



TEXAS
Health and Human
Services

**Texas Department of State
Health Services**

TexasAIM Summit

Holding and Building the Gains

Day 1: Tuesday, December 8th 8:00 AM – 12:45 PM CST

Welcome and Orientation to the Platform

Julie Stagg, MSN, RN, IBCLC, RLC, CPHQ

Healthy Texas Mothers and Babies Branch Manager, TexasAIM Program Director

Maternal and Child Health Unit and Section

Community Health Improvement Division, Texas Department of State Health Services



Housekeeping

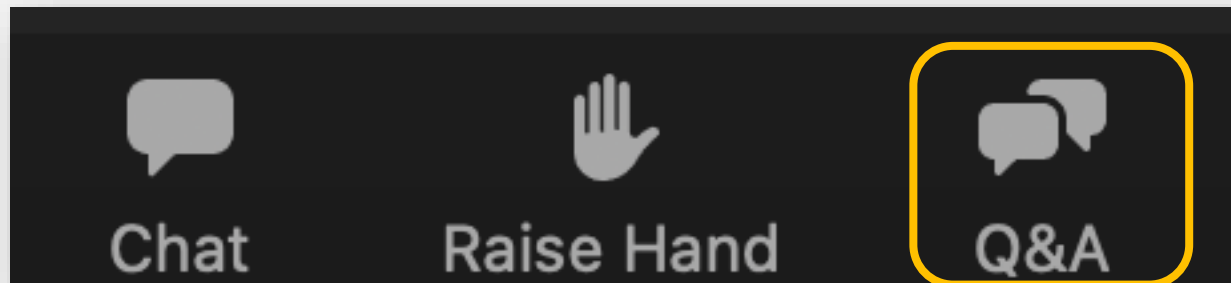


- **Thank you for joining Day 1 of the TexasAIM 2020 Virtual Summit!**
- Today's Summit is being **recorded**. All conference documents, slides and recordings will be made available to you after the Summit concludes.
- **At the end of each day, please complete an evaluation survey.** A link will be shared in the chat and via email.

We want to hear from you!



- Your feedback is very important, and speakers want to hear from you!
- If you have questions for the panelist, please submit these in the **Q&A box**.



Interacting with Attendees



- Please use the **Chat box** to engage with the other attendees and panelists.
- When using the chat box, you can select who you want your message to go to. **Select To: Panelist and Attendees for your message to go to everyone**



To: **Panelists and Attendees** ▼

Type your message here...

Ice Breaker

We have over 600 participants registered-
It's so good to be with you all again!

Please chat in your name, facility, and town



Technical Difficulties



- **Tips for Technical Difficulties:**
 - Check your WiFi signal strength
 - Try restarting
 - Log off and log back on
- **For additional support, contact:**
 - Jon Gibson at jgibson@utsystem.edu, by chat or text to 512-695-4351

Continuing Education Units



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Continuing Education Credits



Continuing education credit/contact hours for this event are provided by The Texas Department of State Health Services, Continuing Education Service and include the following:

Continuing Medical Education:

The Texas Department of State Health Services, Continuing Education Service is accredited by the Texas Medical Association to provide continuing medical education for physicians.

The Texas Department of State Health Services, Continuing Education Service designates this live activity for a maximum of 8.00 *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Continuing Nursing Education:

The Texas Department of State Health Services, Continuing Education Service is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

The Texas Department of State Health Services, Continuing Education Service has awarded 8.00 contact hour(s) of Continuing Nursing Education.

Certificate of Attendance:

The Texas Department of State Health Services, Continuing Education Service has designated 8.00 hour(s) for attendance.

Continuing Education Credits

To receive continuing education credit or a certificate of attendance participants must:

- Complete registration and sign into the sessions using the Zoom link sent to you prior to the event;
- Attend all sessions for each day requesting credits for;
- Participate in education activities;
- Complete and submit evaluation at the end of each day.

Disclosure to the Learner

Commercial Support

This educational event received no commercial support.

Disclosure of Financial Interest

The following Planning Committee members and speakers for this event have disclosed financial interest(s):

- Name of Planning Committee Member/speaker- Veronica Gillispie-Bell
- Name of commercial interest- Abbvie, Inc/Lecturio GnRH
- Nature of the relationship- consultant and speaker's bureau/material support

Non-Endorsement Statement

Accredited status does not imply endorsement of any commercial products or services by the Department of State Health Services, CE Service; Texas Medical Association; or American Nurse Credentialing Center.

Off Label Use

The speakers did not disclose the use of products for a purpose other than what it had been approved for by the Food and Drug Administration.

Expiration for awarding contact hours/credits

If you are requesting continuing education unit (CEU) credits, please complete and submit the CEU summit evaluation for EACH day you attended.

Continuing Education Attendance and Evaluation



- To receive CEU credits you must attend all sessions for Day1 (12/08).
- If you are requesting CEU credits, you must complete **TODAY** the Continuing Education Evaluation for TexasAIM Summit Day 1 (12/08) that will be sent to you this afternoon.
- If you are requesting CEU credits but attending the meeting with another colleague and did NOT log into Zoom, please request your CEU Attendance Verification Package via email at TexasAIM@dshs.texas.gov and Yahaira.Rodriguez@dshs.texas.gov within 24 hours after the completion of this meeting. TexasAIM team will email you an Attendance Verification Package for you to complete.

Continuing Education – Summit Objectives

At the completion of this summit, participants will be able to:

1. Describe strategies to implement practice improvements for readiness, recognition and prevention, response, and/or reporting and systems learning for prevention and management of obstetric hemorrhage and severe hypertension in pregnancy
2. Explain state and national patient care practice recommendations and standards
3. Identify two or more recommendations for addressing factors that contribute to preventable maternal mortality and morbidity in Texas
4. Identify two or more actions that can be incorporated into practice to support patient-centered care.
5. Identify two actions that can be incorporated into practice to support equity in healthcare.



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Views from the Field: Obstetric Hemorrhage Improvement in Action

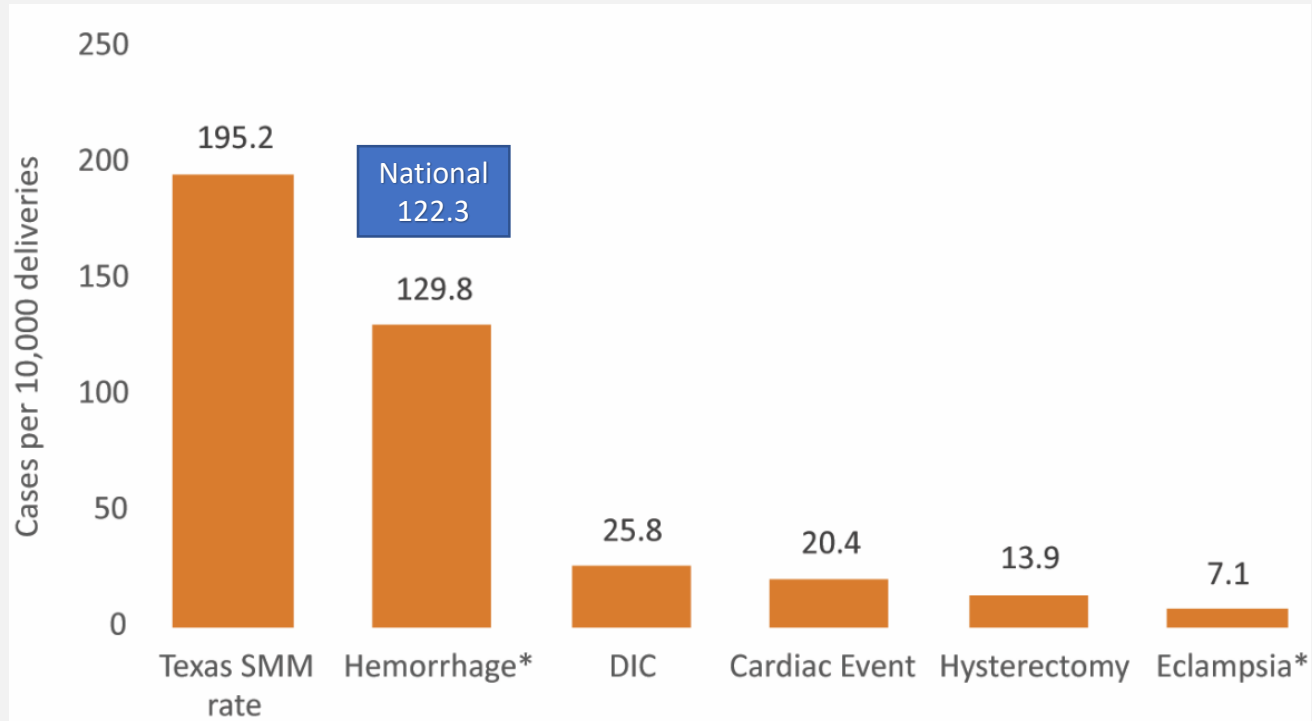
TexasAIM 2020 Virtual Summit

December 8-9, 2020

Dr. Catherine Eppes, MD, MPH– Baylor College of Medicine, Harris Health Ben Taub Hospital; TexasAIM Medical Director

Julie Stagg, MSN, RN- Healthy Texas Mothers and Babies (HTMB) Branch Manager, TexasAIM Program Director, Texas Department of State Health Services (DSHS)

TexasAIM Postpartum Hemorrhage Bundle



*AIM Patient Safety Bundle is available

Data Source: Hospital Inpatient Discharge Public Use Data File, 2014

Prepared by: Maternal & Child Health Epidemiology



READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

First TexasAIM application

University Health System / UT Health
San Antonio, TX / San Antonio

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Kayla Ireland Ireland@uthscsa.edu
cell 210-870-7302

RN Champion: Melanie Baker
~~Melanie Baker@uhs~~
Melanie.Baker@uhs-sa.com
cell 210-414-2895

RN Administration CNO:
Irene Sandate
Irene.Sandate@uhs-sa.com

Hemorrhage + HTN

- Submitted in person on January 19, 2018

KickOff



Hospital CEOs
signed participation
and data use
agreements



Learning
Session 1



Action
Period 1



Learning
Session 3



Action Period 2

Learning
Session 2



Simulation



COVID Calls

Action Period 3



Summit

AIM Obstetric Hemorrhage Bundle Process and Structure Measures

Section Subtitle

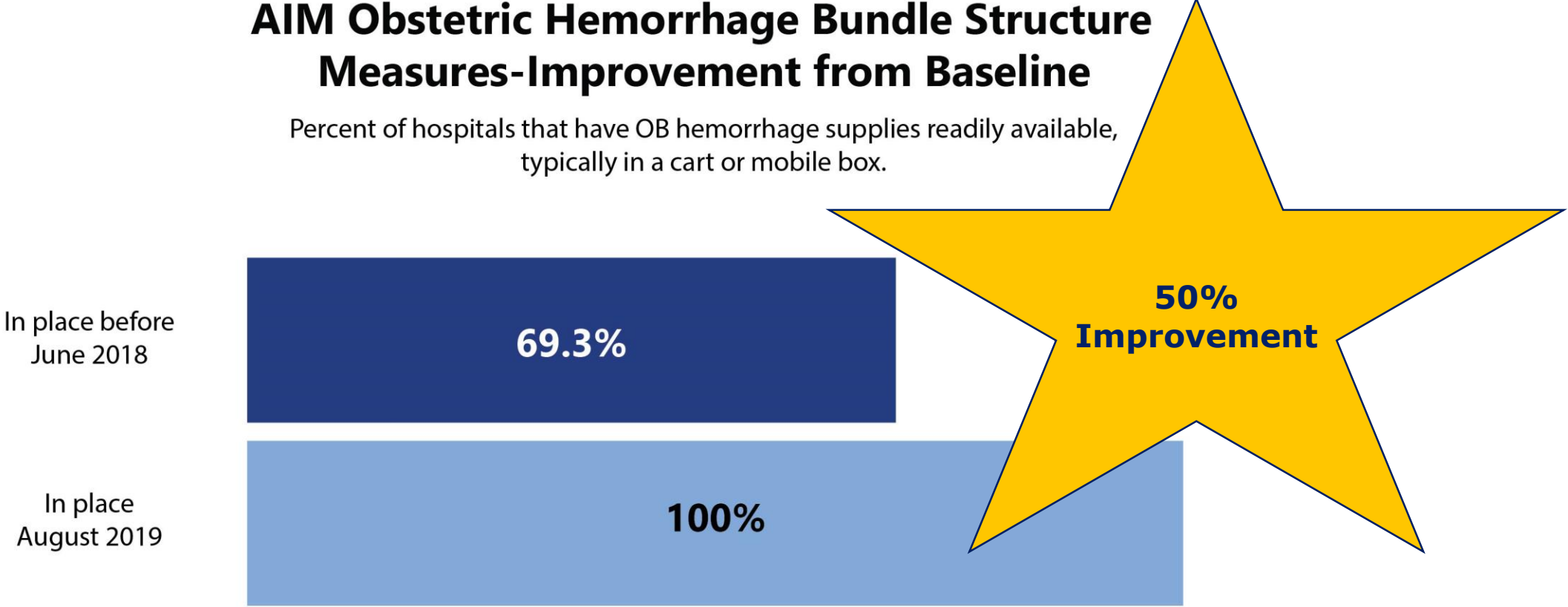


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AIM Obstetric Hemorrhage Bundle Structure Measures-Improvement from Baseline

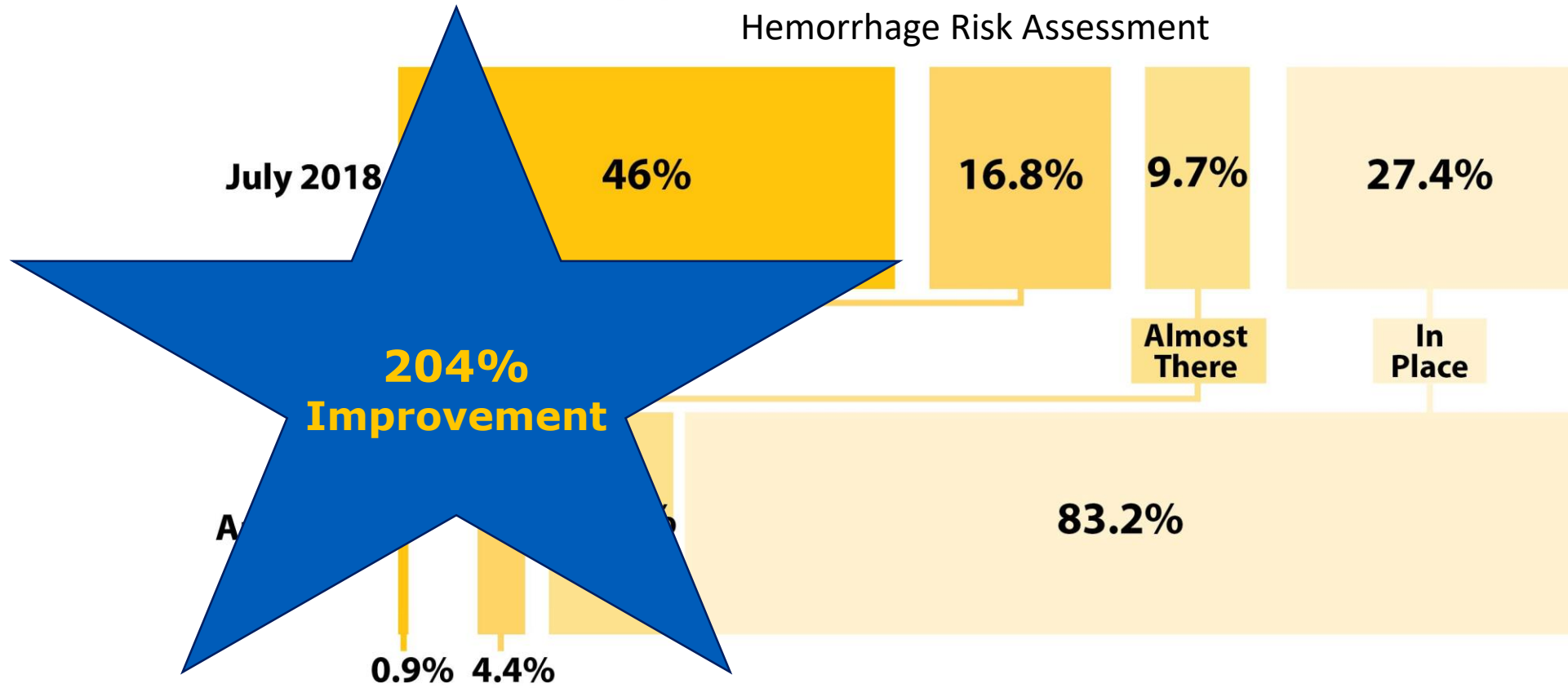
Percent of hospitals that have OB hemorrhage supplies readily available, typically in a cart or mobile box.



Prepared by Maternal and Child Health Epidemiology, October 2020
Source: AIM Structure Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.
For TexasAIM Plus hospitals reporting on structure measures, the percentage of hospitals reporting the bundle component was in place before TexasAIM kickoff in June 2018 and in place through August 2020.

AIM Obstetric Hemorrhage Bundle Process Measures-Improvement from Baseline

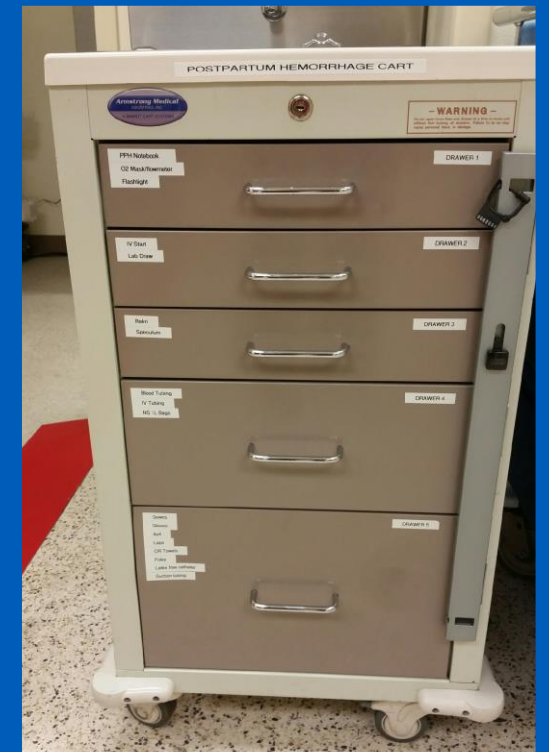
Hemorrhage Risk Assessment



Prepared by Maternal and Child Health Epidemiology, October 2020
 Source: AIM Quarterly Process Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.
 For TexasAIM Plus hospitals reporting on measure for both July 2018 and April 2020 reporting periods, the percentage of hospitals reporting a cumulative proportion for the measure of 0-9%, 10-79%, 80-89%, or 90-100%.

