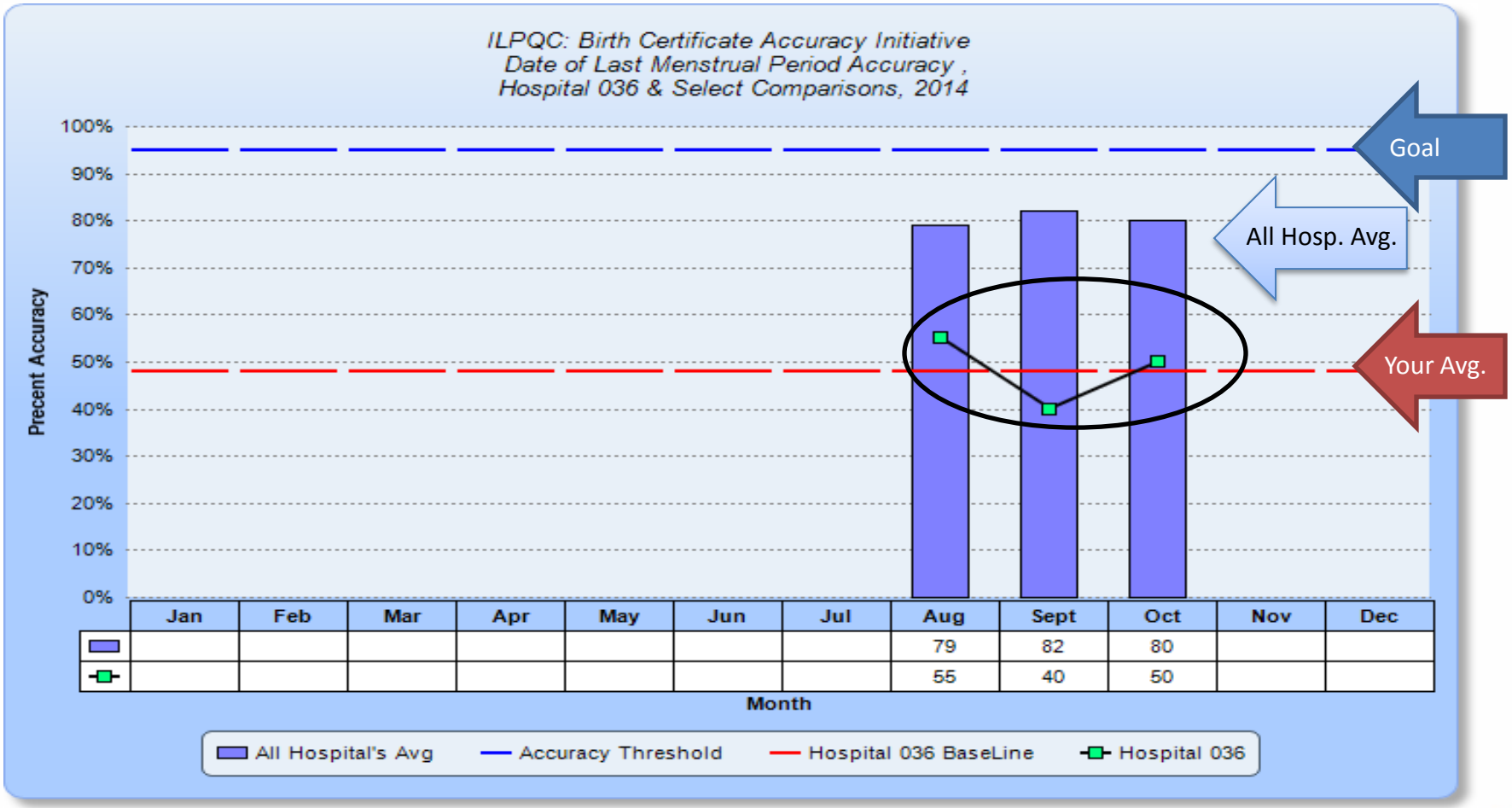
Understanding Your REDCap Reports

- Baseline Reports show data from your baseline audit (Aug., Sep., Oct., 2014)
  - Over all variables
  - Each individual variable
- Monthly Reports show data during your quality improvement work (May – Nov. 2015)
  - Over all variables
  - Each individual variable

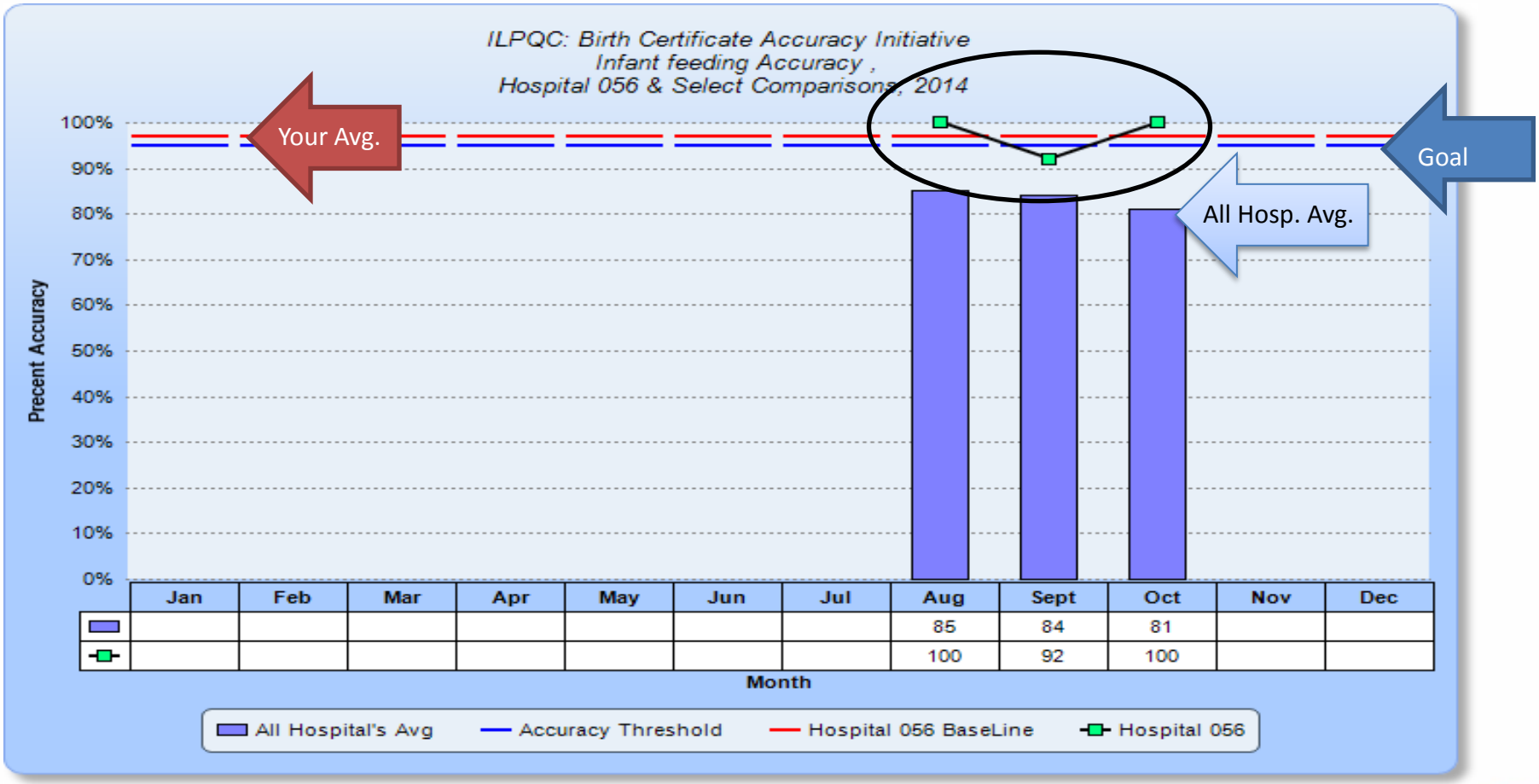
Understanding Your REDCap Reports

- Focus on **your hospital's line graph** to see improvement in your data
- Look for upward trends in accuracy in your May through Nov. audits