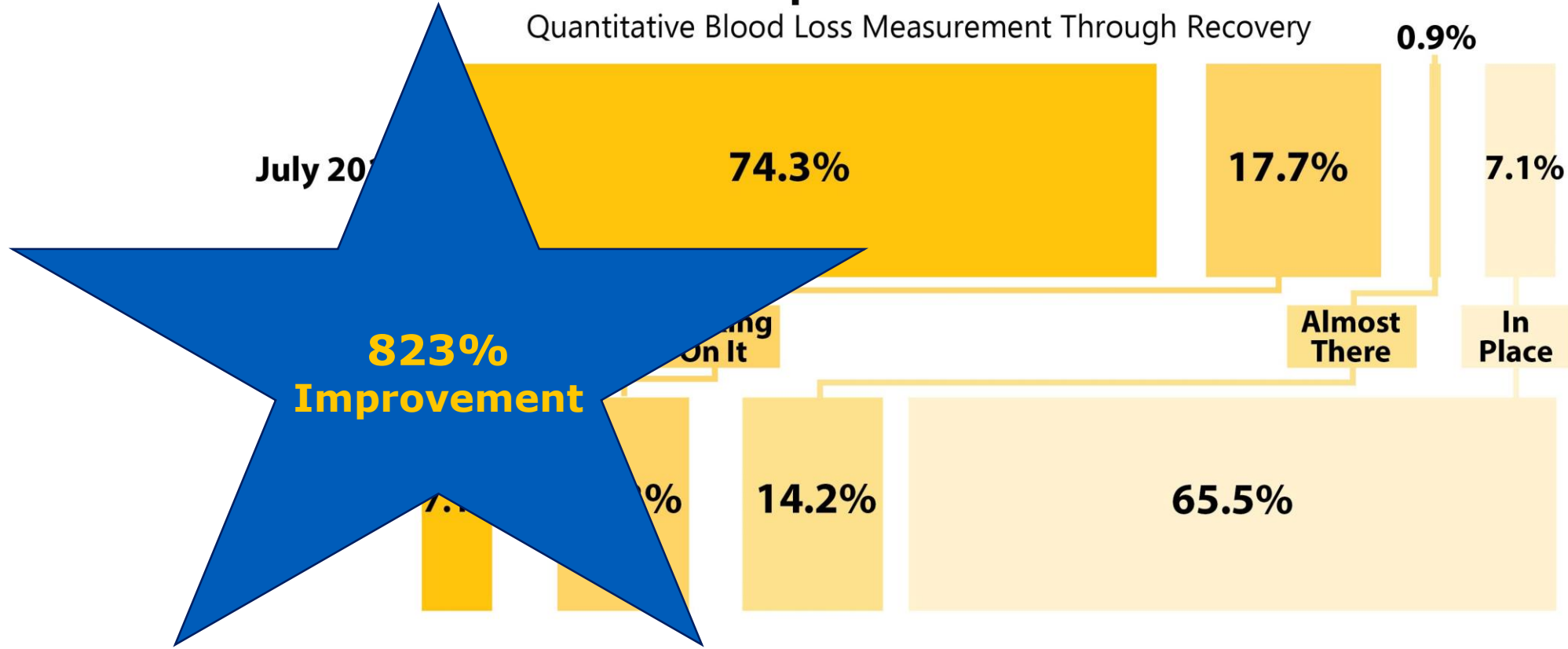
Hemorrhage Cart/ Risk Stratification

1. Creating and implementation of a PPH cart for all deliveries
2. Assess all patients at admission and with changes in clinical status for PPH risk
3. Improve communication with all teams about risk for PPH
4. Tie risk stratification to action—bring PPH cart to all deliveries with risk for PPH



AIM Obstetric Hemorrhage Bundle Process Measures-Improvement from Baseline

Quantitative Blood Loss Measurement Through Recovery



Prepared by Maternal and Child Health Epidemiology, October 2020

Source: AIM Quarterly Process Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.

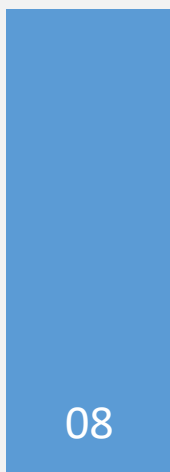
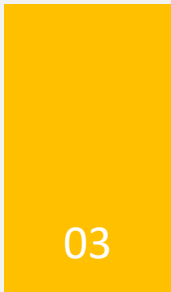
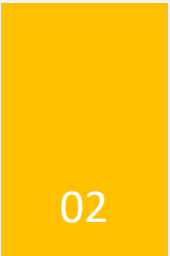
For TexasAIM Plus hospitals reporting on measure for both July 2018 and April 2020 reporting periods, the percentage of hospitals reporting a cumulative proportion for the measure of 0-9%, 10-79%, 80-89%, or 90-100%.

Quantitative Blood Loss

Implementing and Sustaining Change

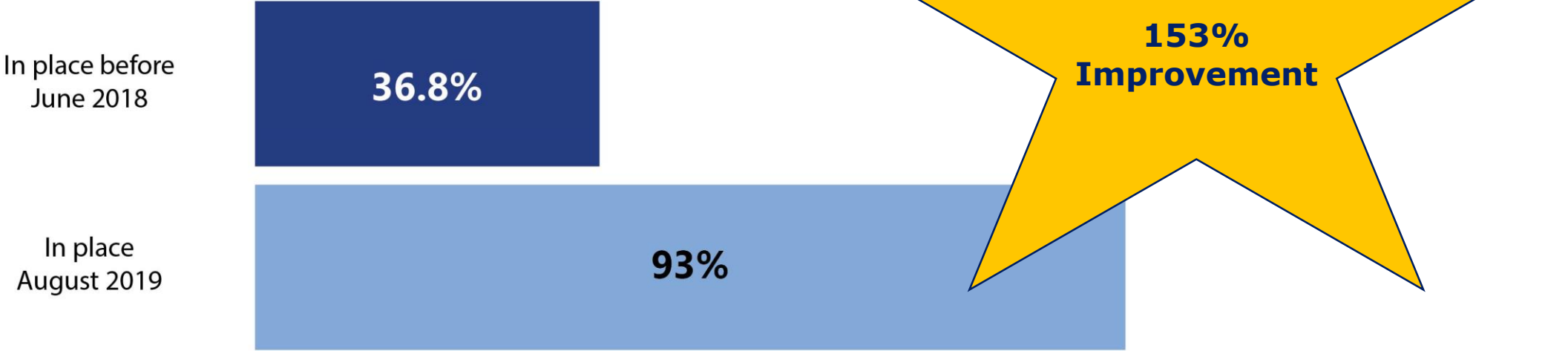
Engaging & Enabling the Whole Organization

Creating a Climate for Change



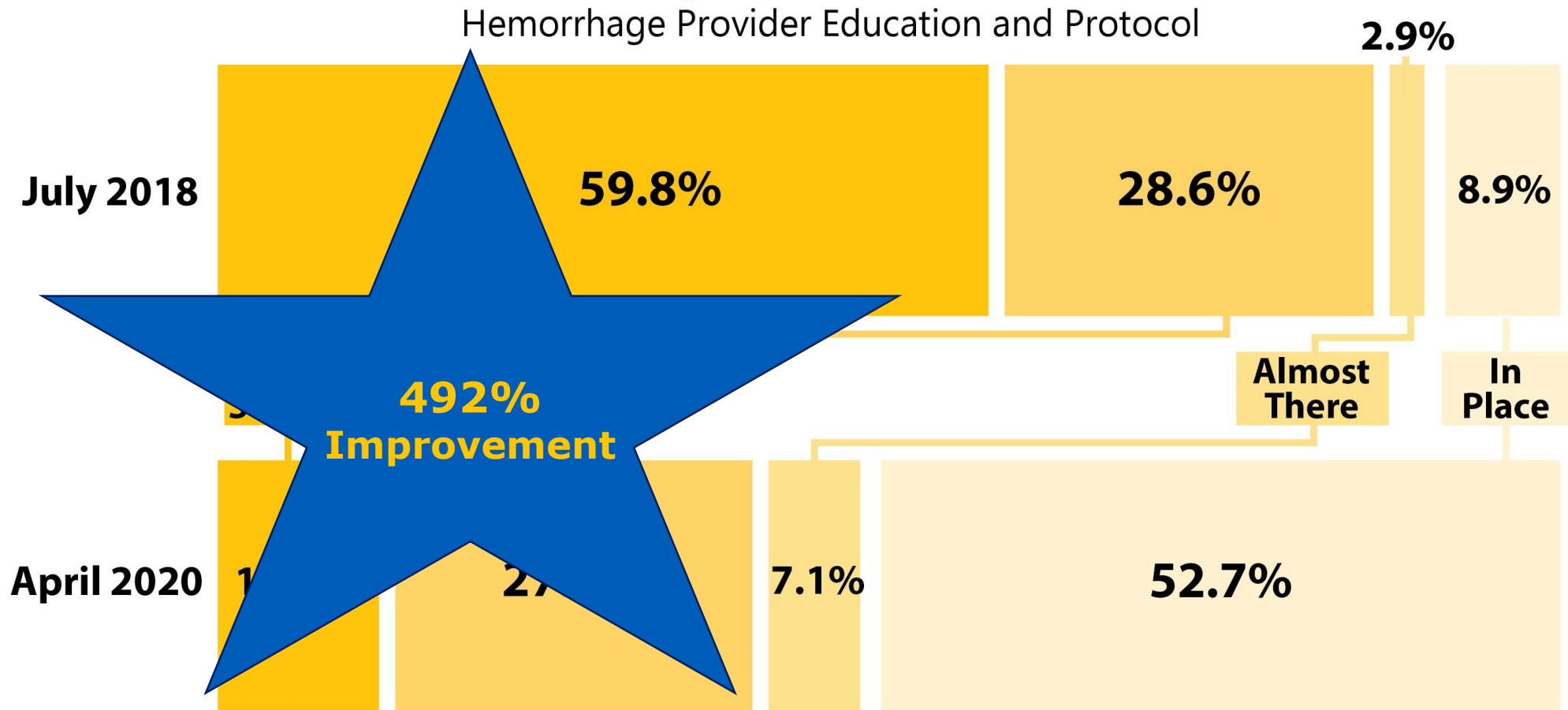
AIM Obstetric Hemorrhage Bundle Structure Measures-Improvement from Baseline

Percent of hospitals with an OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that provides a unit-standard approach using a stage-based management plan with checklists.



Prepared by Maternal and Child Health Epidemiology, October 2020
Source: AIM Structure Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.
For TexasAIM Plus hospitals reporting on structure measures, the percentage of hospitals reporting the bundle component was in place before TexasAIM kickoff in June 2018 and in place through August 2020.

AIM Obstetric Hemorrhage Bundle Process Measures-Improvement from Baseline

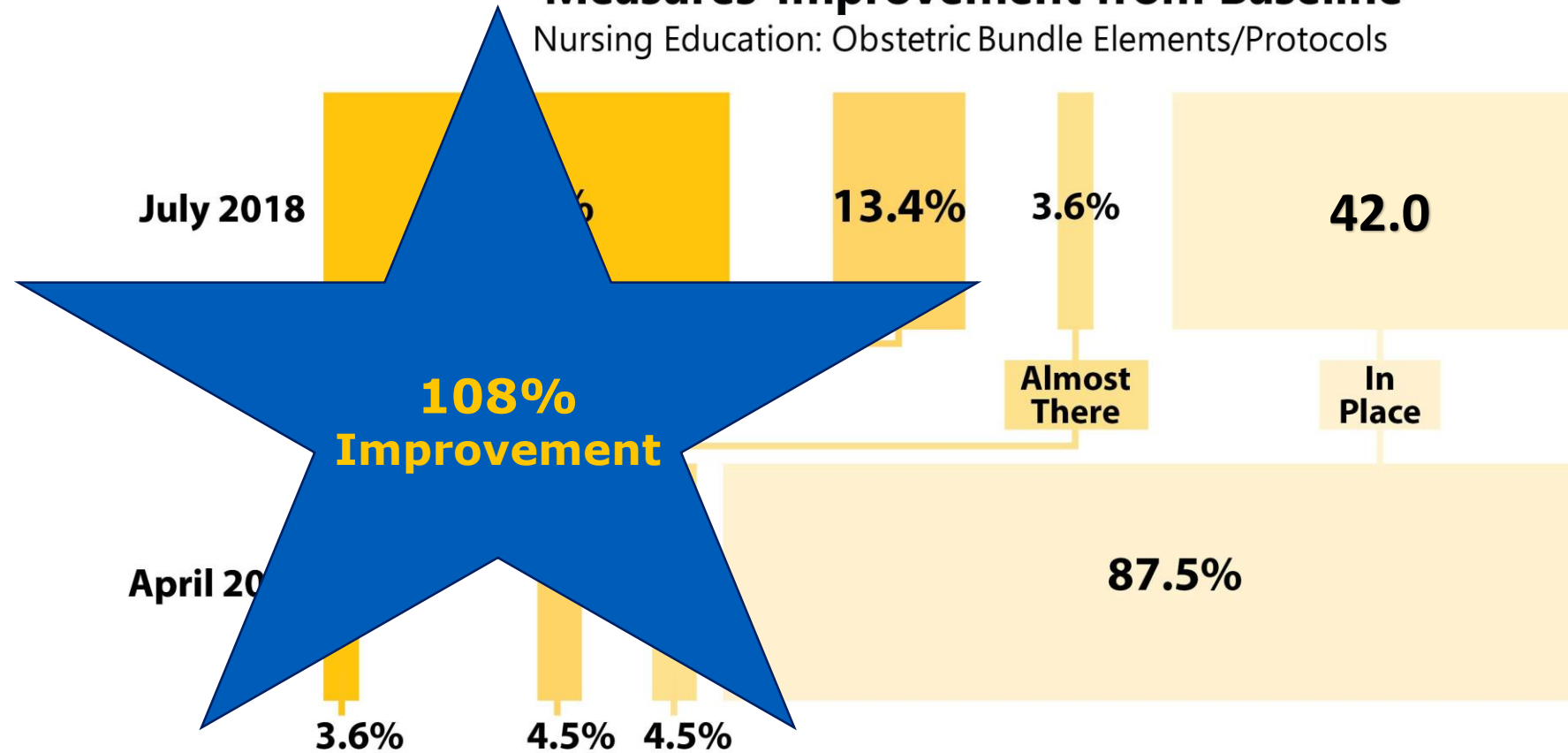


Prepared by Maternal and Child Health Epidemiology, October 2020

Source: AIM Quarterly Process Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.
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AIM Obstetric Hemorrhage Bundle Process Measures-Improvement from Baseline

Nursing Education: Obstetric Bundle Elements/Protocols



Prepared by Maternal and Child Health Epidemiology, October 2020

Source: AIM Quarterly Process Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.

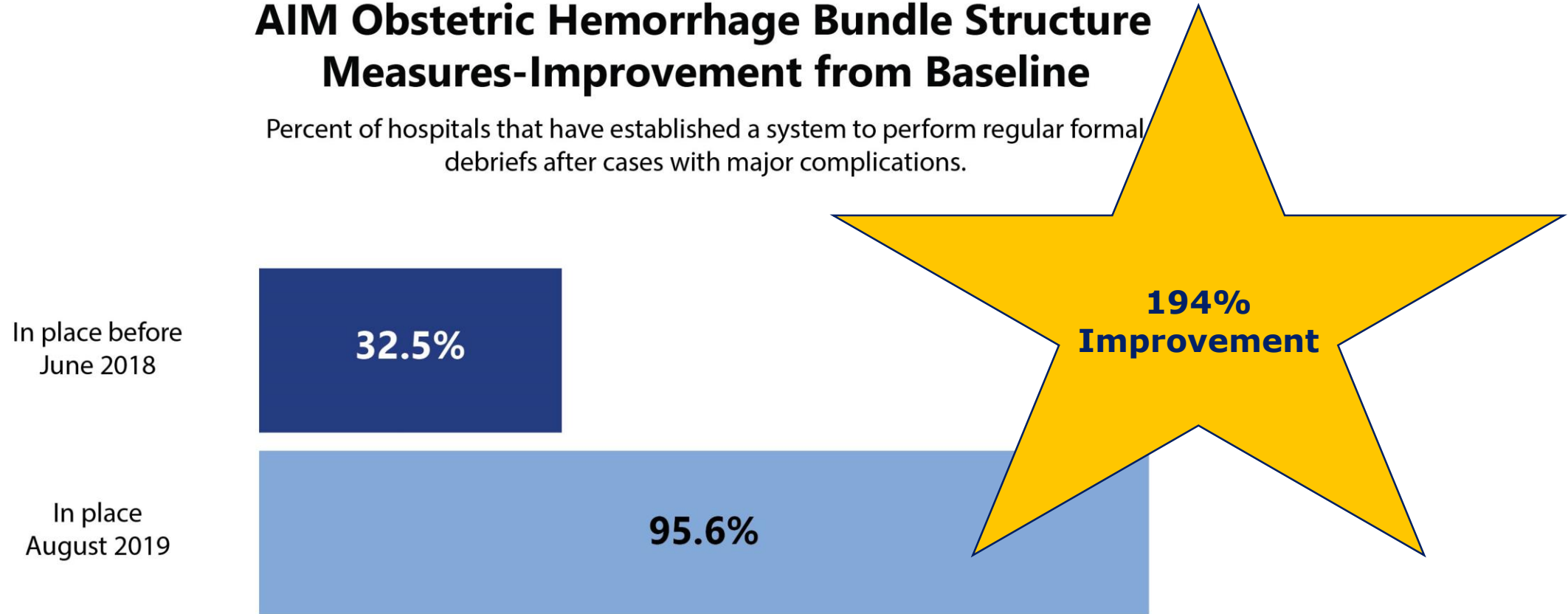
For TexasAIM Plus hospitals reporting on measure for both July 2018 and April 2020 reporting periods, the percentage of hospitals reporting a cumulative proportion for the measure of 0-9%, 10-79%, 80-89%, or 90-100%.

Provider Engagement and Buy-In



AIM Obstetric Hemorrhage Bundle Structure Measures-Improvement from Baseline

Percent of hospitals that have established a system to perform regular formal debriefs after cases with major complications.



Prepared by Maternal and Child Health Epidemiology, October 2020

Source: AIM Structure Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.

For TexasAIM Plus hospitals reporting on structure measures, the percentage of hospitals reporting the bundle component was in place before TexasAIM kickoff in June 2018 and in place through August 2020.

AIM Obstetric Hemorrhage Bundle Structure Measures-Improvement from Baseline

Percent of hospitals that have established a process to perform multidisciplinary systems-level reviews on all cases of severe maternal morbidity (including women admitted to the ICU, receiving ≥ 4 units RBC transfusions, or diagnosed with a)

In place before
June 2018

34.2%

In place
August 2019

95.6%

**180%
Improvement**

Prepared by Maternal and Child Health Epidemiology, October 2020

Source: AIM Structure Measure Data: AIM Data Portal, Healthy Texas Mothers and Babies Branch, DSHS.

For TexasAIM Plus hospitals reporting on structure measures, the percentage of hospitals reporting the bundle component was in place before TexasAIM kickoff in June 2018 and in place through August 2020.

The journey to QAPI Development



Development of data collection



Multidisciplinary case review



Simulation



Debriefs, huddles, pre-briefs

Provisional Finding

- 14% reduction from baseline (2016/2017) in the rate of Severe Maternal Morbidity* among Hemorrhage Cases occurring during initial intervention period [Oct. 2018-Dec. 2019].

**(excludes cases with only a transfusion code)*

TEXAS HOSPITALS ARE
COMMITTED TO

**SAFE
CARE
FOR
EVERY
MOTHER**

February TexasAIM *Practicing for Patients Obstetric Hemorrhage* Simulation Training of the Trainer



Teamwork, Communication and Simulation Train the Trainer Event

Day 1: *Safety Program in Perinatal Care-II (SPPC-II)*, by Johns Hopkins University and Agency for Health Care Research and Quality

Day 2: TexasAIM *Practicing for Patients Obstetric Hemorrhage* Simulation Program

Trainer team: one physician leader, one nurse leader and one educator or maternal health coordinator (optional)

Simulation stats: 120 hospitals and 297 attendees

Training 1: Lubbock

- Sunday, February 9 SPPC-II
- Monday, February 10 SIM

Training 2: Dallas Fort Worth

- Monday, February 10 SPPC-II
- Tuesday, February 11 SIM

Training 3: Dallas Fort Worth

- Tuesday, February 11 SPPC-II
- Wednesday, February 12 SIM

Training 4: San Antonio

- Wednesday, February 19 SPPC-II
- Thursday, February 20 SIM

Training 5: Houston

- Thursday, February 20 SPPC-II
- Friday, February 21 SIM

Thanks to Sim Faculty Volunteers



Carey Eppes,
MD, MPH



Shad Deering,
MD, CHSE, COL(ret) USA



Carlos Carreno,
MD



Carroll Deighton,
MSN, RNC-OB, C-EFM



Shena Dillon,
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Rakhi Dimino,
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MD



Jamie Morgan,
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Sarah M. Page-Ramsey,
MD, FACOG



Amber L. Pocrnich, BSN,
RNC-MNN(e), C-EFM



Brook A. Thomson,
MD, FACOG

TexasAIM

OB Care and COVID-19

March-September 2020

Coronavirus Disease 2019 (COVID-19)

Readiness

Every Hospital¹

- [Assess Preparedness](#) and ensure staff are trained, equipped and capable of practices needed to:
 - Prevent the spread of respiratory diseases including COVID-19 within the facility
 - Promptly identify and isolate patients with possible COVID-19 and inform the correct facility staff and public health authorities
 - Care for a limited number of patients with confirmed or suspected COVID-19 as part of routine operations
 - Potentially care for a larger number of patients in the context of an escalating outbreak
 - Monitor and manage any healthcare personnel that might be exposed to COVID-19
 - Communicate effectively within the facility and plan for appropriate external communication related to COVID-19
 - Obtain the appropriate PPE for possible triage, vaginal delivery and cesarean delivery scenarios

Every Unit²

- Establish systems for prehospital notification of confirmed COVID-19 patients or Persons Under Investigation (PUIs)
 - Coordination with admitting providers
 - Review of local or regional transport protocols include notification for patients arriving via EMS transport (refer to [Interim Guidance for Emergency Medical Services \(EMS\) Systems and 911 Public Safety Answering Points \(PSAPs\) for COVID-19 in the United States](#))
- Create communication channels to disseminate information and changes in clinical management/protocols
- Develop unit surge capacity models to potentially cohort COVID-19 patients or identify triggers for when to transfer out of the facility
- Develop strategies for outpatient prenatal care during the pandemic including telemedicine, monitoring of those at highest risk, and telephone triage
- Align unit staffing models to minimize employee exposure and balance workforce fatigue
- Unit education on [recommendations for COVID-19 infection prevention and control in health care settings](#) and on protocols
- Unit based drills (with post-drill debriefs)

Recognition

Every Patient³

- Assess all patients for signs and symptoms of COVID-19
- Be aware of your geographic region and facilities testing guidelines
- Assess illness severity in symptomatic patients
- Assess clinical and social risks

Response

Every patient with suspected or confirmed COVID-19

- Activate COVID-19 Infection Prevention and Control precautions using unit-standard protocols that include/address:
 - Process for rapidly identifying and isolating patients with confirmed or suspected COVID-19
 - Patient placement
 - Transmission-Based Precautions
 - Movement of patients within the facility
 - Hand hygiene
 - Environmental cleaning
 - Monitoring and managing health care personnel
 - Visitor access and movement within the facility
 - Regular situation monitoring
- Perform triage and testing per unit specific guidelines
- Isolate infants according to the [Infection Prevention and Control Guidance for PUIs](#) until the mother's and infant's transmission-based precautions are discontinued.
- Support and facilitate establishment of lactation, breastmilk feeding of the newborn, and post-illness support of breastfeeding for mothers who wish to breastfeed in accordance with CDC's [Interim Guidance on Breastfeeding for a Mother Confirmed or Under Investigation for COVID-19](#)
- Prepare for discharge postpartum women according to recommendations described in the [Interim Considerations for Disposition of Hospitalized Patients with COVID-19](#).
- Support patient, families and staff experiencing exposure to COVID-19⁴.

Reporting/Systems Learning

Every Unit

- Establish a culture of briefs, huddles, and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of COVID-19 associated severe maternal morbidities for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement committee

TexasAIM COVID-19 Planning and Webinars

Service Delivery Model



Outpatient
Care



Inpatient Care



Workforce



Strategic
planning

Optimizing prenatal
care during the
pandemic

Telemedicine

Care for our high risk

Telephone triage versus

PUI triage and
management

Care during Delivery

Transport

Infant Care

Work exposures/PPE

Communications

Changing the
workforce based on
risks

Wellness

Surge Capacity -
workforce

Surge Capacity-
physical

Supply shortages

Recovery













Wave 1

Wave 2

Wave 3


TexasAIM OB Care and COVID-19 Weekly Webinars

+ New... Past Webinar Recordings Unsorted

 <p>TexasAIM OB Care and COVID-19 Call #...</p> <p>This call featured a panel presentation on disparities and COVID-19.</p>	 <p>TexasAIM OB Care and COVID-19 Webinar #1 Mar...</p> <p>This webinar features a panel presentation on OB Care and COVID-19 Response and</p> <ul style="list-style-type: none"> Guidelines and 	 <p>TexasAIM OB Care and COVID-19 Call #...</p> <p>This call featured a panel presentation on:</p> <ul style="list-style-type: none"> Guidelines and 	 <p>TexasAIM OB Care and COVID-19 Call #...</p> <p>This webinar featured a presentation on:</p> <ul style="list-style-type: none"> New literature
 <p>TexasAIM OB Care and COVID-19 Call #...</p> <p>This webinar featured a presentation on:</p> <ul style="list-style-type: none"> New literature 	 <p>TexasAIM OB Care and COVID-19 Call #...</p> <p>This call featured an update on new literature and a panel Q&A around OB Care and COVID-19.</p>	 <p>TexasAIM OB Care and COVID-19 Call #...</p> <p>This call featured a panel presentation on:</p>	 <p>TexasAIM OB Care and COVID-19 Call #...</p> <p>This call featured a panel presentation on:</p> <ul style="list-style-type: none"> New literature
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TexasAIM Plus Hospital Teams OB Care and COVID-19 Resources



<h3>Docs & Files</h3> <ul style="list-style-type: none"> General COVID Information (Not OB-Specific) Hospital Operations (Not OB-Specific) Conditions, Diagnosis, Treatment and Outcomes 	<h3>Message Board</h3> <ul style="list-style-type: none"> EG Untitled Question — Hil Does 1 RM Physician chart audits Question — Hello, I was 10 LB PPE Are you considering COVID 8 Neonatal Resuscitation Submitted by Laura Uribe 7 OB Care and COVID19 Discussion Board
<h3>Email Forwards</h3> <ul style="list-style-type: none"> TexasAIM@dshs.texas.gov (via Texas... TexasAIM OB Care & COVID-1... TexasAIM@dshs.texas.gov (via Texas... Cancelled: TexasAIM OB Car... TexasAIM@dshs.texas.gov (via Texas... Reminder: TexasAIM OB Care... TexasAIM@dshs.texas.gov (via Texas... Register: TexasAIM OB Care ... TexasAIM@dshs.texas.gov (via Texas... Register: TexasAIM OB Care ... 	<h3>Schedule</h3>  <p>Set important dates on a shared schedule. Subscribe to events in Google Cal, iCal, or Outlook.</p>

TexasAIM OBH Faculty



Carey Eppes, MD, MPH
TexasAIM Faculty Chair



Carlos Carreno,
MD



Carroll Deighton,
MSN, RNC-OB, C-EFM



Jamie Morgan,
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Renee' Jones,
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Suzanne Lundeen,
PhD, RNC-OB, NEA-BC



Patricia Heale,
DNP, RNC-OB, C-EFM



DSHS TexasAIM Ops Team



John Hellerstedt, MD, DSHS
Commissioner



Manda Hall, MD Associate Commissioner
Community Health Improvement Division, DSHS



Jeremy Triplett
Director, Maternal & Child Health Section, DSHS



Michael Spencer, LMSW
Director, Maternal & Child Health Unit, DSHS



Julie Stagg, MSN, RN, IBCLC
Healthy Texas Mothers & Babies Branch Manager, DSHS



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Maternal Health & Safety Coordinator



Megan Coulter, MPH
Maternal Health & Safety Coordinator, TexasAIM Data Lead



Laura Wando, MPH
Maternal Health & Safety Coordinator



Rosa-Maria DiDonato, RNC-OB, C-EFM
Maternal Health & Safety Nurse Consultant



Aliyah Abdul-Wakil, MPH
Maternal & Child Health Epidemiologist

Thank you!

Presentation title

Contact Information



Jamie Morgan, MD
UT Southwestern



Jessica Coker
BSN, RN
Faith Community
Hospital



Brandy Bennet
BSN, RN
Faith Community
Hospital



Douglas Creedon,
MD
Christus Health



Debbie Hart
BSN, RNC- OB, C-EFM
Christus Health

Welcome and Introductions



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Hospital Experience with Implementing the Obstetric Hemorrhage Bundle

Brandi Bennet, BSN, RN

Jessica Coker, BSN, RN

Faith Community Hospital



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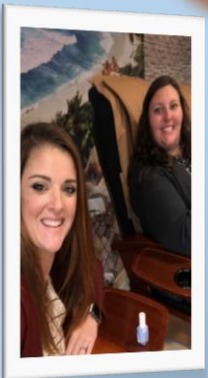
Texas Department of State
Health Services

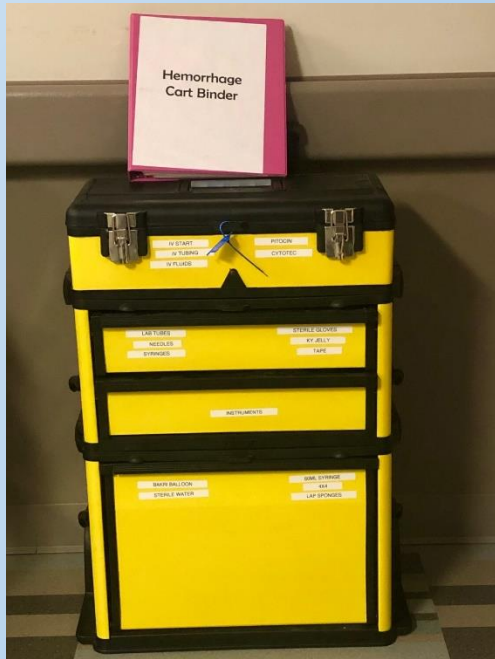
- We are rural hospital in Jacksboro, TX with four LDRP rooms
- We have 5 delivering family practice doctors on staff and average 70-100 deliveries a year.
- We currently are practicing QBL and hemorrhage assessment on 100% of our deliveries
- We audit our charts monthly to ensure that staff and physicians are implementing the new practices correctly.
- We have educational meetings quarterly with staff and physicians and review topics that are pertinent to success on our unit.

Faith Community Hospital



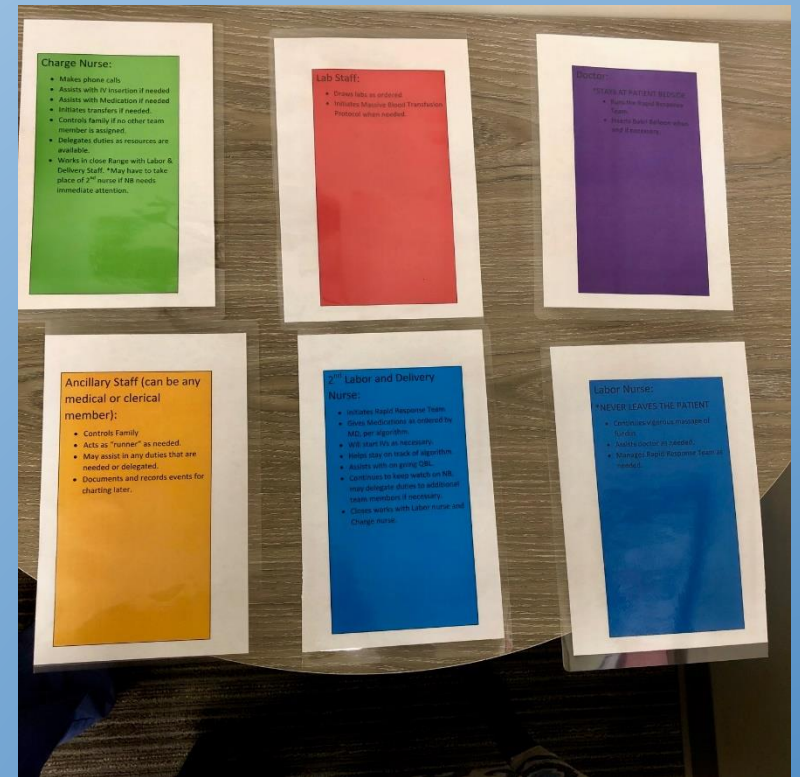
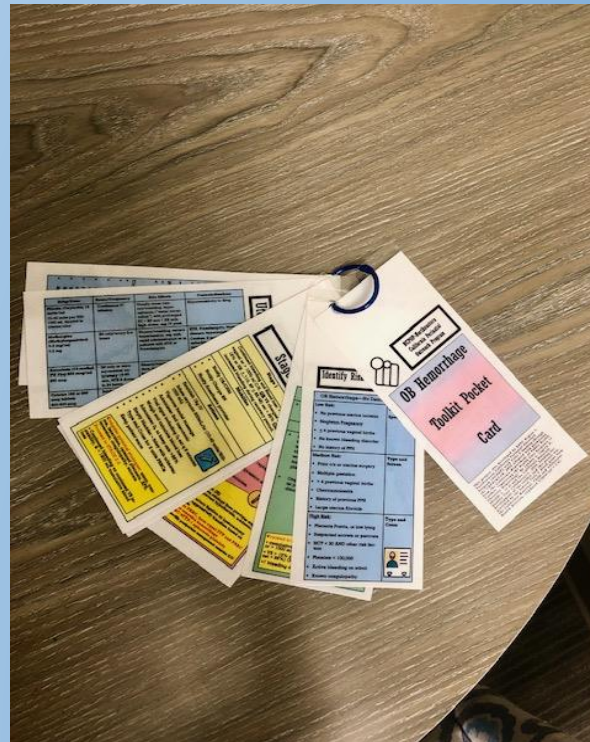
Our Team along the Journey





Our hemorrhage cart is kept at our nurses station and has everything needed for a hemorrhage except for refrigerated medications. These are in a box labeled hemorrhage box in medication fridge.

We have the OB hemorrhage toolkit pocket cards on every one of our monitors hanging on a hook. This way we have easy access to the stages of a hemorrhage and what actions should be in place.

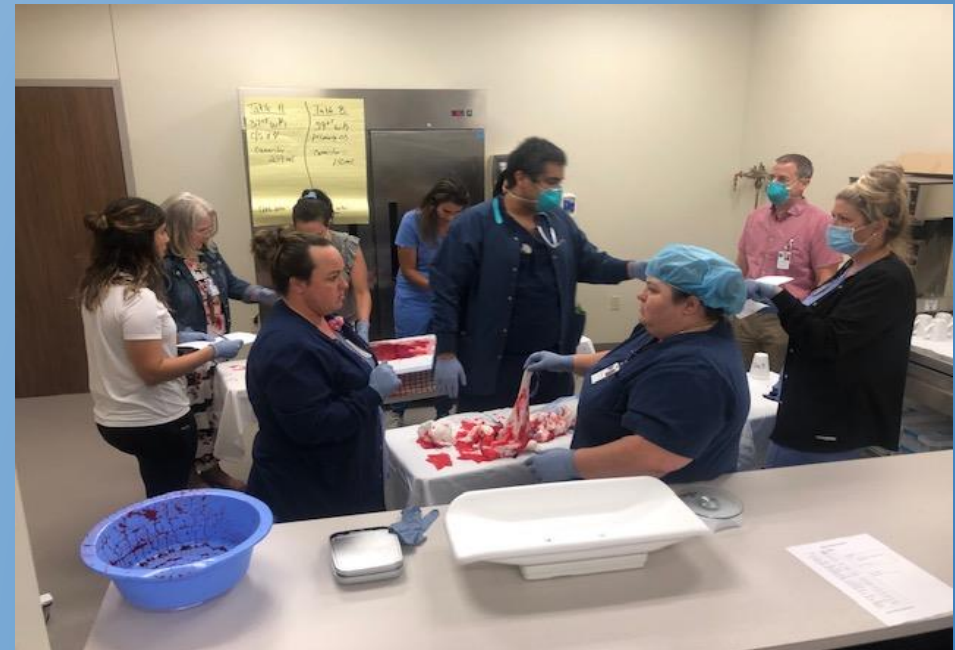
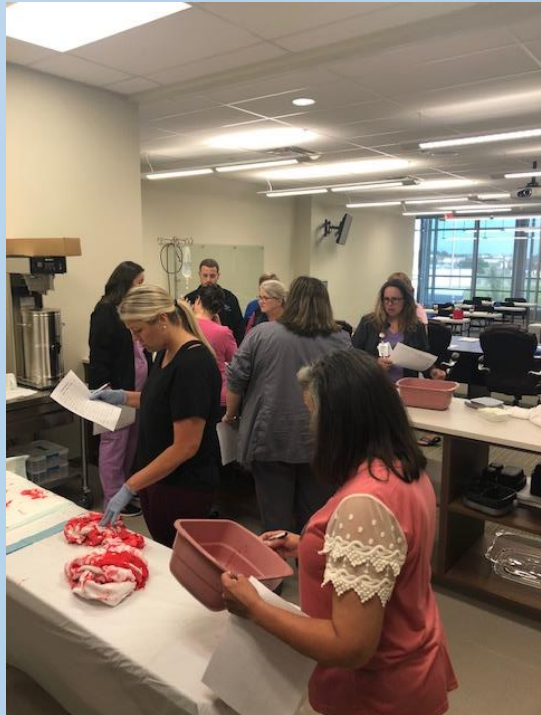


Inside the hemorrhage binder we have role cards that are color coded. We can hand these out to people from different departments and it designates what they need to be doing during the rapid response. Also in this binder we have our hospital policy for postpartum hemorrhage, QBL, massive transfusion, use of Bakri balloon catheter, and emergency release of blood. We have our dry weight flowsheet as well in this binder.

Rapid Response OB hemorrhage

- In the case of a true postpartum hemorrhage, we would announce overhead rapid response OB hemorrhage. At this point lab, ER charge nurse, ward clerk, and any other available nurses in hospital know to come to our unit. We provided an educational in-service to the departments when we first launched.
- In our hemorrhage binder we have the obstetric hemorrhage emergency management plan from CMQCC. We follow these guidelines to indicate what stage of blood loss we are at and what action needs to be taking place. We printed off the checklist format of this form and keep multiple copies in the binder, so the documenting nurse can check off what is being done and write times next to the steps when they are complete.





Thank you TexasAIM!

Ice Breaker

- In the chat box, share one word that describes your experience with TexasAIM Obstetric Hemorrhage initiative....



CHRISTUS Health – The Children’s Hospital of San Antonio

“Views from the Field – Obstetric Hemorrhage Improvement in Action”



Implementation of the Obstetric Hemorrhage Bundle

Keys to Success

1. Commitment from Hospital to improve Obstetric Patient Safety
2. Physician, Nurse and Administration involvement
3. Vision of Obstetric Hemorrhage management
4. Physician leadership to demonstrate hemorrhage recognition, response and reporting (debriefs)
5. Nursing involvement in education, simulation, implementation
6. OB Team participation In-Situ Simulation

Commitment from hospital to improve obstetric patient safety

1. The Children's Hospital of San Antonio and Baylor College of Medicine are committed to develop a High Reliability Organization by improving safety, quality and efficiency.
2. We recognized that OB Women's health mortality and morbidity in Texas were some of the highest in the nation.
3. When TexasAIM was created we registered to be part of the AIM Plus program so that we could also be part of the solution for improvement.