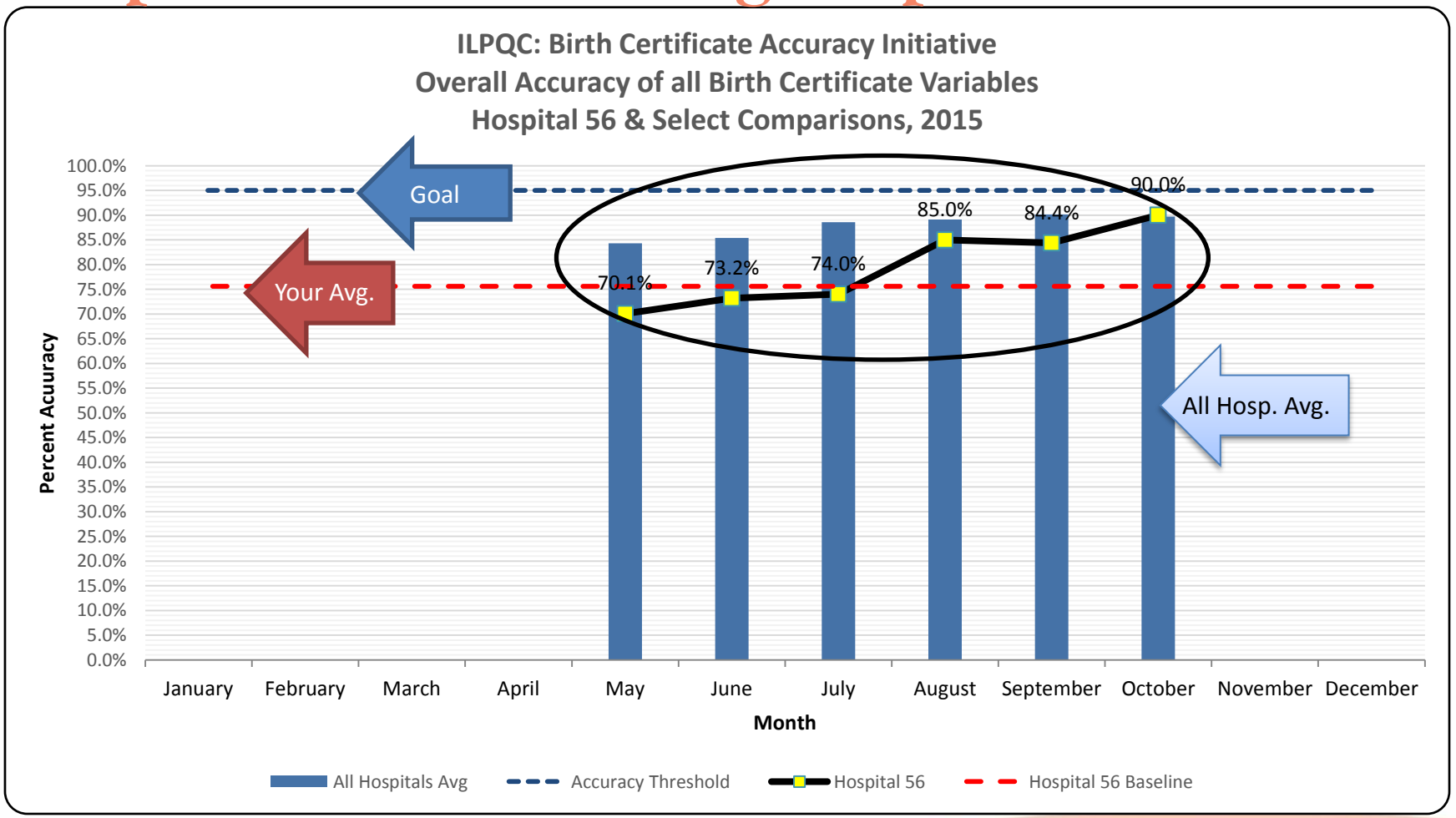
Understanding Your Baseline Reports: Low Accuracy Example



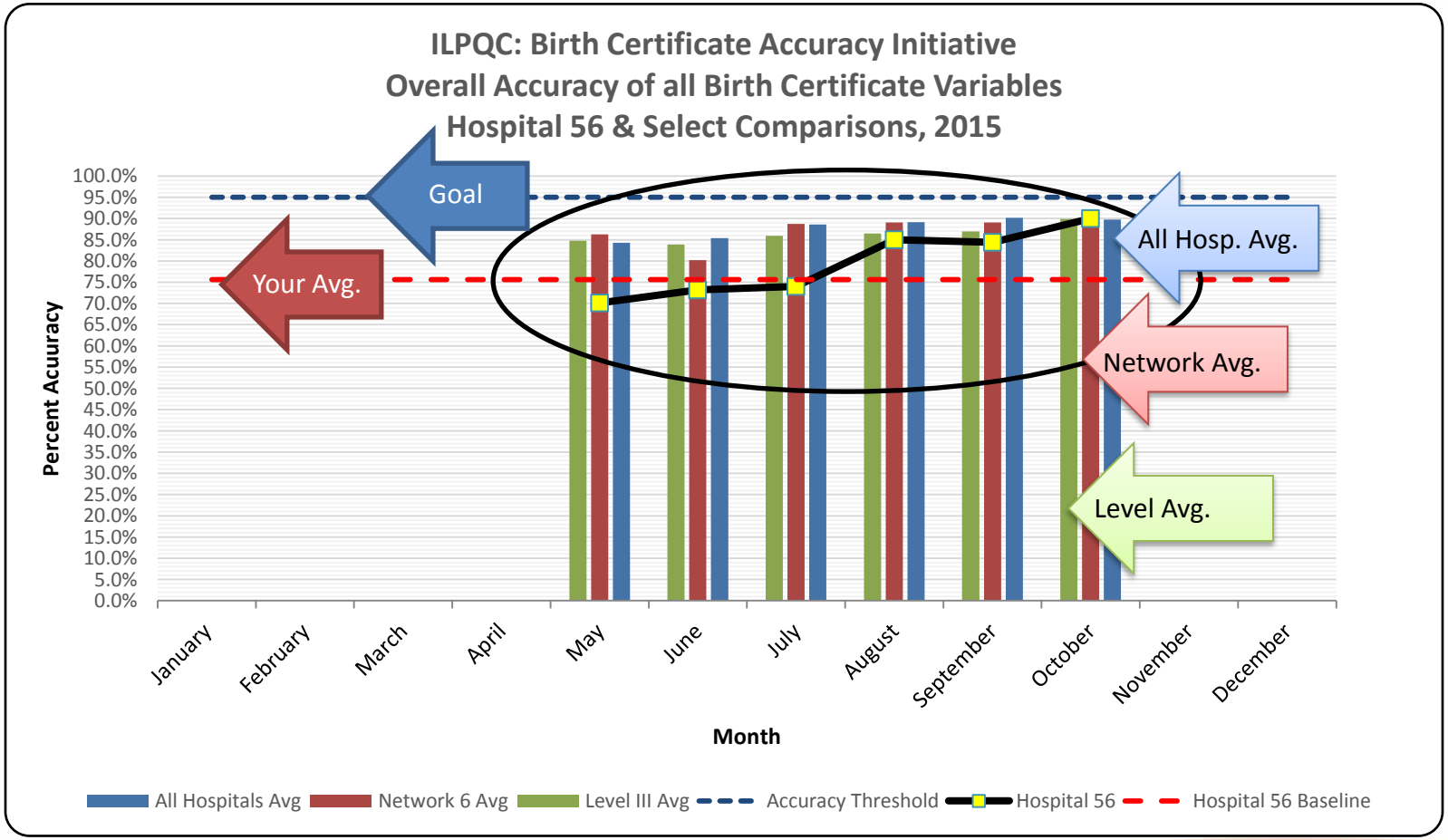
Understanding Your Baseline Reports: High Accuracy Example