Physician, Nurse and Administration Involvement

1. Physician leadership was the key motivating factor for beginning implementation.
2. Nurses are a “captive audience” for the hospital so, it is easier to provide and mandate education and simulation to nurses.
3. Administrators were educated and motivated by our physician leadership thru executive meetings and nursing leadership at Perinatal Service Line meetings.

OB Physician involvement at AIM Summits

- The Baylor OB Physicians are highly motivated and involved in all of the TexasAIM Summits.
- They provided the enthusiasm and leadership for the hospital to implement the OB Hemorrhage Bundles.



Vision of Obstetric Hemorrhage Management

1. Many of our Baylor OB Physicians had already been part of successful OB Hemorrhage bundle implementation in other hospital systems. They had the Vision and the Leadership power to drive the change in practice.
2. Some of our nurses had been involved in OB Hemorrhage bundle management. We used them to help with education and simulation. They provided the vision and enthusiasm.
3. Administrators were aware of our Perinatal Safety Goals and the Texas AIM collaboration and were very supportive in sending Physicians and Nurses to these Summits.

Physician leadership to demonstrate hemorrhage recognition, response and reporting (debriefs)

1. Our OB Hospitalists who had been involved in OB Hemorrhage management were great examples to demonstrate how to calculate QBL at vaginal deliveries and C/Section deliveries. They taught the nurses and the other physicians. They led by example.
2. OB Hospitalists are often the first physicians to respond to OB Hemorrhage events on the unit. Their presence helps in early recognition and administration of medications, blood transfusion, balloon tamponade or taking the patient to OR.
3. The OB Primary care physician will assume care upon arrival to unit. Patient care is not delayed waiting for physicians.
4. The OB Hospitalists have also been leaders in conducting Debriefs after an event.

Nursing involvement in Education/ Simulation/ Debriefs

1. We began nursing education and simulation 3 years ago at our Annual Nurse Competency training days.
2. We assign the AIM Hypertension, AIM Hemorrhage, and AIM MEWS Scoring Healthstream Modules to ALL Women's Services nurses upon hire and every year for ANC.
3. During our ANC sessions, we do Simulation of OB Hemorrhage, OB Hypertensive Emergency and Maternal Cardiac Arrest every year.
4. We add and rotate other OB Emergencies such as Cord Prolapse, Malignant Hyperthermia, Shoulder Dystocia, Uterine Rupture and Newborn collapse.
5. We also educate about debriefs and Team STEPPS communication.

Nursing Simulation

- Our Annual Nurse Competency Simulations provided a starting point for Education and Simulation for ALL Nurses.
- It was a safe place to learn and practice skills and work on Team STEPPS communication.



OB Team participation for In-Situ Simulation

1. We have conducted some In-Situ simulations on the L&D or MBU Units in the past 3 years.
2. In July of 2020 we implemented monthly In-Situ Simulations. We set up a calendar for the year. Each month has a simulation topic.
3. We changed up the days of the week, time of the day, and place of the simulation each month to try and include as many people as possible on various shifts and areas such as L&D or MBU.
4. We sent this calendar out to ALL OB Physicians as well as Nurses. The OB department secretary sends out a calendar reminder to ALL Physicians the week of the Simulation.

In-Situ Simulation Schedule



**The Children's Hospital
of San Antonio™**
CHRISTUS Health

Women's Services **In-Situ SIMULATION SCHEDULE 2020**

July 14 – Tuesday @ 0730 on L&D
“Hemorrhage, How to get blood!”

August 12 – Wednesday @ 1700 on L&D
“Hemorrhage, How to get blood!”

September 8 – Tuesday @ 2000 on MBU
“Hypertensive Emergency”

October 22 – Thursday @ 0730 on MBU
“Hypertensive Emergency”

November 11 – Wednesday @ 1700 on L&D
“Maternal Cardiac Arrest”

December 14 – Monday @ 2000 on L&D
“Maternal Cardiac Arrest”

OB Team participation for In-Situ Simulation

1. According to the In-Situ Theme we also include other departments in our simulations. We let them know ahead of time. We explain what our theme is and what we expect from their participation.
 - Blood Bank
 - NICU
 - ICU
 - Main Operating Room
 - Pharmacy, chaplain, security, ED, etc.

Goals for In-Situ Simulation

1. We begin simulation in a Pre-Sim huddle. We start with Basic Assumption in simulation participation.
2. Educate the Team about the topic of the simulation and the hospital process and procedures. We share our goals for the Sim.
3. We assign roles ahead of time: Primary Nurse, OB Hospitalist, Patient's Provider, Anesthesia, Charge Nurse, Staff Nurse, etc.
4. If we have extra participants, they can be observers.
5. Even though we have specific goals for the Sim, we often discover other process or education opportunities. (how to open crash cart)

Basic Assumption in Simulation

“Everyone here is intelligent, well-trained, wants to do their best and is here to improve patient care. This is not a test of individuals. It is a test of process, a tool to identify and potentially fix gaps on our unit, in our teamwork, in our communication and the overall reliability of the care we provide. It is also an opportunity to learn and ask questions in a safe environment.”

Our Successes and Sustainability for OB Hemorrhage Bundle

Readiness:

1. Hemorrhage cart in ALL units: L&D, MBU, Antepartum/PACU
2. Immediate access to Hemorrhage medications all Pyxis
3. OB Response team, call RRT or Code Team if needed
4. Massive and emergency release forms for blood
5. Unit based Drills
6. Sustainability Challenges: New people are hired and respond to emergencies from various depts. Requires continue training on these basics

Our Successes and Continuity for OB Hemorrhage Bundle

Recognition

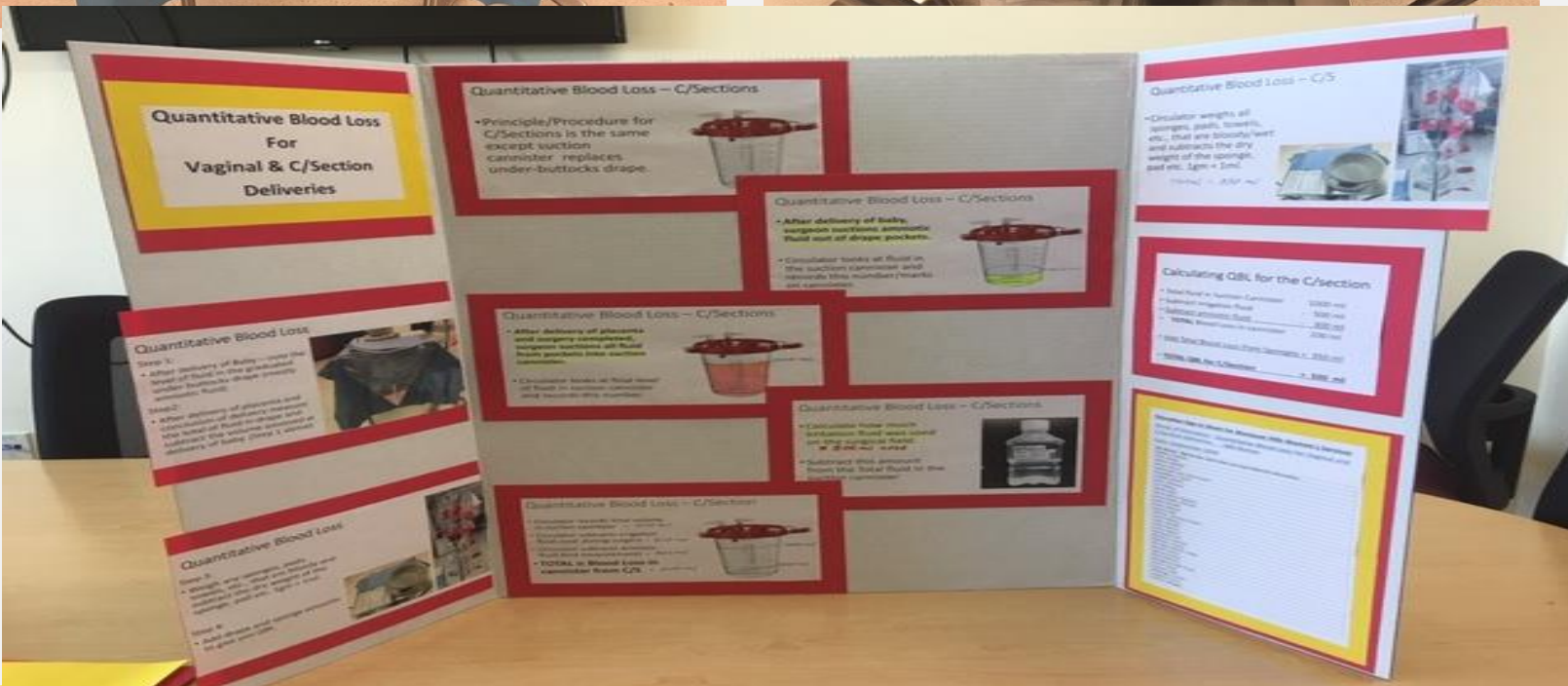
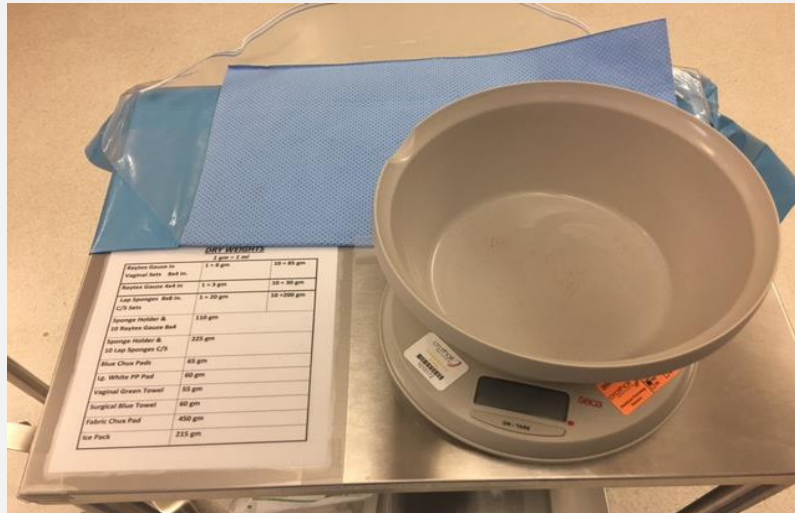
1. Assessment of Hemorrhage risk in EMR.
2. Measurement of QBL – Vaginal and C/Section

*Nurses complete hemorrhage assessment on admission. We are working on “Action” for this assessment, ie. order blood/hold at admission for high risk.

* We realize that with more accurate QBL we will identify more OB Hemorrhage. The goal is for early recognition and response for better outcomes, not less events.

*Our documentation for QBL for C/sections was upgraded to another EMR field. We have to re-educate nurses about this change.

Visual Aides for Team Education



Our Successes and Continuity for OB Hemorrhage Bundle

Response

1. Stage-Based, OB Hemorrhage management protocols in Hemorrhage Notebook on cart.
2. Support programs for patients and families.
3. We are working on support for family during these events. We try to designate a staff person or chaplain to be with family during emergencies.

Our Successes and Continuity for OB Hemorrhage Bundle

Reporting

1. Daily huddles at the beginning of every shift to share report on patients.
2. Attendance AM huddle: physicians, anesthesia, nurses, surgical tech, pharmacy, social work, discharge planner.
3. Night huddle: OB Hospitalist, nurses, anesthesia, surgical tech.
4. Post event debriefs. Led by Physicians and Charge Nurses. Expectation to organize them after every OB Emergency. Great improvement for our OB Hemorrhage debriefs. October we had 7 Hemorrhages and 7 Debriefs.
5. Multidisciplinary Reviews in QAPI meetings. Developing a structured process for M&M review of designated OB events.

Our Challenges with implementation and sustainability

1. Community physicians are difficult to get involved in education and simulation. They are not connected to Healthstream for education. Do not attend monthly simulation. No system compels them to participate.
2. Nursing staff turn over requires continuous re-education. Hemorrhage assessment, QBL at deliveries, how to access blood – what forms or orders to use. How to alert OB Emergency teams.
3. In-Situ simulation has challenges. On simulation days, when the unit gets busy and nurses and physicians are needed for patient care, we still hold simulation with the staff that can attend. Try to make In-Situ simulation less than 30 minutes.

The Impact this work has made on: Patients and Staff

- **Patients:** early recognition and response to hemorrhage results in early stabilization and better outcomes.
- Recently we had a patient that needed Massive Transfusion Protocol implemented due to 3 liter blood loss in the OR. We had early recognition and response and the patient remained hemodynamically stable during the event.
- **Staff** are developing confidence and familiarity in the hemorrhage preparations and interventions: medications, cart, QBL, and notifying physicians early.
- Debriefs after hemorrhage in October were 100%
- **November In-Situ Sim had 8 Physicians attend!!!!**

Thank you!

CHRISTUS Santa Rosa Health System
The Children's Hospital of San Antonio

Dr. Douglas Creedon and Debbie Hart RN

Panel Discussion

Jamie Morgan, MD

Facilitator



TEXAS
Health and Human
Services

Texas Department of State
Health Services

End of Session 1-Time to Stretch!





TEXAS
Health and Human
Services

**Texas Department of State
Health Services**

Aligning Maternal Health State and National Perspectives

Carrie Kroll

Texas Hospital Association



TEXAS
Health and Human
Services

Texas Department of State
Health Services



Carrie Kroll
Texas Hospital
Association



Karen Kendrick MSN,
RN, CPHQ
Texas Hospital
Association



Michael D. Warren,
MD, MPH, FAAP
Maternal Child
Health Bureau HRSA



Kathryn Menard,
MD MPH
UNC Chapel Hill



Elizabeth
Stevenson, RN
DSHS

Welcome and Introductions



TEXAS
Health and Human
Services

Texas Department of State
Health Services



Texas Hospital Association Supports TexasAIM



Karen Kendrick MSN,
RN, CPHQ
Texas Hospital
Association



Maternal Health: An Opportunity to Accelerate Upstream Together

Texas AIM Summit

December 8, 2020

Michael D. Warren, MD MPH FAAP
Associate Administrator
Maternal and Child Health Bureau (MCHB)

Vision: Healthy Communities, Healthy People



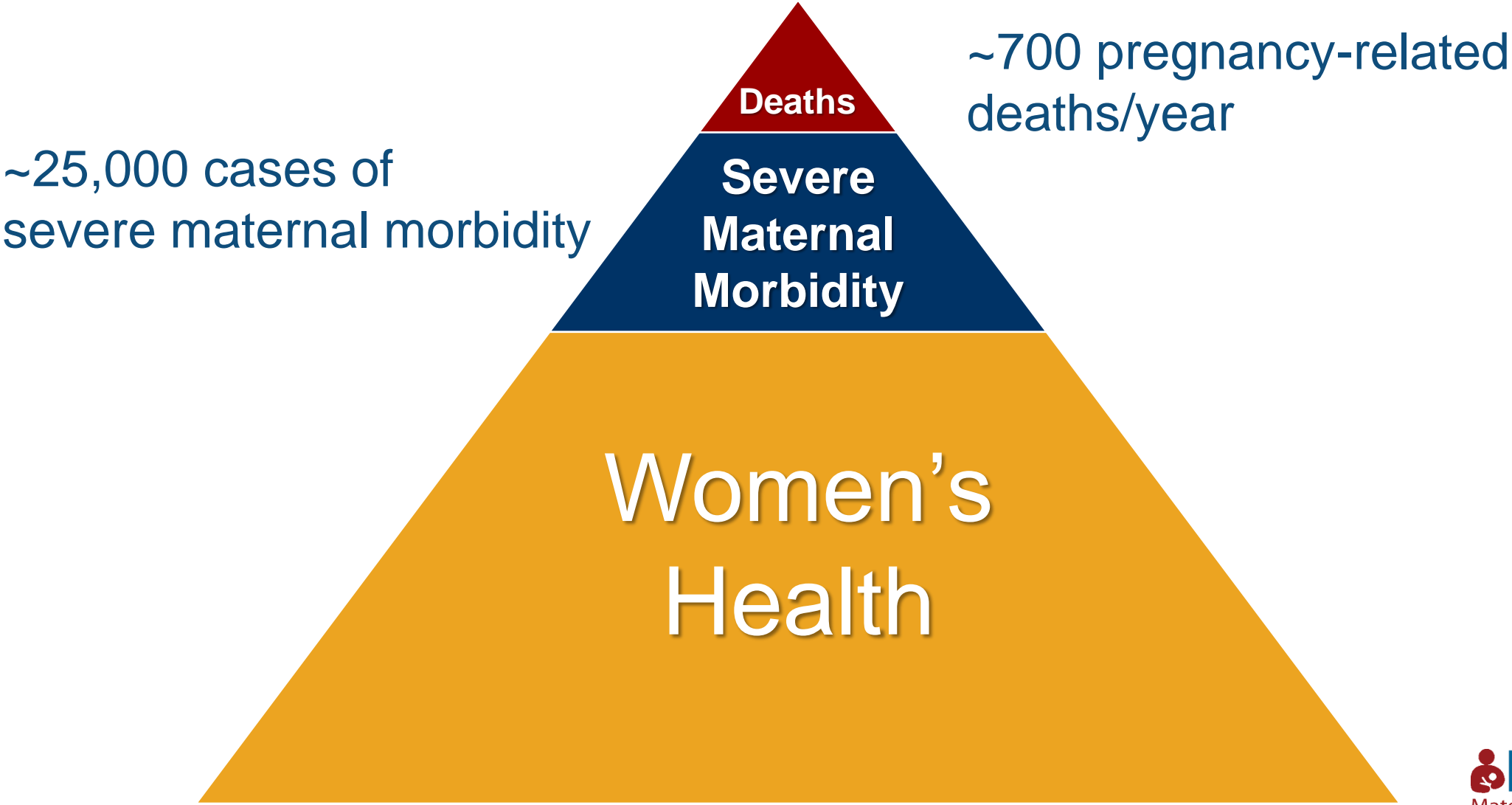
Maternal and Child Health Bureau



Mission:
Improve the health and well-being of
America's mothers, children, and families.



Maternal Morbidity & Mortality in Context



The Action Plan outlines **THREE SPECIFIC TARGETS** to help the nation improve its maternal mortality outcomes:



TARGET 1:

Reduce the maternal mortality rate by 50 percent in 5 years.



TARGET 2:

Reduce the low-risk cesarean delivery rate by 25 percent in 5 years.



TARGET 3:

Achieve blood pressure control in 80 percent of women of reproductive age with hypertension in 5 years.



Read more about the *HHS Action Plan* and the *Surgeon General's Call to Action* here:
www.womenshealth.gov

4 KEY GOALS

designed to achieve the overall vision, which reflect the importance of bringing a life course perspective to improving maternal and infant health outcomes.



Check out the **HHS ACTION PLAN & THE SURGEON GENERAL'S CALL TO ACTION** for more info.

www.womenshealth.gov



POSTPARTUM

maintain ongoing touch points for women with medical and social service providers to ensure warning signs are identified and addressed, and by providing accessible information on parenting skills, self-esteem building and stress management, as well as other family supports



GOAL 1

Healthy Outcomes for All Women of Reproductive Age



GOAL 2

Healthy Pregnancies and Births



GOAL 3

Healthy Futures



GOAL 4

Improve Data and Bolster Research



PRE-PREGNANCY

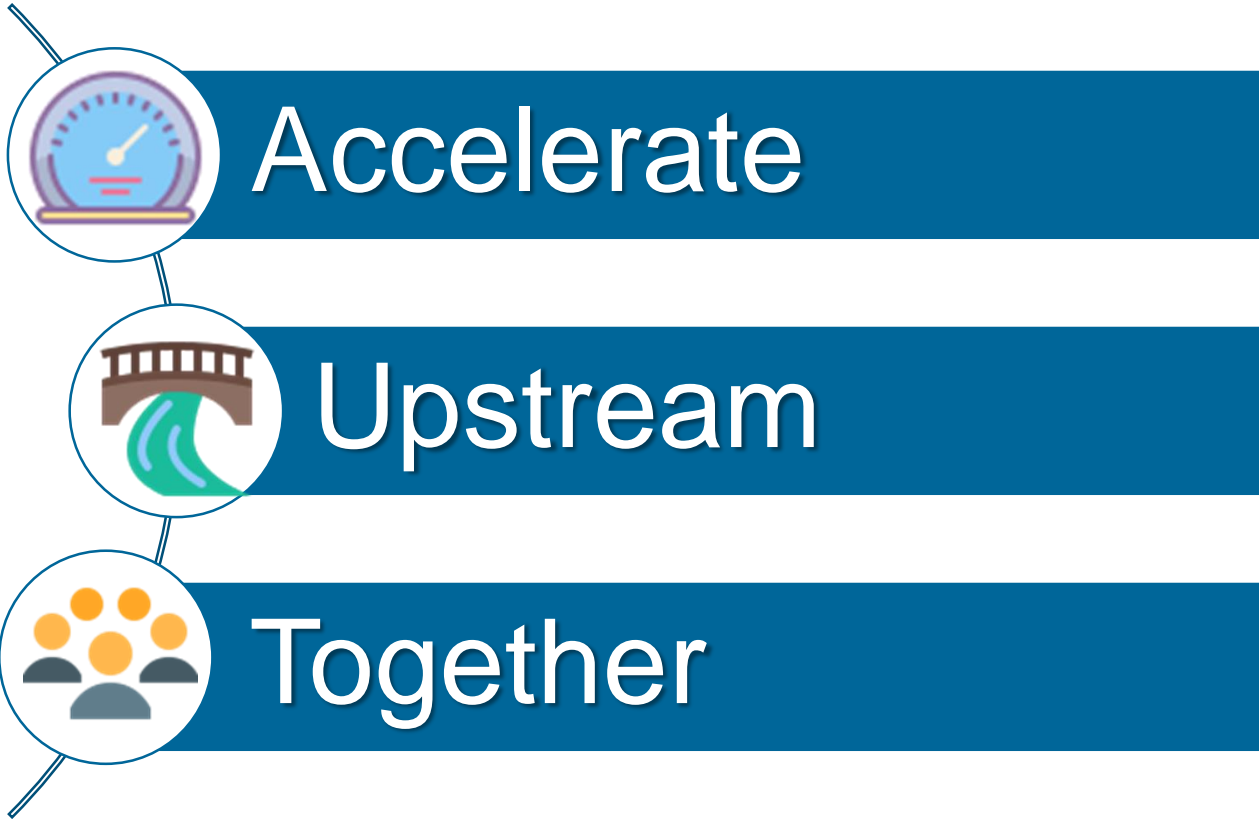
perform recommended screenings and treat all young girls, adolescents, and women for a variety of health risk factors



DURING PREGNANCY

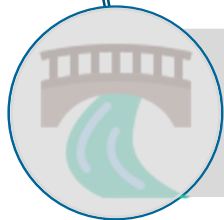
continue prevention efforts into pregnancy to prevent or mitigate the development of complications

Paradigm for Improving Maternal and Child Health

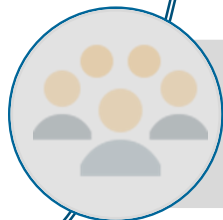




Accelerate



Upstream



Together

LETTER OF TRANSMITTAL.

U. S. DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, September 25, 1916.

SIR: I transmit herewith a report entitled "Maternal Mortality from all Conditions Connected with Childbirth in the United States and Certain Other Countries," by Dr. Grace L. Meigs, in charge of the hygiene division of this bureau. This report has been prepared because the bureau's studies of infant mortality in towns and rural districts reveal a connection between maternal and infant welfare so close that it becomes plain that infancy can not be protected without the protection of maternity.

In this study Dr. Meigs undertakes to do no more than to assemble and interpret figures already published by the United States Bureau of the Census and by the statistical authorities of various foreign countries, and to state accepted scientific views as to the proper care of maternity. She points out clearly that maternal mortality is in great measure preventable, that no available figures show a decrease in the United States in recent years, and that certain other countries now exhibit more favorable rates. This report reveals an unconscious neglect due to age-long ignorance and fatalism. It is earnestly believed that whenever the public realizes the facts it will awake to action and that adequate provision for maternal and infant welfare will become an integral part of all plans for public health protection.

The generous assistance of the United States Bureau of the Census in the preparation of this report is gratefully acknowledged.

Dr. Meigs desires that special mention be made of the assistance of Miss Emma Duke, head of the statistical division of the Children's Bureau, and of Miss Viola Paradise, research assistant in the division of hygiene.

Respectfully submitted.

JULIA C. LATHROP,
Chief of Bureau.

HON. WILLIAM B. WILSON,
Secretary of Labor.

5

“...clearly that maternal mortality is in great measure preventable, that no available figures show a decrease in the United States in recent years, and that certain other countries now exhibit more favorable rates....”

ACCELERATE: Improvements in Clinical Care



READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

PATIENT
SAFETY
BUNDLE

Obstetric Hemorrhage



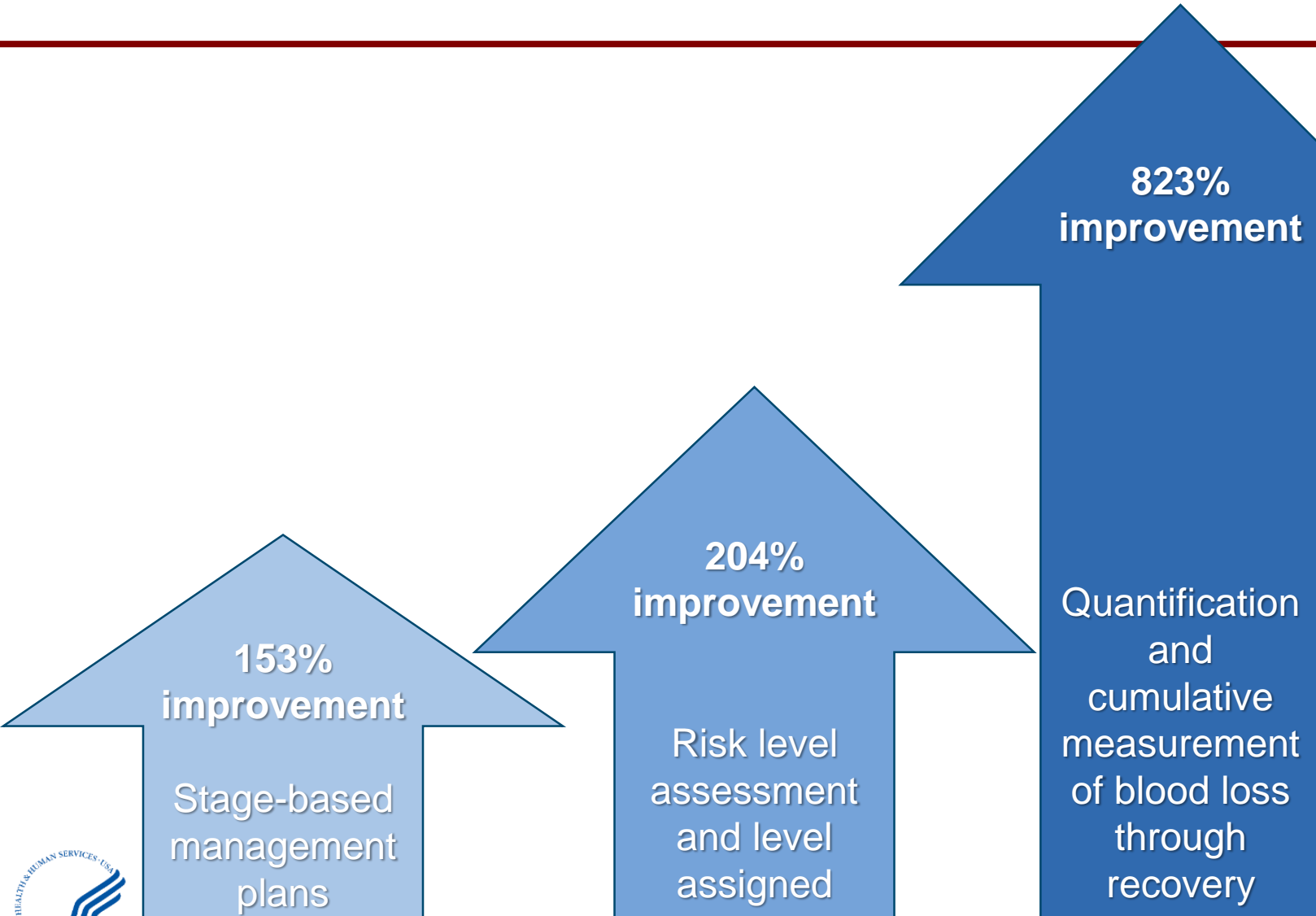
ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

As of October 2020:

- **38 states** enrolled in AIM
- Nearly **1,500 hospitals** participating in bundle implementation



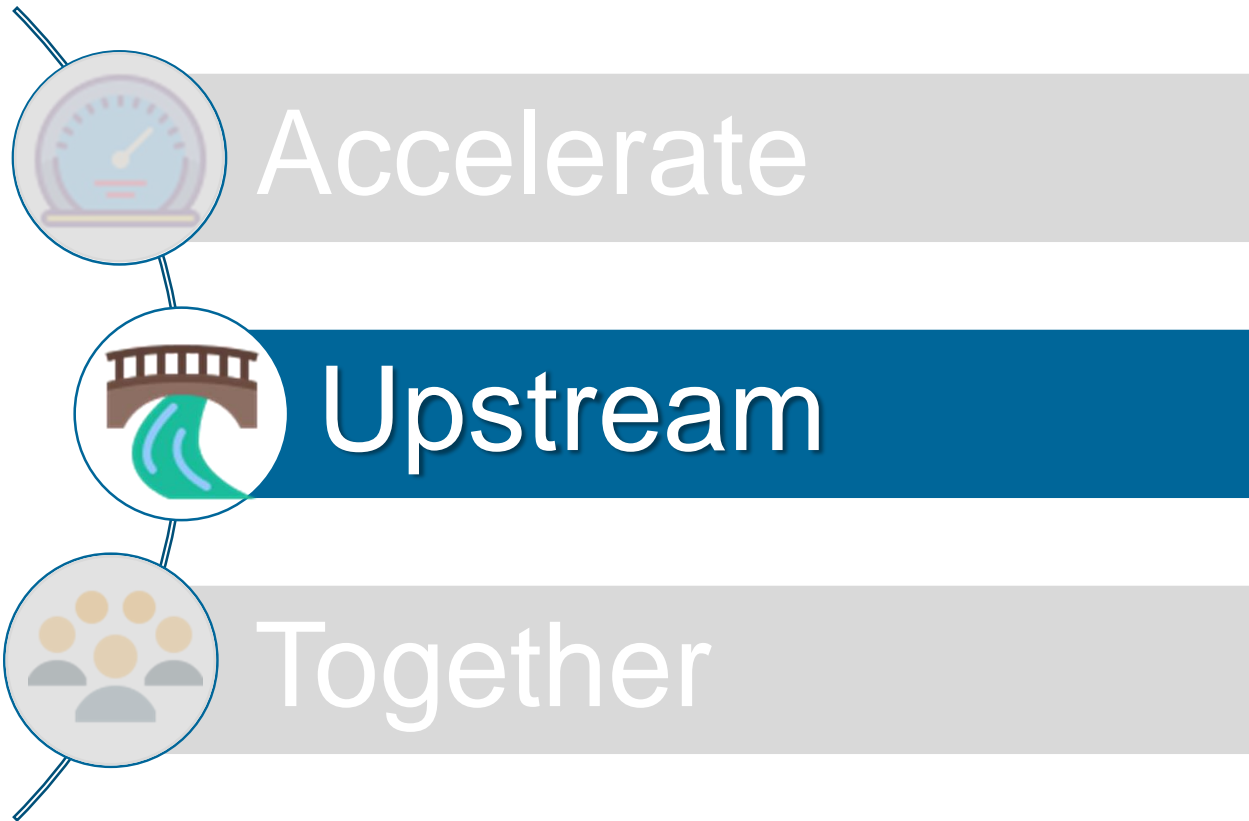
ACCELERATE: Reducing Hemorrhage in Texas



TEXAS
Health and Human
Services

Texas Department of State
Health Services

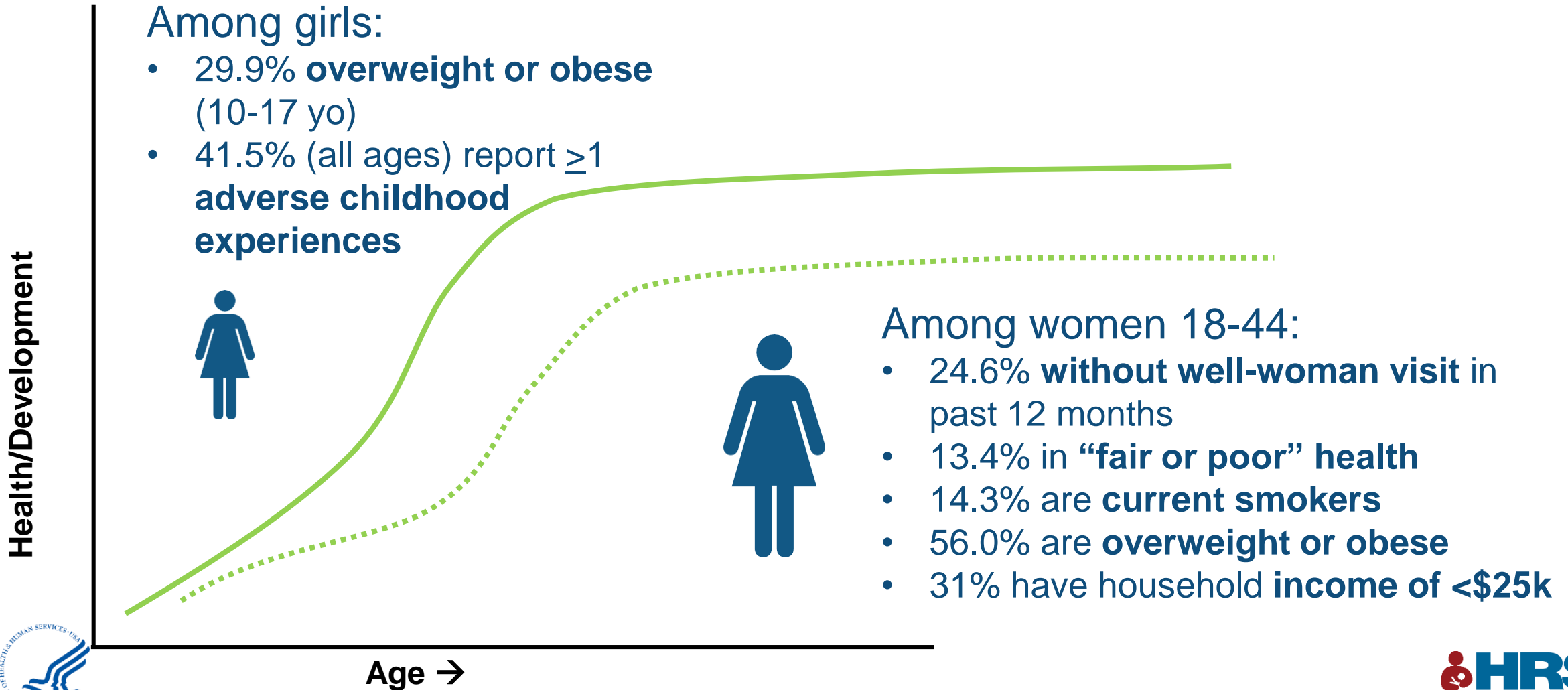




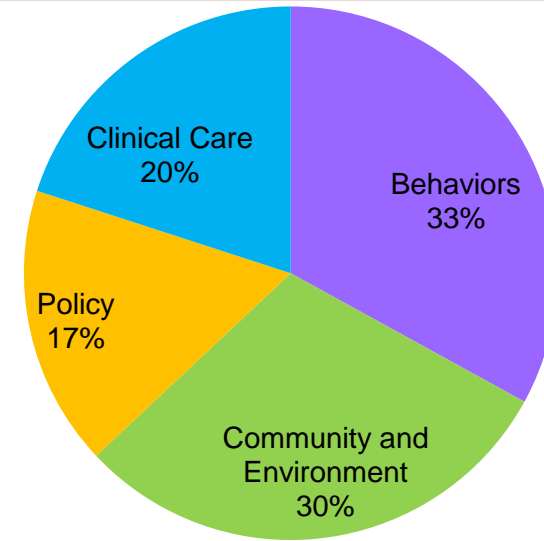
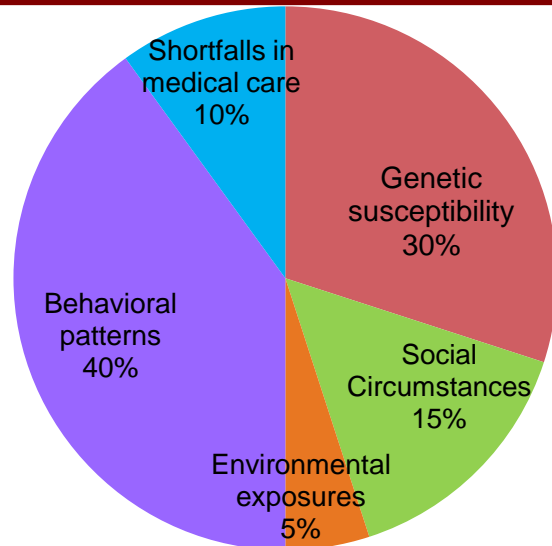
“Upstream” Thinking



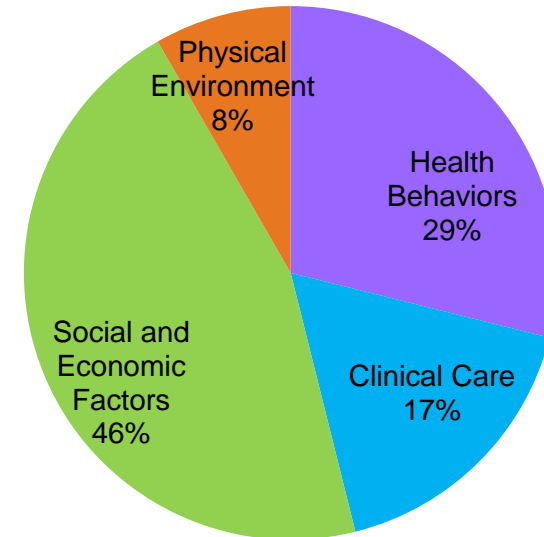
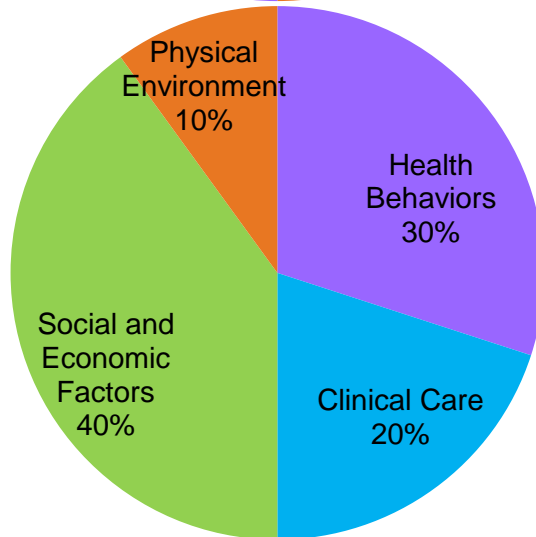
Life Course Approach



What Determines Health?