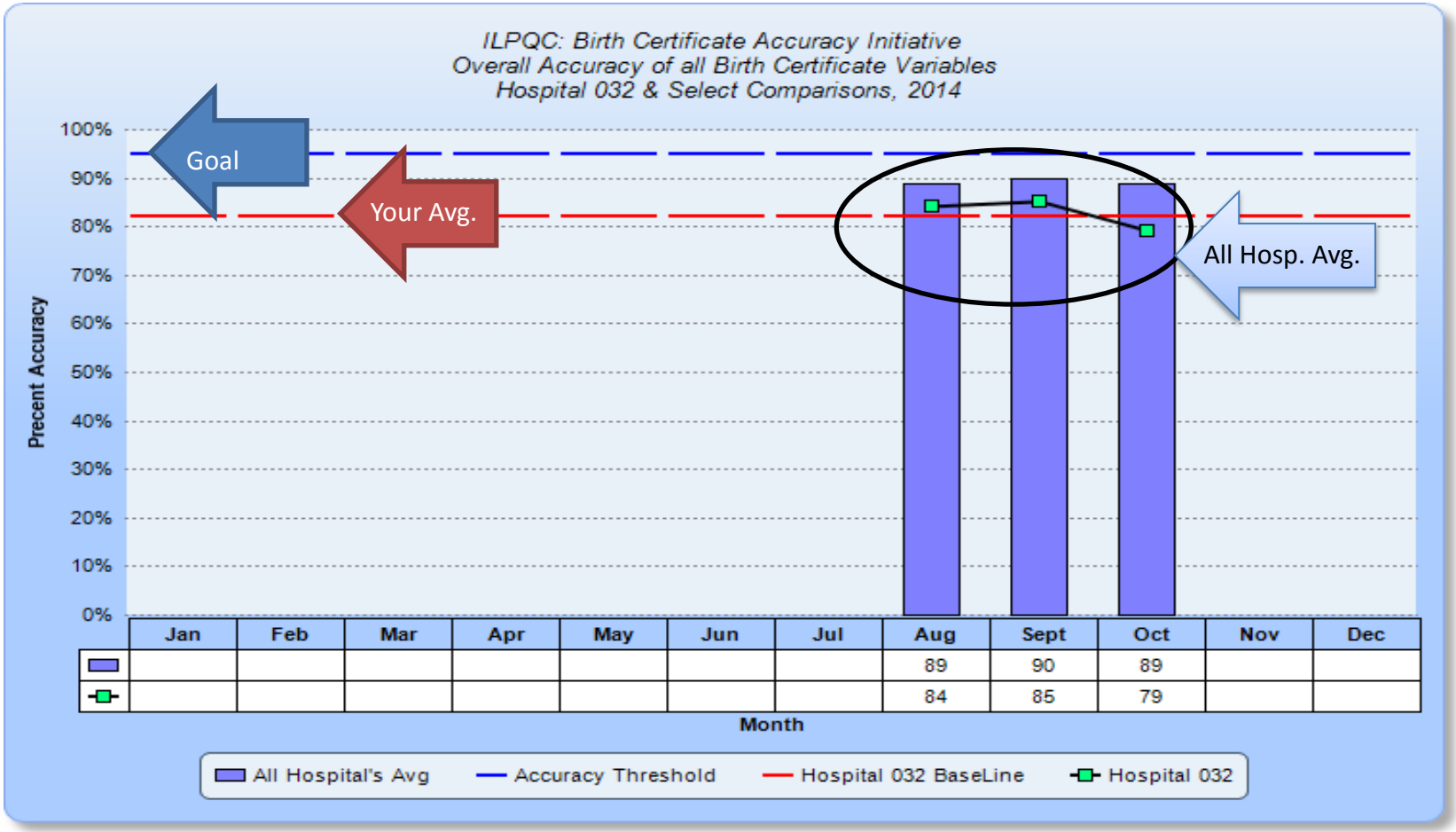
Understanding Your Monthly Reports: Monitoring Improvement



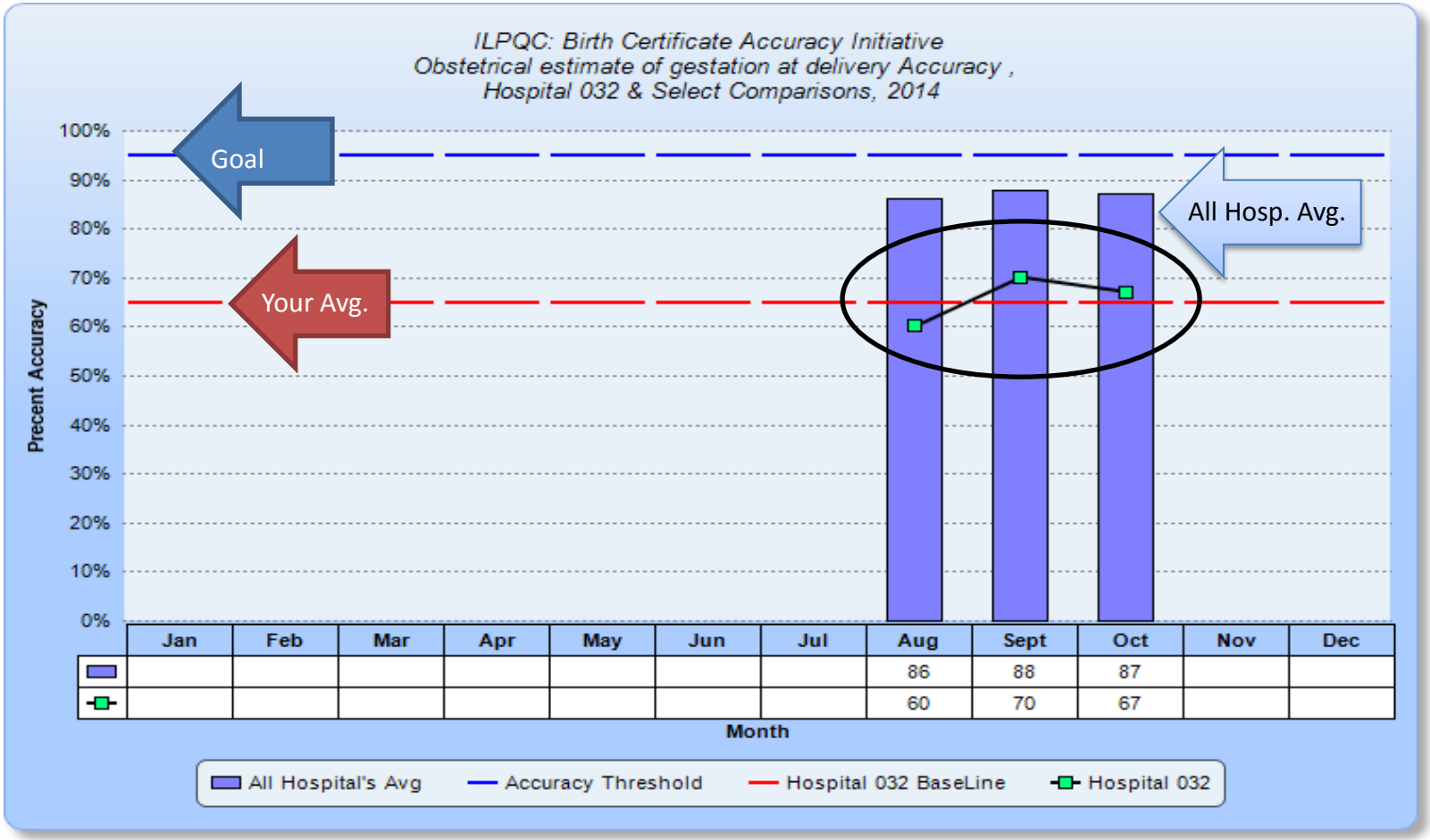
Understanding Your Monthly Reports: Monitoring Improvement