**Health
care
accounts
for only
10-20%
of overall
health**



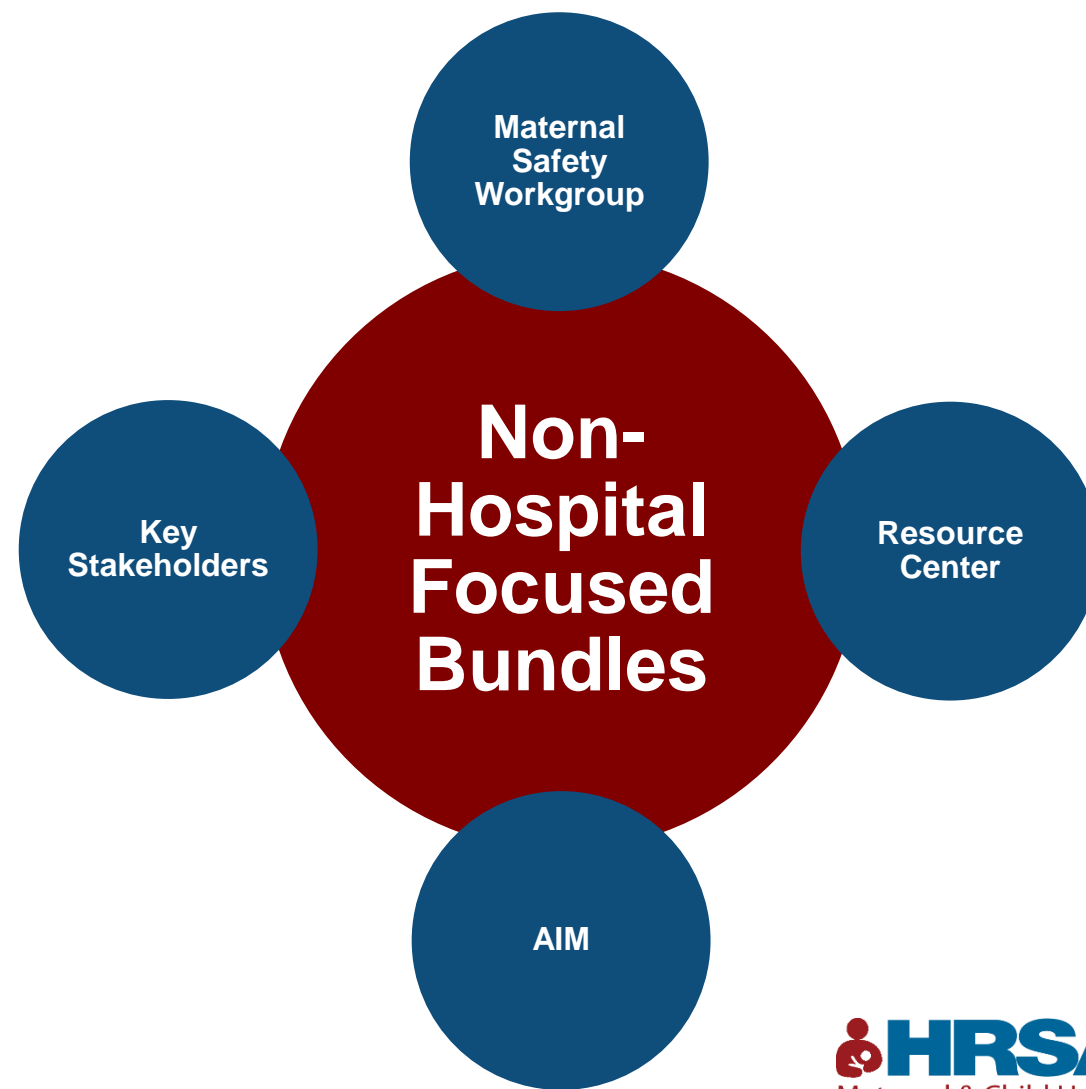
UPSTREAM: Focus on Prevention

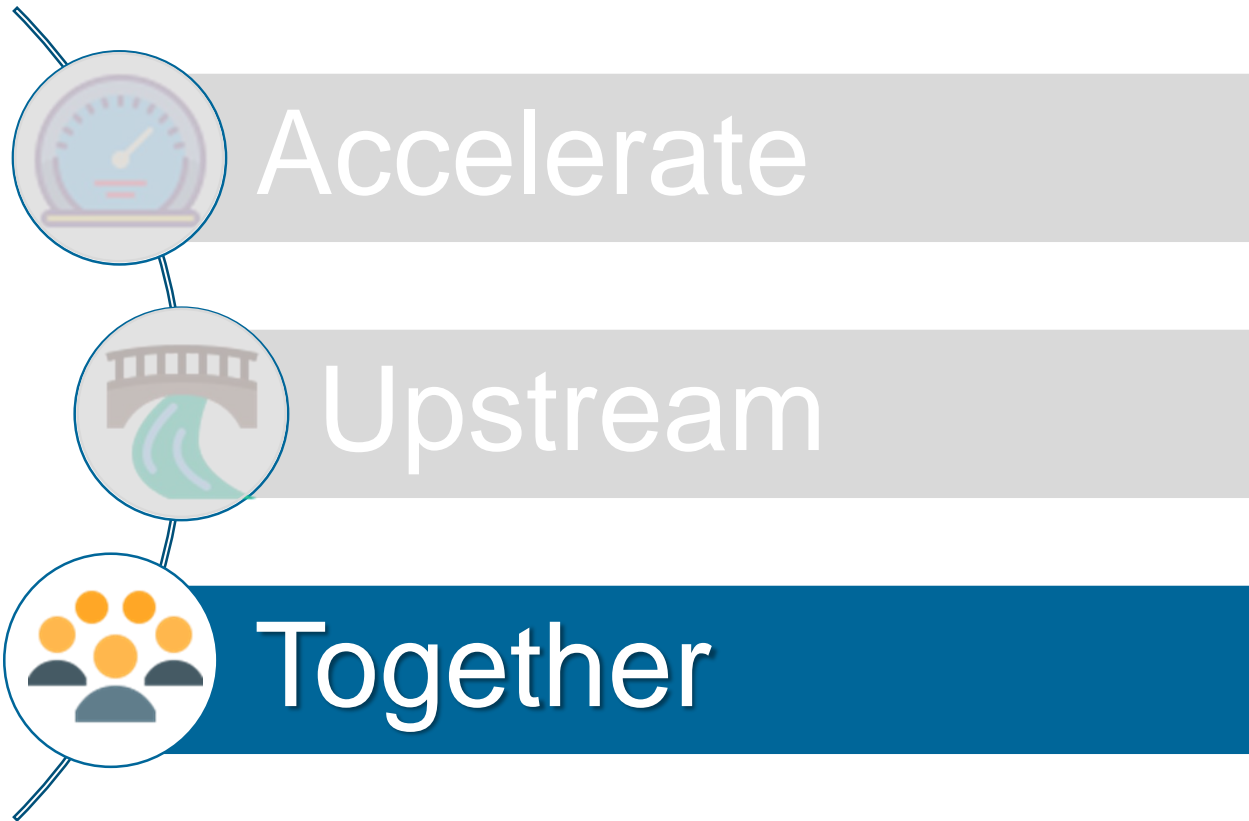


UPSTREAM: Non-Hospital Interventions

AIM Community Care Initiative (AIM-CCI)

- In 2011-2015, nearly 2/3 of pregnancy-related deaths in the U.S. occurred during pregnancy or one week to one year after delivery
- AIM-CCI Pilot sites:
 - New Orleans, LA
 - Grand Rapids, MI
 - Atlanta, GA
 - Jackson, MS





TOGETHER: Federal/State Partnerships

- **Title V MCH Block Grant**
 - Reaches 92% of pregnant women, 98% of infants, and 59% of all children nationally
- **Texas FY20 Application:**
 - Proposed activities:
 - Implement health equity strategies
 - Enhance health and safety efforts
 - Support health education and resources for families and providers
 - Related performance measures:
 - Disparity between black/white severe maternal morbidity
 - Health status of women of childbearing age
 - Pregnancy smoking



TOGETHER: Hearing the Voices of Women

CDC's "Hear Her" Campaign

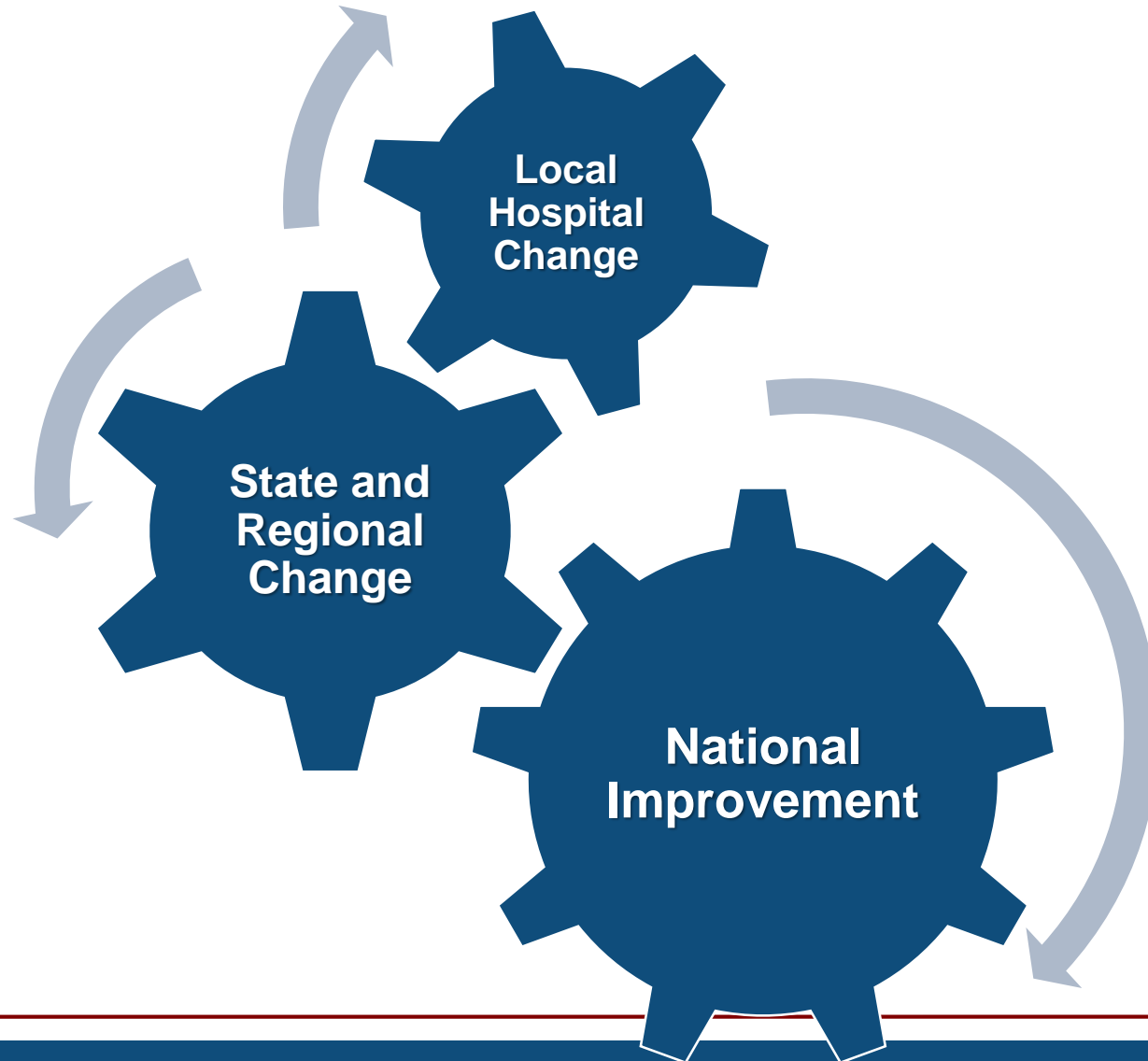
A graphic for the CDC's "Hear Her" campaign. On the left is a close-up portrait of a Black woman with long dark hair, looking directly at the camera with a neutral expression. To her right, the word "HEAR" is written in large, bold, white capital letters. Below it, "HEAR HER concerns" is written in smaller, teal capital letters. A vertical line separates this from the right side, which contains the text "700 women die every year in the United States from pregnancy-related complications" in white and teal.

HEAR
HEAR HER concerns

700 women die
every year in the United States
from pregnancy-related
complications

<http://www.cdc.gov/hearher>

TOGETHER: What You Do Matters!



Communities

Health Systems

Patients and
Families

Providers

Health Facilities

Contact Information

Michael Warren, Michael D. Warren, MD, MPH, FAAP

Associate Administrator

Maternal and Child Health Bureau (MCHB)

Health Resources and Services Administration (HRSA)

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Web: mchb.hrsa.gov



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Joint Commission's New Standards for Maternal Safety: Practical Implementation

Texas AIM Summit, December 8, 2020

M. Kathryn Menard, MD MPH



SCHOOL OF MEDICINE

Obstetrics and Gynecology



LoMC

Levels of Maternal Care

All Texas hospitals that provide OB care need maternity state designation by **August 31, 2021** to receive Medicaid funding



R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 24, August 21, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

Provision of Care, Treatment, and Services standards for maternal safety

Effective July 1, 2020, 13 new elements of performance (EPs) will be added to the standards for hospitals. These new requirements are within the Provision of Care, Treatment, and Services (PC) Chapter, PC.06.01.01 and PC.06.01.03 and are designed to improve the quality of care for patients at all stages of pregnancy and postpartum. The United States ranks 65th in the world for maternal death.¹ Because of worsening maternal morbidity and mortality, we conducted a literature review to determine what areas held the most potential impact. The review identified early recognition, and timely treatment for maternal hemorrhage as having the highest impact in states working on decreasing maternal complications. An advisory panel assembled by The Joint Commission, resulting in the new requirements.

New requirements release
 August 2019, originally
 effective July 2020
 Revised March 2020

New Standards for Perinatal Safety

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical *The Joint Commission Perspectives®*. To begin your subscription, call 800-746-6578 or visit <http://www.jcrinc.com>.

Please note: Where applicable, this report shows current standards and EPs first, with deleted language struck through. Then, the revised requirement follows in bold text, with new language underlined.

APPLICABLE TO THE HOSPITAL ACCREDITATION PROGRAM
 Effective July 1, 2020

Provision of Care, Treatment, and Services (PC) Chapter

PC.06.01.01
 Reduce the likelihood of harm related to maternal hemorrhage.

Element(s) of Performance for PC.06.01.01

- Complete an assessment using an evidence-based tool for determining maternal hemorrhage risk on admission to labor and delivery and on admission to postpartum. (See also PC.01.02.01, EPs 1 and 2; PC.01.02.03, EP 3; RC.02.01.01, EP 2)
- Develop written evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that include the following:
 - The use of an evidence-based tool that includes an algorithm for identification and treatment of hemorrhage
 - The use of an evidence-based set of emergency response medications that are immediately available on the obstetric unit
 - Required response team members and their roles in the event of severe hemorrhage
 - How the response team and procedures are activated
 - Blood bank plan and response for emergency release of blood products and how to initiate the hospital's massive transfusion procedures
 - Guidance on when to consult additional experts and consider transfer to a higher level of care
 - Guidance on how to communicate with patients and families during and after the event
 - Criteria for when a team debrief is required immediately after a case of severe hemorrhage

Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, anesthesiology, nursing, laboratory, and blood bank.

Standard PC.06.01.01: Reduce the likelihood of harm related to maternal hemorrhage.

Standard PC.06.01.03: Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia.



READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

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- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage



READINESS

Every Unit

- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

PATIENT SAFETY BUNDLE

Hypertension

PC.06.01.01: Reduce the likelihood of harm related to maternal hemorrhage.

1. Complete an assessment using an evidence-based tool for determining maternal hemorrhage risk on admission to labor and delivery and on admission to postpartum. (See also PC.01.02.01, EPs 1 and 2; PC.01.02.03, EP 3; RC.02.01.01, EP 2)
2. Develop written evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that include the following:
 - The use of an evidence-based tool that includes an algorithm for identification and treatment of hemorrhage
 - The use of an evidence-based set of emergency response medications that are immediately available on the obstetric unit
 - Required response team members and their roles in the event
 - How the response team and procedures are activated
 - Blood bank plan and response for emergency release of blood
 - Hospital's massive transfusion procedures
 - Guidance on when to consult additional experts and consultants
 - Guidance on how to communicate with patients and families
 - Criteria for when a team debrief is required immediately after the event

Note: The written procedures should be developed by a multidisciplinary team with representation from obstetrics, anesthesiology, nursing, laboratory, and pharmacy.
3. Each obstetric unit has a standardized, secured, and dedicated hemorrhage supply kit that must be stocked per the hospital's defined process and, at a minimum, contains the following:
 - Emergency hemorrhage supplies as determined by the hospital
 - The hospital's approved procedures for severe hemorrhage response
4. Provide education to all staff and providers who treat pregnant and postpartum patients about the hospital's hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.

Note: Education provided should be role-specific.
5. Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Drills include representation from each discipline identified in the hospital's hemorrhage response procedure and include a team debrief after the drill.
6. Review hemorrhage cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided by the hemorrhage response team during the event.
7. Provide education to patients (and their families including the designated support person whenever possible). At a minimum, education includes the following:
 - Signs and symptoms of postpartum hemorrhage during hospitalization that alert the patient to seek immediate care
 - Signs and symptoms of postpartum hemorrhage after discharge that alert the patient to seek immediate care



READINESS

Every unit

Bundle

Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compression stitches

TJC (3)

... standardized, secured, and dedicated **hemorrhage supply kit** that must be stocked per the hospital's defined process and, at a minimum, contains:

- Emergency hemorrhage supplies as **determined by the hospital**
- The hospital's approved procedures for severe hemorrhage response



READINESS

Every unit

Bundle

Immediate access to **hemorrhage medications** (kit or equivalent)

TJC (1)

Written procedures must include:

- An evidence-based set of emergency **response medications that are immediately available** on the obstetric unit



READINESS

Every unit

Bundle

Establish a **response team** – who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)

TJC

Written procedures must include:

- Required **response team** and their roles
- **How the response team and procedures are activated**
- Guidance on when to consult additional experts and consider transfer to higher level of care



READINESS

Every unit

Bundle

Establish **protocols for massive transfusion** and emergency release transfusion (O-negative, uncrossmatched)

TJC

Written procedures must include:

- Blood bank plan and response for **emergency release of blood products** and how to initiate the hospital's massive transfusion procedures



READINESS

Every unit

Bundle

Unit education on protocols, unit-based **drills** (with post-drill debriefs)

TJC

- Role-specific education to **all staff and providers** who treat pregnant and postpartum patients... **At a minimum at orientation, every 2 years and when procedures change**
- **Annual drills** to determine system issues to include all disciplines mentioned in the procedures.
- Include a **team debrief** after the drill.