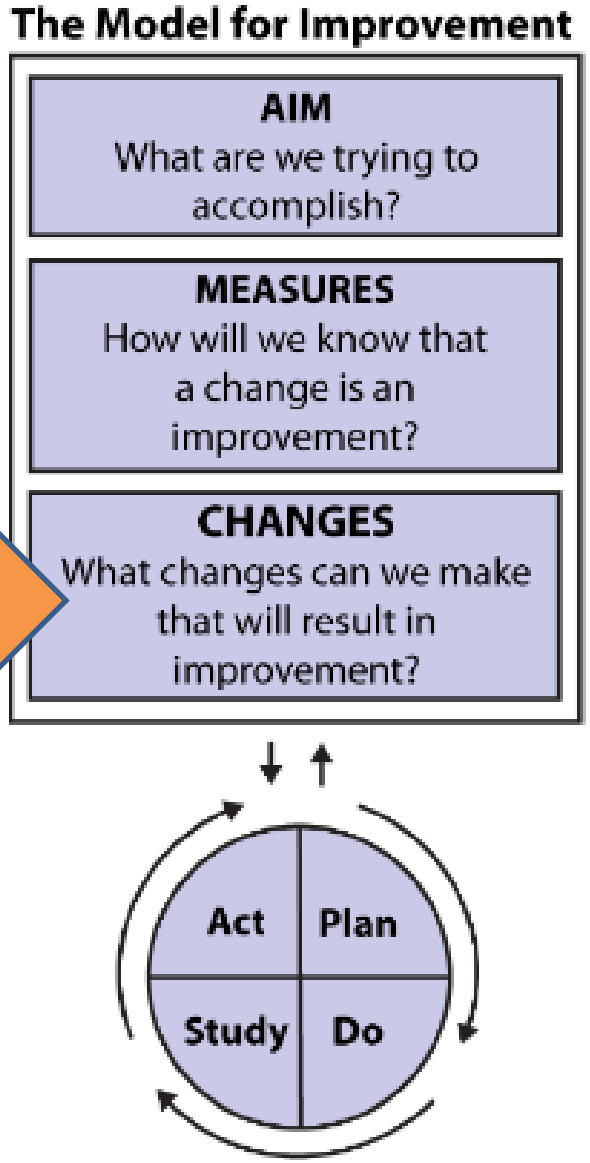


Understanding Your Baseline Reports: Overall Report Example



Understanding Your Baseline Reports: Gestational Age Example





Question 3

Identify changes

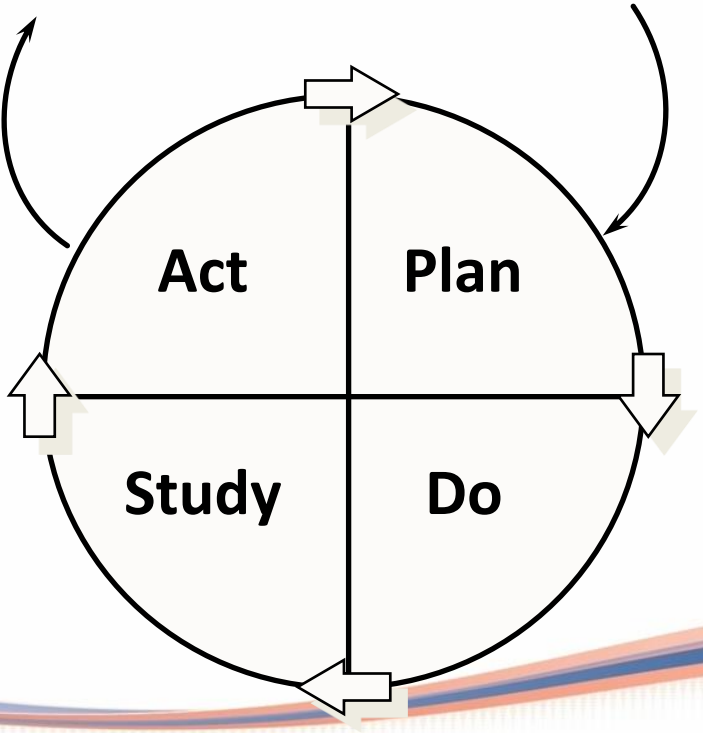
P–D–S–A
Sequential small tests of change

Model for Improvement

What are we trying to accomplish? ← **Aim**

How will we know that a change is an improvement? ← **Measures**

What changes can we make that will result in improvement? ← **Changes**



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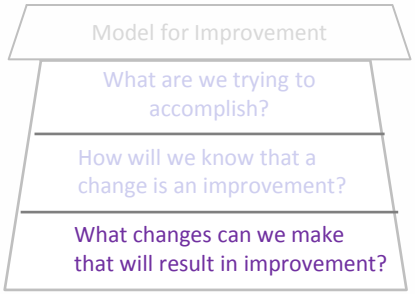
Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP.
The Improvement Guide: A Practical Approach to Enhancing Organizational Performance

What is a PDSA or sequential small test of change?



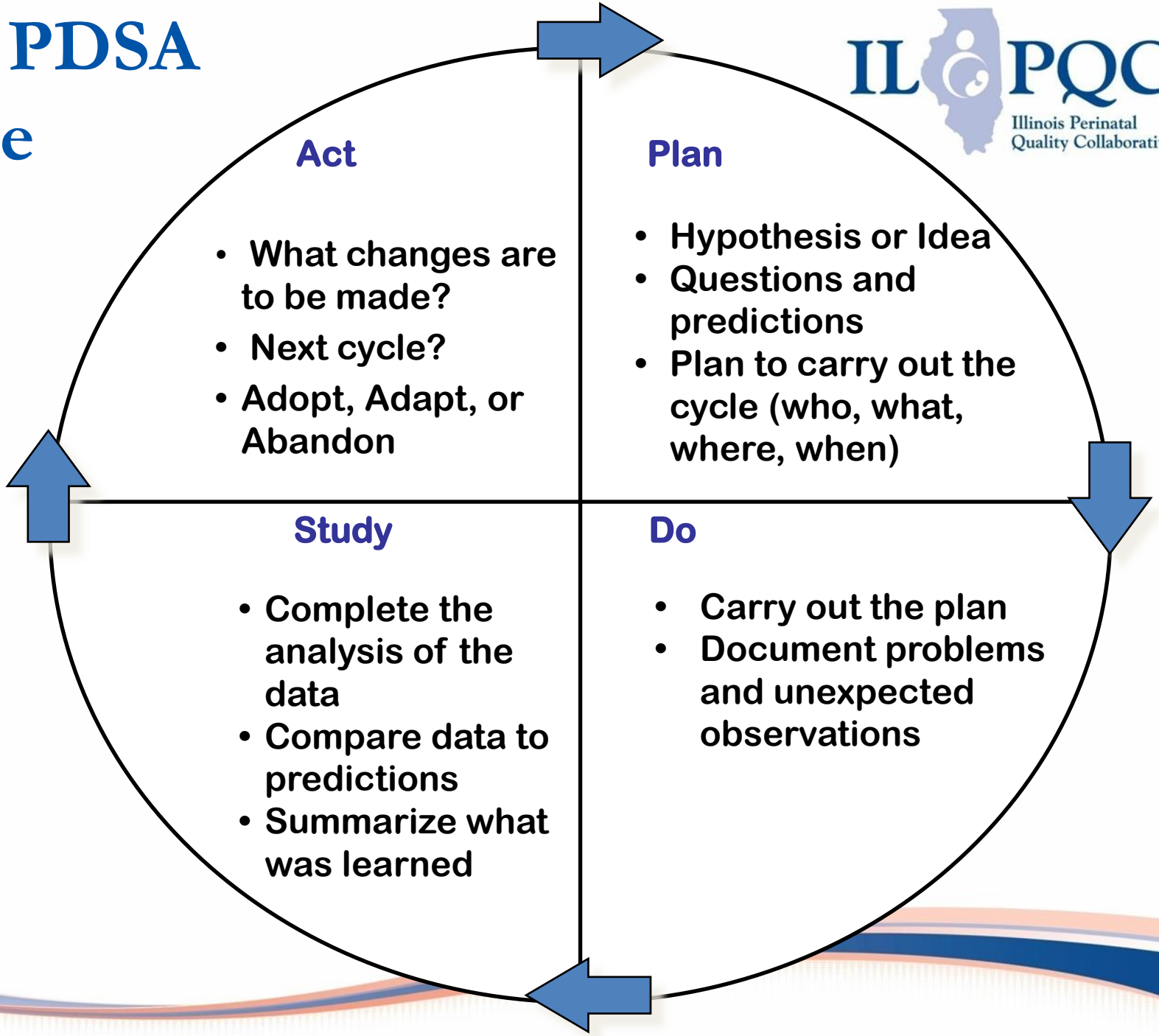
Putting a *small* change into effect on a temporary basis and *learning* about its impact.

What is Not a Test?

- Data collection
- Implementing a solution

- Rolling out an educational program
- Getting a form, policy, procedure approved by the official committees

The PDSA Cycle



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Identify Possible Changes

- Think Creatively
  - Brainstorm with your QI team
  - Collect ideas from staff who contribute to the birth registry
- Adapt known good ideas
  - Read the professional literature
  - Network with other hospitals and Office of Vital Statistics
  - Look at the Key Driver Diagram
- Look at your process flow map again
  - Identify opportunities within the gaps

Plan...Do...Study...Act

- **Plan** ***the test***
  - What is the objective of the test? population?
  - What tasks are necessary in order to conduct the test?
  - Develop the action plan of tasks – who, when, wha
  - How will you measure the impact of the test?
  - What do you predict will happen?

- **Do--*test the change***

- **Study** ***the results of the test***
  - What were the results from the test?
  - Were there any unexpected observations?
  - Was your prediction correct?
  - What do you need to do next?

- **Act** ***on your results***
  - **Adapt** – do you need to make revisions & re-test?
  - **Adopt** – do you need to scale up a successful test?
  - **Abandon** – did your test fail but you were able to learn from it?

Key Points for PDSAs

1. Do initial PDSAs on smallest scale possible
   - A “cycle of one” usually best: one patient, one doctor, one day
   - “Failed” cycles are good learning opportunities, particularly when small

2. As move to implementation, test under as many conditions as possible
   - Think about factors that could lead to breakdowns, supports needed, “naysayers”

Key Points for PDSAs (cont'd)

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3. Always identify the prediction or hypothesis before testing the change
   - Allows improved learning from "failures" and refinement of your theory
4. Use a "study measure" specific to the PDSA
   - Usually not one of the project measures
   - Is a measure specific to the small test of change
   - Qualitative results are very valuable in early PDSAs

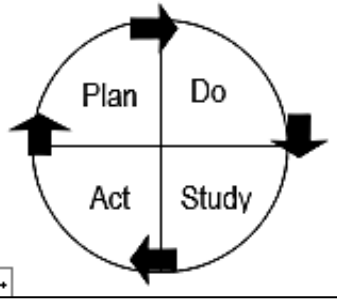
Smaller Scale Tests: The Power of "one"

Conduct the test with

- one day
- one physician
- one patient

PDSA: Improving Accuracy of GA Variable Abstraction

PLAN



PDSA WORKSHEET

Team Name: Hospital ABC	**Date of test:** 5/4/2015	**Test Completion Date:** 5/5/2015
Overall team/project aim: Improve birth registry accuracy so that focused 17 focused variables identified on the IVRS audit sheet will be transmitted accurately in 95% of records		
What is the objective of the test? To better understand the process of abstracting the correct GA in the patient chart.		

PLAN:

Briefly describe the test:

- The team lead will meet with the birth abstractor to identify how many places in the patient chart GA is documented and if the documentation is all the same.

How will you know that the change is an improvement?

- The birth abstractor will have an identified source of information for accurate Gestational Age in the chart.

What driver does the change impact?

- Identification and spread of best practices for data entry and verification.

What do you predict will happen?

- While there are probably numerous places GA is documented, the abstractor will know where to obtain the correct information.

PLAN

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1. Patti will schedule a meeting with Kate to review 3 patient charts with her for abstraction of GA.	Patti	5/4/2015	L&D
2. Patti and Kate will choose 3 recently submitted births to IVRS.EMR and paper charting for mom and infants will be accessed.	Patti & Kate		L&D back desk computers via EMR and paper chart
3. Kate will point out to Patti the numerous areas GA is documented in each of the 3 charts.(Patti will document findings)	Kate Patti		L&D back desk
4. Kate will select the GA variable from the chart to be submitted.	Kate		L&D back desk
5. Patti & Kate will check if this was the variable submitted to IVRS.	Patti & Kate		L&D back desk

Plan for collection of data: Patti will use the GA Check Sheet to keep track of number of times GA is documented as well as the result.