RECOGNITION & PREVENTION

Every patient

Bundle

Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)

TJC

Complete an assessment using an evidence-based tool for determining maternal hemorrhage risk

- on admission to Labor & Delivery
- **on admission to Postpartum**



RECOGNITION & PREVENTION

Every patient

Bundle

Measurement of **cumulative blood loss** (formal, as quantitative as possible)

TJC

Written procedures must include:

- the use of an evidence-based tool that includes an algorithm for identification... of hemorrhage



RECOGNITION & PREVENTION

Every patient

Bundle

Active management of 3rd stage of labor (department-wide protocol)

TJC

{No specific mention of 3rd stage management}



RESPONSE

Every hemorrhage

Bundle

Unit-standard, **stage-based, obstetric hemorrhage emergency management plan** with checklists

TJC

Develop written evidence-based procedures for **stage-based management** of pregnant and postpartum patients who experience maternal hemorrhage

- The written procedures should be developed by a multi-disciplinary team that includes Obstetrics, Anesthesiology, Nursing, Laboratory, and Blood Bank.



RESPONSE

Every hemorrhage

Bundle

Support program for patients, families, and staff for all significant hemorrhages

TJC

- Written procedures must include guidance on how to **communicate with patients/families** during/after event
- Provide **education to patients** (and family/support persons) that includes (at minimum) signs and symptoms of postpartum hemorrhage that alert the patient to seek immediate care:
 - during hospitalization
 - after discharge

REPORTING/SYSTEMS LEARNING

Every unit

Bundle	Joint Commission
Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities	Written procedures must include criteria for when a team debrief is required immediately after a case of severe hemorrhage.
Multidisciplinary review of serious hemorrhages for systems issues	Review hemorrhage cases that meet hospital-established criteria to evaluate effectiveness of care, treatment, and services provided by the hemorrhage response team during the event
Monitor outcomes and process metrics in perinatal quality improvement (QI) committee.	{No mention of metrics, monitoring, QI process}

Standard PC.06.01.01: Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia.

1. Develop written evidence-based procedures for measuring and remeasuring blood pressure. These procedures include criteria that identify patients with severely elevated blood pressure.

2. Develop written evidenced-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes the following:

- The use of an evidence-based set of emergency response medications that are stocked and immediately available on the obstetric unit
- The use of seizure prophylaxis
- Guidance on when to consult additional experts and consider transfer to a higher level of care
- Guidance on when to use continuous fetal monitoring
- Guidance on when to consider emergent delivery
- Criteria for when a team debrief is required

Note: The written procedures should be developed by a multidisciplinary team representation from obstetrics, emergency department, anesthesiology, nursing, and pharmacy.

3. Provide role-specific education to all staff and providers who treat pregnant/postpartum patients about the hospital's evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.

Note: The emergency department is often where patients with symptoms or signs of severe hypertension present for care after delivery. For this reason, education should be provided to staff and providers in emergency departments regardless of the hospital's ability to provide labor and delivery services.

4. Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Severe hypertension/preeclampsia drills include a team debrief.

5. Review severe hypertension/preeclampsia cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided to the patient during the event.

6. Provide printed education to patients (and their families including the designated support person whenever possible). At a minimum, education includes:

- Signs and symptoms of severe hypertension/preeclampsia during hospitalization that alert the patient to seek immediate care
- Signs and symptoms of severe hypertension/preeclampsia after discharge that alert the patient to seek immediate care
- When to schedule a postdischarge follow-up appointment

Elements of Performance for PC.06.03.01

1. Develop written evidence-based **procedures for measuring** and remeasuring blood pressure. These procedures include criteria that **identify patients** with severely elevated blood pressure.



RECOGNITION & PREVENTION

Every Patient

- Standard protocol for measurement and assess all pregnant and postpartum women
- Standard response to maternal early warning sig investigating patient symptoms and assessment (AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women about signs and symptoms of hypertension and preeclampsia

Elements of Performance for PC.06.03.01

2. Develop written evidenced-based **procedures for managing pregnant and postpartum patients** with severe hypertension/preeclampsia that includes the following:

- The use of an evidence-based set of emergency response **medications that are stocked and immediately available** on the obstetric unit
- The use of **seizure prophylaxis**
- Guidance on when to **consult additional experts** and **consider transfer** to a higher level of care
- **Guidance on when to use continuous fetal monitoring**
- **Guidance on when to consider emergent delivery**
- Criteria for when a **team debrief** is required

Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, emergency department, anesthesiology, nursing, laboratory, and pharmacy.

RESPONSE

Every case of severe hypertension/preeclampsia

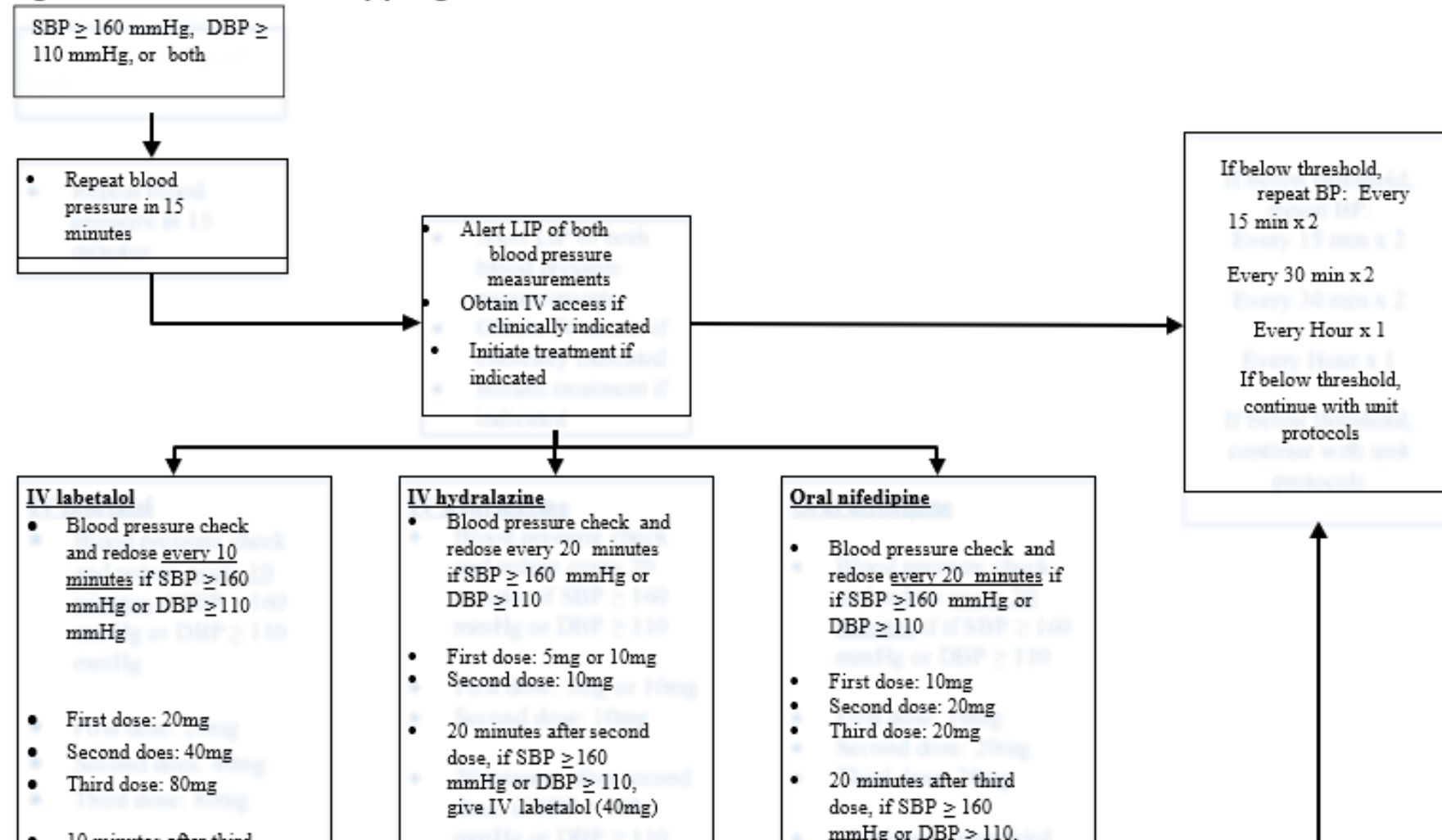
- Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
 - Severe hypertension
 - Eclampsia, seizure prophylaxis, and magnesium over-dosage
 - Postpartum presentation of severe hypertension/preeclampsia
- Minimum requirements for protocol:
 - Notification of physician or primary care provider if systolic BP \geq 160 or diastolic BP \geq 110 for two measurements within 15 minutes
 - After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)
 - Includes onset and duration of magnesium sulfate therapy
 - Includes escalation measures for those unresponsive to standard treatment
 - Describes manner and verification of follow-up within 7 to 14 days postpartum
 - Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

Note: "Facility-wide" indicates all areas where pregnant or postpartum women receive care. (E.g. L&D, postpartum critical care, emergency department, and others depending on the facility).

Management of Hypertension in Pregnant or Postpartum Patients



Figure 1. Medication Therapy Algorithm



Elements of Performance for PC.06.03.01

3. Provide role-specific **education to all staff and providers** who treat pregnant/postpartum patients about the hospital's evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or **every two years**.

Note: The **emergency department** is often where patients with symptoms or signs of severe hypertension present for care after delivery. For this reason, education should be provided to staff and providers in emergency departments regardless of the hospital's ability to provide labor and delivery services.

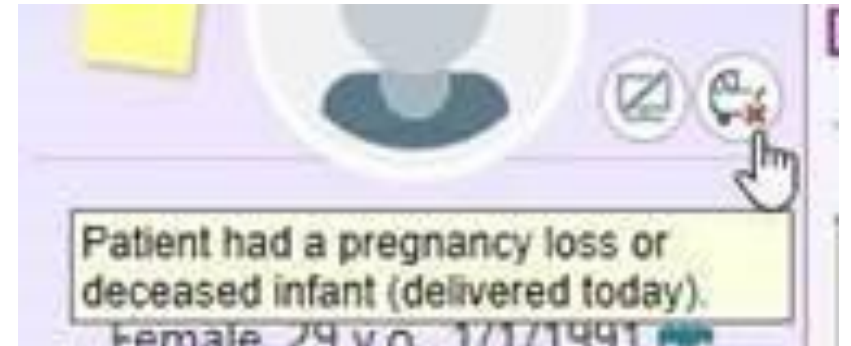


READINESS

Every Unit

- Standards for early warning signs, diagnostic criteria, mo severe preeclampsia/eclampsia (include order sets and a
- Unit education on protocols, unit-based drills (with post-
- Process for timely triage and evaluation of pregnant and hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension should be stocked and immediately available on L&D an patients may be treated. Include brief guide for administ
- System plan for escalation, obtaining appropriate consul transport, as needed

Identify women at risk: EPIC tool “hover to discover”



Ob HTN infographic for non-Ob teams



SEVERE HYPERTENSION IN PREGNANT & POSTPARTUM PATIENTS

HOVER TO DISCOVER IN EPIC!



- ✓ The baby carriage icon indicates a recently pregnant patient status (the time from delivery will noted be in parenthesis next to the icon)
- ✓ The stork icon indicates the patient is pregnant
- ✓ Only applies to patients that receive care where EPIC is used



URGENT OB CONTACTS

Vocera: "URGENT CALL L&D CHARGE NURSE"

Vocera: "URGENT CALL OB CHIEF"

DEFINITION

**BP ≥ 160/
- 110**



- ✓ Defined as any TWO systolic blood pressure greater than or equal to 160 OR diastolic blood pressure greater than or equal to 110 that has been taken correctly AND persists for 15 minutes or more
- ✓ Warrants immediate attention from the provider to prevent seizures, stroke or death in the pregnant or recently pregnant (postpartum) patient

GOAL

TREAT WITHIN 60 MINUTES OF DIAGNOSIS!

TREATMENT ALGORITHMS

Labetalol, Hydralazine and Nifedipine

<https://unchealthcare-uncmc.policystat.com/policy/5219857/latest/>

Consider Magnesium Sulfate for seizure prophylaxis

Elements of Performance for PC.06.03.01

4. **Conduct drills at least annually** to determine system issues as part of ongoing quality improvement efforts. Severe hypertension/preeclampsia drills include a **team debrief**.



READINESS

Every Unit

- Standards for early warning signs, diagnostic criteria, mo severe preeclampsia/eclampsia (include order sets and a
- Unit education on protocols, unit-based drills (with post-
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- System plan for escalation, obtaining appropriate consul transport, as needed

Elements of Performance for PC.06.03.01

**5. Review severe hypertension/
preeclampsia cases** that meet
criteria established by the hospital
to evaluate the effectiveness of the
care, treatment, and services
provided to the patient during the
event.



REPORTING/SYSTEMS LEARNING

ry unit

Establish a culture of huddles for high risk patients
identify successes and opportunities

Multidisciplinary review of all severe hypertension
ICU for systems issues

Monitor outcomes and process metrics

Elements of Performance for PC.06.03.01

6. **Provide printed education to patients** (and their families including the designated support person whenever possible). At a minimum, education includes:

- **Signs and symptoms** of severe hypertension/preeclampsia **during hospitalization** that alert the patient to seek immediate care
- **Signs and symptoms** of severe hypertension/preeclampsia **after discharge** that alert the patient to seek immediate care
- When to schedule a postdischarge **follow-up appointment**

RESPONSE

Every case of severe hypertension/preeclampsia

- Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
 - Severe hypertension
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 - Includes onset and duration of magnesium sulfate therapy
 - Includes escalation measures for those unresponsive to standard treatment
 - Describes manner and verification of follow-up within 7 to 14 days postpartum
 - Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

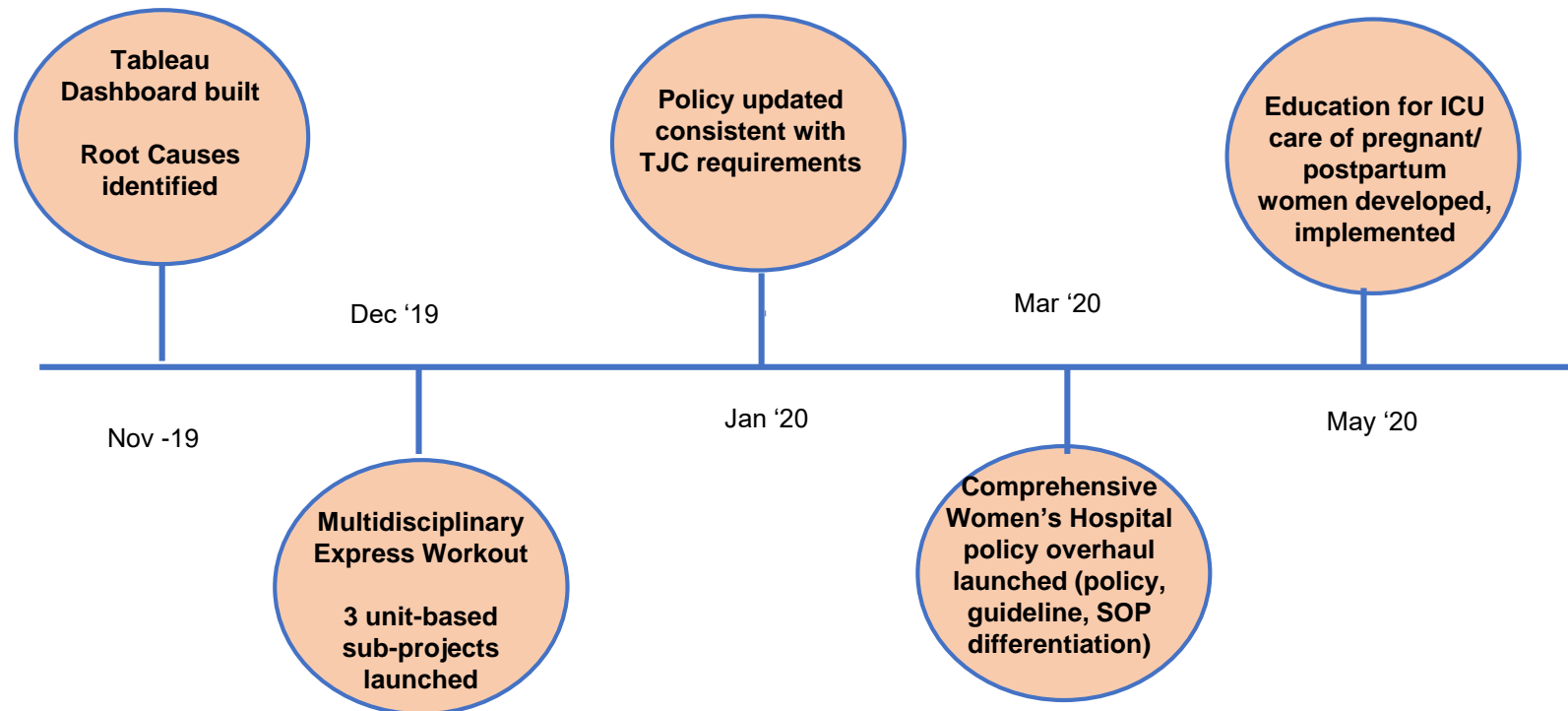
Note: "Facility-wide" indicates all areas where pregnant or postpartum women receive care. (E.g. L&D, postpartum critical care, emergency department, and others depending on the facility).

OB Value Stream Leadership Team

MFM, GOG, OB Anesthesia, Midwifery, FM (MCH), Newborn Nursery, Nursing

Hypertension

MAJOR MILESTONES:





Collaborative Learning and Quality Improvement

- Statewide Perinatal Quality Collaboratives

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html>

- Alliance for Innovation in Maternal Health (AIM)

<https://safehealthcareforeverywoman.org/aim/>



- Maternal Health Innovations

<https://maternalhealthlearning.org/>



Maternal Health
Learning & Innovation Center™



THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

Hospital Level of Care Designations for Maternal Care

December 8, 2020

Elizabeth Stevenson, BSN, RN, Designation Manager

Maternal Levels of Care

Why do we need maternal levels of care?

To provide support to improve maternal and neonatal care; to improve patient outcomes.

- There is a lack of standardization for perinatal care in hospitals.
- We have a very high maternal mortality rates in Texas.
- Texas ranked in the bottom 5% for birth of VLBW babies in a Level III NICU.
- There is a high cost of delivery-related services paid by Medicaid.



Texas Department of State
Health Services

Maternal Levels of Care

- Top Causes of Maternal Deaths in Texas
 - Cardiovascular/Coronary Conditions
 - Mental Health Disorders
 - Hemorrhage
 - Preeclampsia/Eclampsia
 - Infection
 - Embolism



Maternal Levels of Care

The Level of Care program promotes the standardization of hospital services and processes.

- The program promotes the use of current national standards.
- Standards are evidence-based.
- Quality and Performance Improvement is the basis for this work.



Maternal Levels of Care

- The Maternal Level of Care program standardizes the services provided by facilities based on their Level of Care.
- Services and patient acuity increase at every level.
 - Level I – Basic Care
 - Level II – Specialty Care
 - Level III – Subspecialty Care
 - Level IV – Comprehensive Care
- The goal of the Maternal Levels of Care program is to maintain quality perinatal care at all levels of service within the hospital.