Gestational Age Check Sheet

Chart #1	Area where GA was documented	Gestational Age that was documented
1.	Mother's Worksheet	38.4 (based on wheel from mom's LMP)
2.	OB admit note	37 weeks
3.	Prenatal form from OB office	37.2 weeks based on 1st trimester U/S
4.	Nurse's notes	37.4 weeks
5.	Pediatrician's exam	38 weeks per Dubowitz
6.	Lactation Consultant notes	37.4 weeks
7,8,9,…	…	…

Patti and Kate found *22 instances* where GA was documented throughout the chart. Many differed. Kate stated that of these she would have submitted 37.4 weeks for the GA. Her rationale was that it was the most reoccurring throughout the chart.

DO

DO: Test the changes.

Was the cycle carried out as planned? [X] Yes ☐ No

Record data and observations.

- Patti recorded the number of times Kate found documentation of GA in the chart on the Check Sheet (22). Kate showed Patti which of the choices she would select for the submission (37.4). They both looked into the IVRS to learn what GA was submitted. (38).

What did you observe that was not part of our plan?

- The GA chosen by Kate did not match the GA that was submitted into IVRS.

STUDY

STUDY:

Did the results match your predictions? ☐ Yes [X] No

Compare the result of your test to your previous performance:

- This was the initial PDSA

What did you learn?

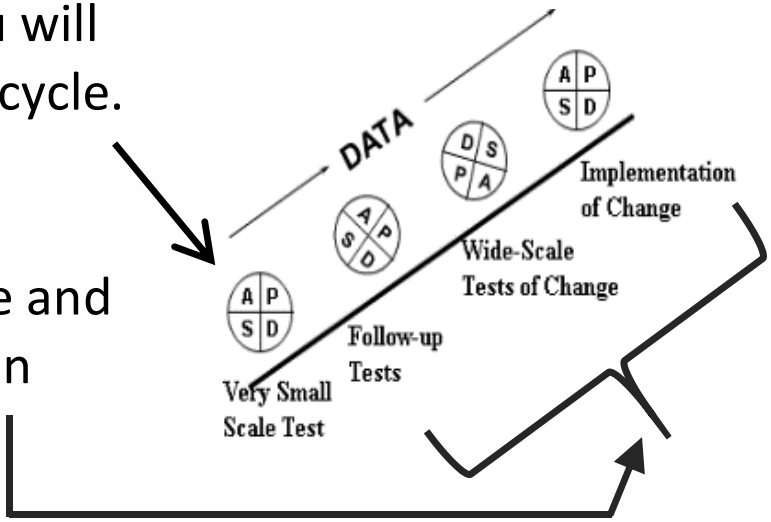
- There are numerous places the GA is documented; they are not always consistent. Different abstractors have different methods of abstracting the data.

Decide to Abandon, Adapt, or Adopt.

Abandon: Discard change idea and try a new one.

Adapt: Improve the change and continue testing. Describe what you will change in your next PDSA cycle.

Adopt: Select changes to implement on a large scale and develop an implementation plan for sustainability.



If you plan to adopt, what plans do you have for your next 2-3 PDSA cycles for follow-up tests and implementation:

ACT

ACT: Decide to Adopt, Adapt, or Abandon.

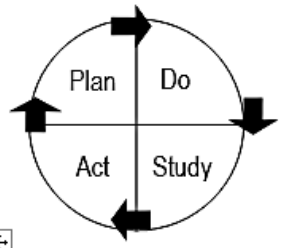
[X] Adapt: Improve the change and continue testing plan.

Plans/changes for next test:

- Patti will work with the other 2 abstractors on 5/5, completing the same GA Check List as was used with Kate.

[ ] Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

[ ] Abandon: Discard this change idea and try a different one



PDSA WORKSHEET

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Overall team/project aim: Improve birth registry accuracy so that focused 17 focused variables identified on the IVRS audit sheet will be transmitted accurately in 95% of records		
What is the objective of the test? To better understand the process of abstracting the correct GA in the patient chart.		

PLAN:

Briefly describe the test:

- The team lead will meet with the birth abstractor to identify how many places in the patient chart GA is documented and if the documentation is all the same.

How will you know that the change is an improvement?

- The birth abstractor will have an identified source of information for accurate Gestational Age in the chart.

What driver does the change impact?

- Identification and spread of best practices for data entry and verification.

What do you predict will happen?

- While there are probably numerous places GA is documented, the abstractor will know where to obtain the correct information.

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1. Patti will schedule a meeting with Kate to review 3 patient charts with her for abstraction of GA.	Patti	5/4/2015	L&D
2. Patti and Kate will choose 3 recently submitted births to IVRS.EMR and paper charting for mom and infants will be accessed.	Patti & Kate		L&D back desk computers via EMR and paper chart
3. Kate will point out to Patti the numerous areas GA is documented in each of the 3 charts.(Patti will document findings)	Kate Patti		L&D back desk
4. Kate will select the GA variable from the chart to be submitted.	Kate		L&D back desk
5. Patti & Kate will check if this was the variable submitted to IVRS.	Patti & Kate		L&D back desk

Plan for collection of data: Patti will use the GA Check Sheet to keep track of number of times GA is documented as well as the result.

DO: Test the changes.

Was the cycle carried out as planned? [X] Yes [ ] No

Record data and observations.

- Patti recorded the number of times Kate found documentation of GA in the chart on the Check Sheet (22). Kate showed Patti which of the choices she would select for the submission (37.4). They both looked into the IVRS to learn what GA was submitted. (38).

What did you observe that was not part of our plan?

- The GA chosen by Kate did not match the GA that was submitted into IVRS.

STUDY:

Did the results match your predictions? [ ] Yes [X] No

Compare the result of your test to your previous performance:

- This was the initial PDSA

What did you learn?

- There are numerous places the GA is documented; they are not always consistent. Different abstractors have different methods of abstracting the data.

ACT: Decide to Adopt, Adapt, or Abandon.

[X] Adapt: Improve the change and continue testing plan.

Plans/changes for next test:

- Patti will work with the other 2 abstractors on 5/5, completing the same GA Check List as was used with Kate.

[ ] Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

[ ] Abandon: Discard this change idea and try a different one

The abstractors are compiling a “Truth in Source” workbook along with the lead OB for *each* of the variables in IVRS. They are starting with the 17 chosen by ILPQC.

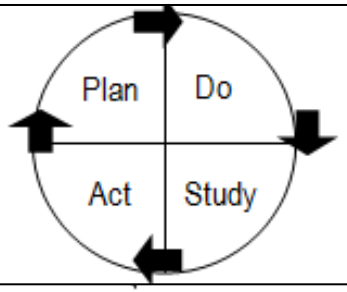
PDSA: Improving the Process of Abstracting BC Data

Plan for the Change:

- Will "Steal Shamelessly" and adopt the process of RN completing Facility Worksheet
- Will notify the nurses at staff meeting next week
- Will have ppt tutorial for nursing staff to view


WHAAAAAAAAAT?

PLAN



PDSA WORKSHEET

Team Name: Hospital 123	Date of test: 5/10/15	Test Completion Date: 5/10/15
Overall team/project aim: Improve birth registry accuracy so that focused 17 focused variables identified on the IVRS audit sheet will be transmitted accurately in 95% of records.		
What is the objective of the test? To improve the accuracy of the data that is being documented on the Facility WS.		

PLAN:

Briefly describe the test:

- The RN who is caring for the patient will complete a portion of the Facility Worksheet instead of the Unit Secretary.

How will you know that the change is an improvement?

- The RN will be able to complete the Facility Worksheet in a shorter period of time and with greater accuracy than the Unit Secretary.

What driver does the change impact?

- Identification and spread of best practices for data entry and verification.

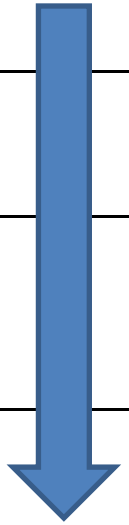
What do you predict will happen?

- The RN will be able to complete the necessary information more accurately; uncertain however if this will be time prohibitive.

PLAN

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.) Place the Facility WS in the Patient Chart along with prenatal faxes upon admission.	Unit Secretary	5/10/15	L&D Admission Desk
2.) RN will review and complete questions 1-24 while admitting/caring for the patient.	L&D RN	5/10/15	L&D room
3.) After mom has delivered, L&D RN will make certain that the Facility WS is completed through question #24.	L&D RN	5/10/15	
4.) The L&D RN will note the time it took to complete the Facility WS questions 1-24. She will also note any variables that were difficult to complete.	L&D RN	5/10/15	
5.) The RN will turn in the Facility WS to the Unit Secretary once mom is in Recovery/Post-Partum.	L&D RN	5/10/15	



Plan for collection of data: Catherine will select one nurse to test this process on one patient. She will review the Facility WS with that RN and ask her to note the time required to complete WS.

DO

DO: Test the changes.

Was the cycle carried out as planned? ☒ Yes ☐ No

Record data and observations.

- The L&D RN was able to complete the Facility WS questions #1-24 in under 10 minutes. She did have some difficulty with the variable "total number of PNV" due to not having updated prenatals from OB office.

What did you observe that was not part of our plan?

- The RN discovered that some of the necessary data was not found in the patient chart.

STUDY

STUDY:

Did the results match your predictions? ☒ Yes ☐ No

Compare the result of your test to your previous performance:

- The RN was able to easily obtain the necessary data to complete the Facility WS as she was the primary caregiver for mom. The RN estimated it took her less than 10 minutes to complete this information; (markedly shorter time period than required of the Unit Secretary.)

What did you learn?

- The nurse did not feel this to be burdensome or time prohibitive.

ACT

ACT: Decide to Adopt, Adapt, or Abandon.

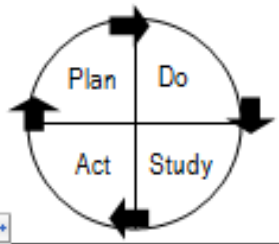
[x] Adapt: Improve the change and continue testing plan.

Plans/changes for next test:

- Catherine will select a Post-Partum/Newborn Nursery RN to test completion of the Facility WS in the same manner for questions #25-36.

[ ] Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

[ ] Abandon: Discard this change idea and try a different one



PDSA WORKSHEET

Team Name: Hospital 123	Date of test: 5/10/15	Test Completion Date: 5/10/15
Overall team/project aim: Improve birth registry accuracy so that focused 17 focused variables identified on the IVRS audit sheet will be transmitted accurately in 95% of records.		
What is the objective of the test? To improve the accuracy of the data that is being documented on the Facility WS.		

PLAN:

Briefly describe the test:

- The RN who is caring for the patient will complete a portion of the Facility Worksheet instead of the Unit Secretary.

How will you know that the change is an improvement?

- The RN will be able to complete the Facility Worksheet in a shorter period of time and with greater accuracy than the Unit Secretary.

What driver does the change impact?

- Identification and spread of best practices for data entry and verification.

What do you predict will happen?

- The RN will be able to complete the necessary information more accurately; uncertain however if this will be time prohibitive.

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.) Place the Facility WS in the Patient Chart along with prenatal faxes upon admission.	Unit Secretary	5/10/15	L&D Admission Desk
2.) RN will review and complete questions 1-24 while admitting/caring for the patient.	L&D RN	5/10/15	L&D room
3.) After mom has delivered, L&D RN will make certain that the Facility WS is completed through question #24.	L&D RN	5/10/15	
4.) The L&D RN will note the time it took to complete the Facility WS questions 1-24. She will also note any variables that were difficult to complete.	L&D RN	5/10/15	
5.) The RN will turn in the Facility WS to the Unit Secretary once mom is in Recovery/Post-Partum.	L&D RN	5/10/15	

Plan for collection of data: Catherine will select one nurse to test this process on one patient. She will review the Facility WS with that RN and ask her to note the time required to complete WS.

DO: Test the changes.

Was the cycle carried out as planned? ☒ Yes No

Record data and observations.

- The L&D RN was able to complete the Facility WS questions #1-24 in under 10 minutes. She did have some difficulty with the variable "total number of PNV" due to not having updated prenatals from OB office.

What did you observe that was not part of our plan?

- The RN discovered that some of the necessary data was not found in the patient chart.

STUDY:

Did the results match your predictions? ☒ Yes No

Compare the result of your test to your previous performance:

- The RN was able to easily obtain the necessary data to complete the Facility WS as she was the primary caregiver for mom. The RN estimated it took her less than 10 minutes to complete this information; (markedly shorter time period than required of the Unit Secretary.)

What did you learn?

- The nurse did not feel this to be burdensome or time prohibitive.

ACT: Decide to Adopt, Adapt, or Abandon.

☒ Adapt: Improve the change and continue testing plan.

Plans/changes for next test:

- Catherine will select a Post-Partum/Newborn Nursery RN to test completion of the Facility WS in the same manner for questions #25-36.

☐ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

☐ Abandon: Discard this change idea and try a different one

After completing the PDSA ramp, a decision was made to split the completion of the Facility WS amongst the L&D and Newborn Nursery RN's. The Unit Secretary then submits the data into IVRS.

IL PQC
Illinois Perinatal Quality Collaborative

"The focus of healthcare for women and infants over the next century depends on the quality of the data collected by those who fill out the birth certificates."

Bill Callaghan, MD MPH
Centers for Disease Control and Prevention
December 1, 2011

Team Storyboard Viewing

- Tell your team's story from 11:15 – 12:00 pm
- Learn what other teams are doing
- Understand other teams' birth certificate abstraction and data entry process
- Share your ideas and thought with others
  - Opportunities for improvement
  - Change ideas
  - Strengths
  - Support needed

Working Lunch with Team/ Table

- Pick up box lunch in corridor and return to your table
- Discuss storyboards and complete worksheets during lunch with team and/or table from 12:00 – 12:45 pm
  - "Steal Shamelessly Share Seamlessly, Storyboard Worksheet" in folders
  - Use worksheet to discuss storyboards as a team / table and record ideas from other teams

SPECIAL OPPORTUNITY FOR TEAMS WHO HAVE NOT YET COMPLETED THEIR BASELINE AUDITS OR SUBMITTED DATA IN REDCAP!

Please find Kate Finnegan at the "Getting Started" table during the working lunch to get your questions answered and identify next steps.

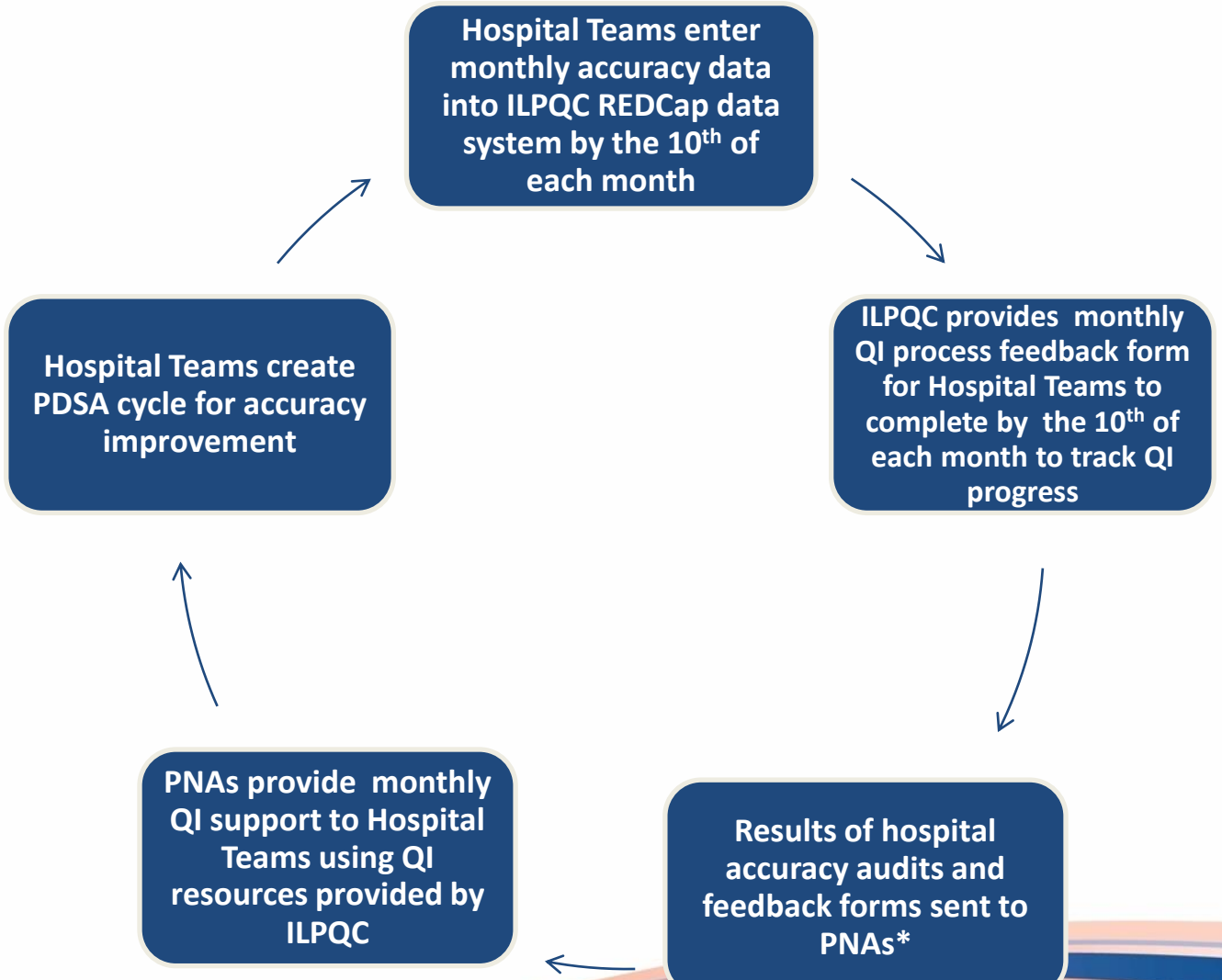
Small Group Discussion Breakout

- Small Group Breakout by Perinatal Network from 12:45 – 1:45 pm)
  - 12:45 – 1:05 pm: Each Perinatal Network group brainstorms:
    - ❑ Barriers to accuracy in the birth certificate data collection and entry process
    - ❑ Opportunities for change in the birth certificate data collection and entry process
    - ❑ If time allows, discuss the PDSA examples from the morning presentations to think about small tests of change. Remember the rule of 1!
  - 1:05 – 1:35 pm: Group breaks down into hospital teams to discuss and work on “Steal Shamelessly Share Seamlessly 30-60-90 day plan Worksheet” and “PDSA worksheet” in folders
  - 1:35 – 1:45 pm: PNAs facilitate discussion with all hospital teams to identify key areas to share with large group

Debrief with Large Group

- Debrief from small groups to large group 1:45 – 2:00 pm

QI Cycle Support Recap



*PNA: Perinatal Network Administrator

QI Cycle Support Recap

- **Monthly** QI cycle process implemented in partnership with the Perinatal Network Administrators
  - OB Teams webinar on the 4th Monday of each month, 12:30-1:30
    - Team Talks, education, support
  - Data reporting via REDCap and QI reporting via SurveyMonkey
  - QI coaching calls with Perinatal Network Administrators

QI Process Feedback Form

- 9 Question form sent via SurveyMonkey
  - Team/Hospital information
  - PDSA cycle update
  - Planned changes
  - Needs for help/support

QI Process Feedback Form (1/3)

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Birth Certificate Accuracy Initiative Monthly Process Survey – May 2015

Directions: Please provide us with the following information on your quality improvement process and progress. In addition to your monthly birth certificate accuracy audit data that you submit into the ILPQC REDCap data systems, this information is critical to providing you with timely and relevant quality improvement support to help you meet the 95% birth certificate accuracy goal for this initiative. This survey will be sent to your quality improvement team lead on a monthly basis for the duration of the birth certificate accuracy initiative to facilitate quality improvement and support.

1. Hospital Name (Select from Drop Down List of all Birthing Hospital Names): *Please note: if you not see your hospital name on this list, contact info@ilpqc.org.

***What city/town is your hospital located in?**

2. Perinatal Network

3. Date (MM/DD/YYY): *Please note: this survey must be completed by 10th of the month for the previous month.

4. How many times did your quality improvement team meet this month to discuss birth certificate accuracy?

QI Process Feedback Form (2/3)

Illinois Perinatal Quality Collaborative

5. Please briefly describe the Plan, Do, Study, Act (PDSA) cycle(s) you completed this month in the following sections:

a. Plan: What was your hospital's aim for improvement this month? What changes did you test this month? How did you implement the test of change (Who, What, When, Where, How)?

b. Do: When did you implement your first test of change? What barriers did you experience and how did you overcome them?

c. Study: What did you learn? Is it what you expected?

d. Act: What changes do you plan to test next month? How will you implement your next test of change?

QI Process Feedback Form (3/3)

ILPQC Illinois Perinatal Quality Collaborative

6. What changes in your practice have resulted from your participation in this project?

7. Please list anything you would like help or support with:

8. Do you have any suggestions for our monthly OB Teams conference calls?

9. Is there anything else you would like to report?

Next Steps

- Conduct first monthly audit and enter data into REDCap by June 15
- Submit first monthly QI feedback form via SurveyMonkey by June 15
  - Monthly data and QI feedback forms are due by the 15th of the next month
- Review your reports immediately in REDCap
  - Data team will review data for errors within 48 hrs
- Contact ILPQC or your PNA with any questions

Next OB Teams Meeting

- June 22, 12:30-1:30pm
- Need 3 teams to sign up for “Team Talks” for June – December meetings

Questions & Wrap-up Panel

ILPQC Administrative Team

Ann Borders
ILPQC Executive Director, OB Lead

Aki Noguchi and Pat Ittmann
Neonatal Leads

Patricia Lee King
State Project Director

Kate Finnegan
Project Coordinator

Email us at info@ilpqc.org
Website: www.ilpqc.org

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THANKS TO OUR SPONSORS

ILLINOIS CHIPRA
Quality Demonstration Project
Improving Child Health and Medical Homes for Illinois All Kids

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IHA Illinois Hospital Association

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