Maternal Level of Care

- Patient Populations
 - Level I – Basic Care
 - Generally healthy patients, no significant risks identified
 - Level II – Specialty Care
 - Conditions with a low to moderate risks identified
 - Level III – Subspecialty Care
 - Low risk to significant complex conditions with high risks identified
 - Level IV – Comprehensive Care
 - Low risk to the most complex conditions, including fetuses, with high risks identified



Maternal Level of Care

Maternal Requirements

- Massive/Obstetrical Hemorrhage and Transfusion
- Hypertensive Disorders
- Sepsis/Systemic Infection
- Venous Thromboembolism
- Shoulder Dystocia
- Behavioral Health Disorders – depression, substance abuse and addiction
- Social Services and Pastoral Care

Alliance for Innovation on Maternal Health (AIM) and TexasAIM

- Obstetric Hemorrhage
- Severe Hypertension in Pregnancy
- Maternal Venous Thromboembolism
- Maternal Mental Health: Perinatal Depression and Anxiety
- Obstetric Care for Women with Opioid Use Disorder
- Support After a Severe Maternal Event
- Reduction of Peripartum Racial and Ethnic Disparities



Maternal Level of Care

- How are the hospitals evaluated for the provision of maternal care?
 - The designation process provides verification of services defined by each Level of Care.
 - A survey is conducted by subject matter experts to evaluate evidence demonstrating a facility's provision of care. The survey includes:
 - A review of documentation of the facility's program
 - Interviews with providers and staff
 - Tour of the facility
 - Review of medical records to evaluate the patient care provided
 - The DSHS designation program reviews evidence presented by the hospital to verify compliance with the rules.



Maternal Level of Care

Evidence of Compliance with Standards and Patient Outcomes

- Implementation and adherence to policies/procedures
- Experienced and trained staff available to coordinate and provide care
- Multi-disciplinary collaboration
- Effective Quality and Performance Improvement process
- Outreach to other healthcare providers to improve perinatal care throughout the region and state



Maternal Level of Care

- Performance Improvement
 - Plan begins with defined Standards of care.
 - Check – Identify events or variations / deviations from standard of care.
 - If yes, develop corrective action plan.
 - Implement and track the action plan.
 - Analyze data. Are the actions taken effective?
 - Was the desired goal met?
 - If yes, provide the evidence of the event resolution.
 - If not, corrective action plan needs revised.



Maternal Level of Care

- Outreach from QAPI Process
 - Review care provided prior to transfer.
 - Identify any opportunities for improvement.
 - Discuss findings with the facility the patient was transferred from.
 - Assist with education and/or processes for the hospital as appropriate.
 - Improved maternal outcomes is the goal.



Maternal Level of Care

- Comparison of Programs
 - Standards of Care
 - Geographic considerations
 - Regional coordination
 - Certificate of Need



Thank you!

Hospital Level of Care Designations for Maternal Care

Elizabeth Stevenson, Designation Manager

Elizabeth.Stevenson@dshs.texas.gov Work Cell 512-284-1132

Session 2: Panel Discussion

Carrie Kroll

Facilitator



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Texas Department of State
Health Services

End of Session 2



TAKE A BREAK



10 Minutes





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**Texas Department of State
Health Services**

TexasAIM Making Health Care Safer for Every Mother



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Texas Department of State
Health Services



Manda Hall, MD



John W. Hellerstedt, MD



Aliyah Abdul-Wakil, MPH



Lisa M. Hollier MD, MPH, FACOG

Welcome and Introductions



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Health Services

Maternal Health and Safety: A State Public Health Priority

John W. Hellerstedt, MD

Commissioner, Texas Department of State Health Services (DSHS)



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Maternal Health and Safety: By the Numbers (Data Updates)

Aliyah Abdul-Wakil

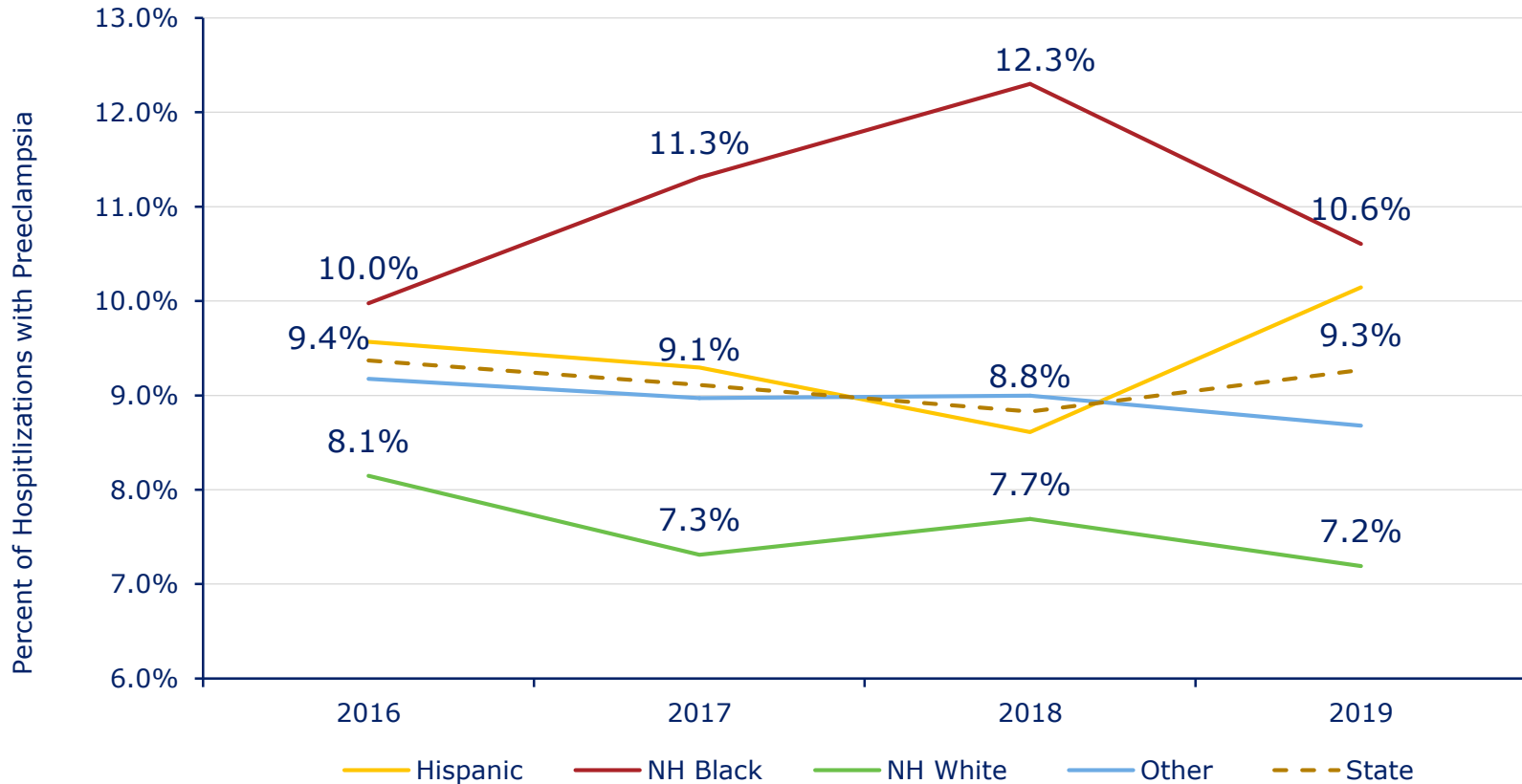
DSHS



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Severe Maternal Morbidity among Preeclampsia Cases by Race from 2016-2019



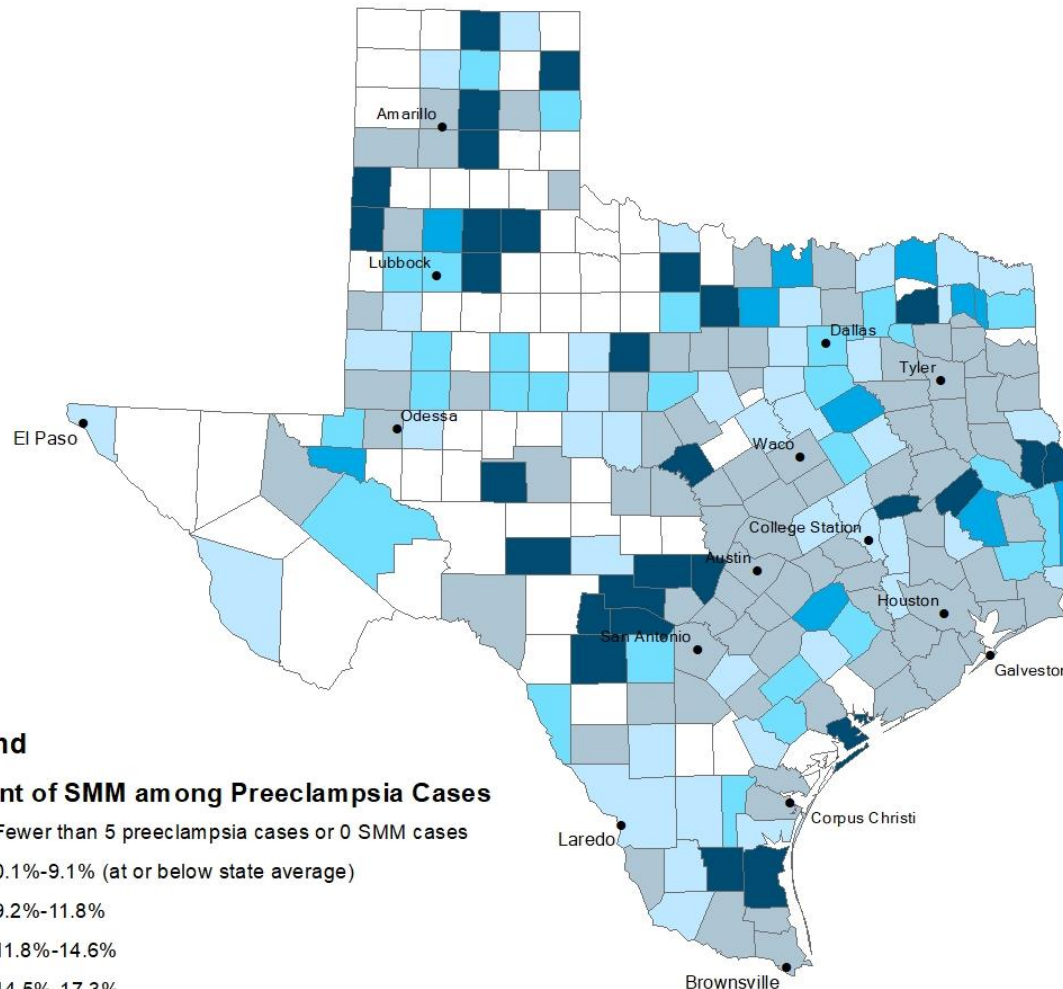
Source: Hospital Inpatient Discharge Public Use Data File, 2016-2019, Texas Health Care Information Collection, DSHS
 The AIM SMM codes list v6 6-27-2020 was used to identify preeclampsia cases and SMM
 Prepared by: Maternal Child Health Epidemiology Unit
 Dec 2020

Severe Maternal Morbidity among Preeclampsia Cases by County, TX 2016-2019



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Legend

Percent of SMM among Preeclampsia Cases

- Fewer than 5 preeclampsia cases or 0 SMM cases
- 0.1%-9.1% (at or below state average)
- 9.2%-11.8%
- 11.8%-14.6%
- 14.5%-17.3%
- 17.4% and above

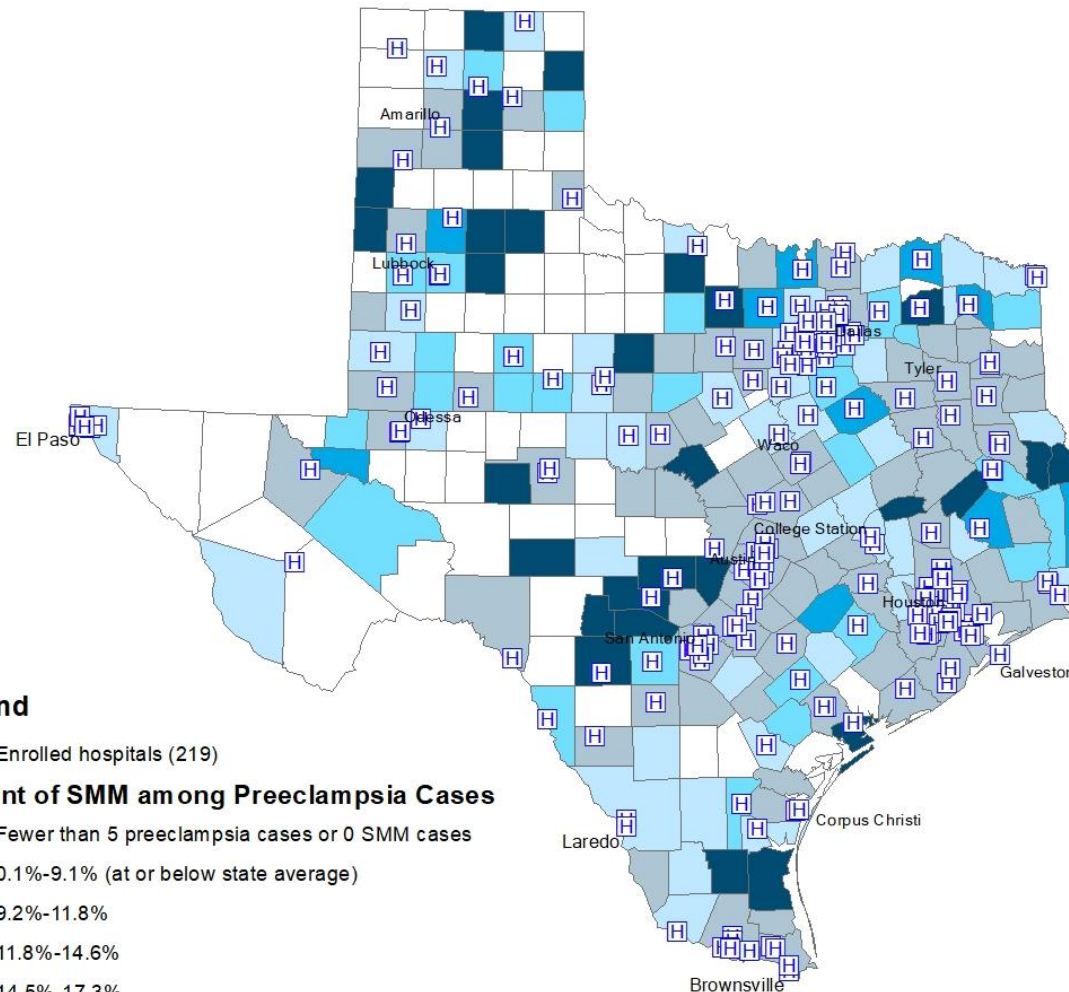
Source: Texas AIM Enrollment Data, Hospital Inpatient Discharge Public Use Data File, 2016-2019, Texas Health Care Information Collection, DSHS.
The AIM SMM code list v6-27-2020 was used to identify preeclampsia and SMM cases.
Prepared by: Maternal & Child Health Epidemiology, 12/4/2020.

Severe Maternal Morbidity among Preeclampsia Cases and Texas AIM Hospitals, TX 2016-2019



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Legend

Enrolled hospitals (219)

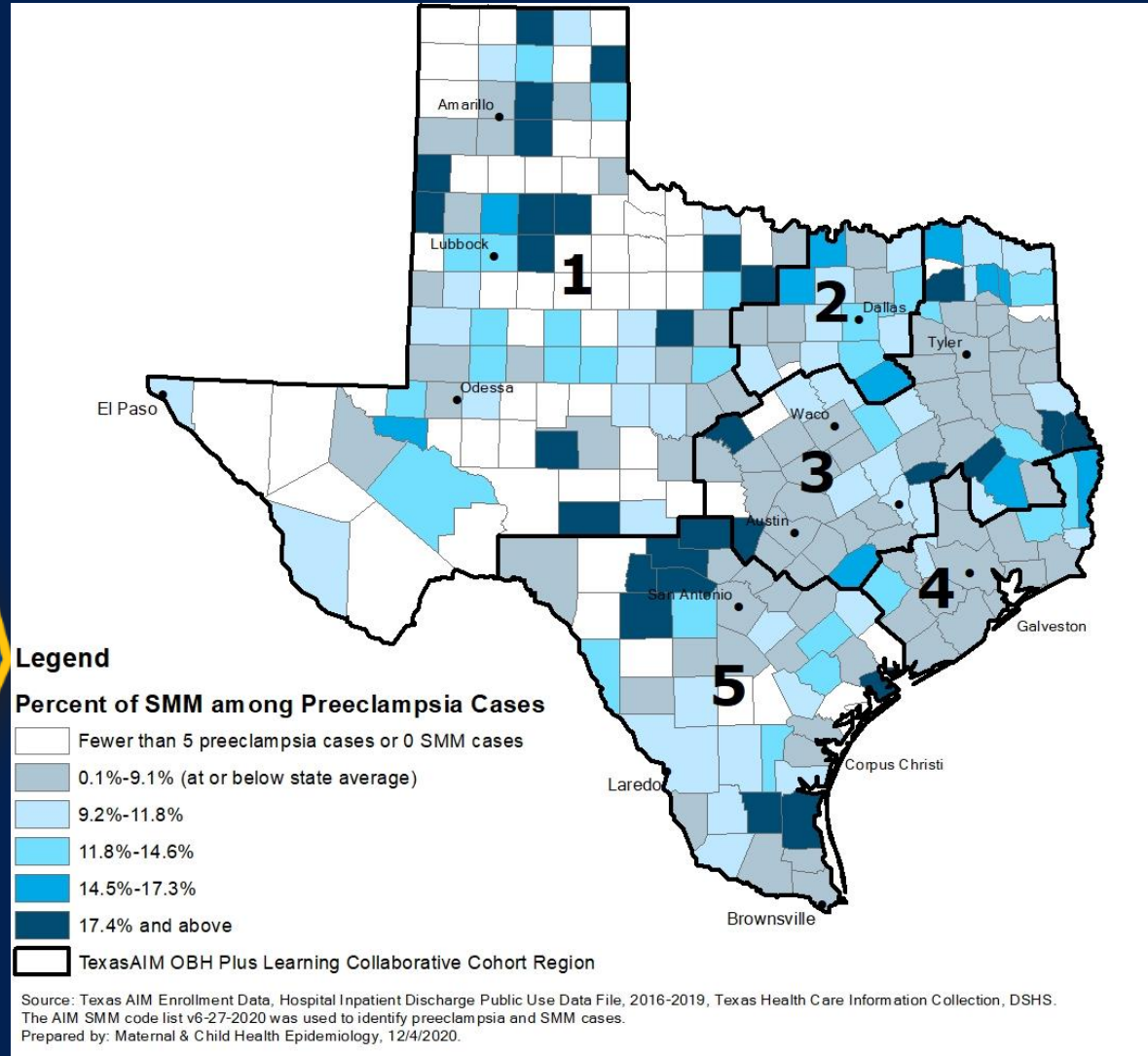
Percent of SMM among Preeclampsia Cases

- Fewer than 5 preeclampsia cases or 0 SMM cases
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- 9.2%-11.8%
- 11.8%-14.6%
- 14.5%-17.3%
- 17.4% and above

Source: Texas AIM Enrollment Data, Hospital Inpatient Discharge Public Use Data File, 2016-2019, Texas Health Care Information Collection, DSHS.
The AIM SMM code list v6-27-2020 was used to identify preeclampsia and SMM cases.
Prepared by: Maternal & Child Health Epidemiology, 12/4/2020.

Severe Maternal Morbidity among Preeclampsia Cases by Cohort Region, TX 2016-2019

~55,000 Preeclampsia Cases in Texas from 2016-2019



1	9.2%-11.8% (30% above state average)
2	11.8%-14.6% (60% above state average)
3	0.1%-9.1% (at or below state average)
4	0.1%-9.1% (at or below state average)
5	0.1%-9.1% (at or below state average)



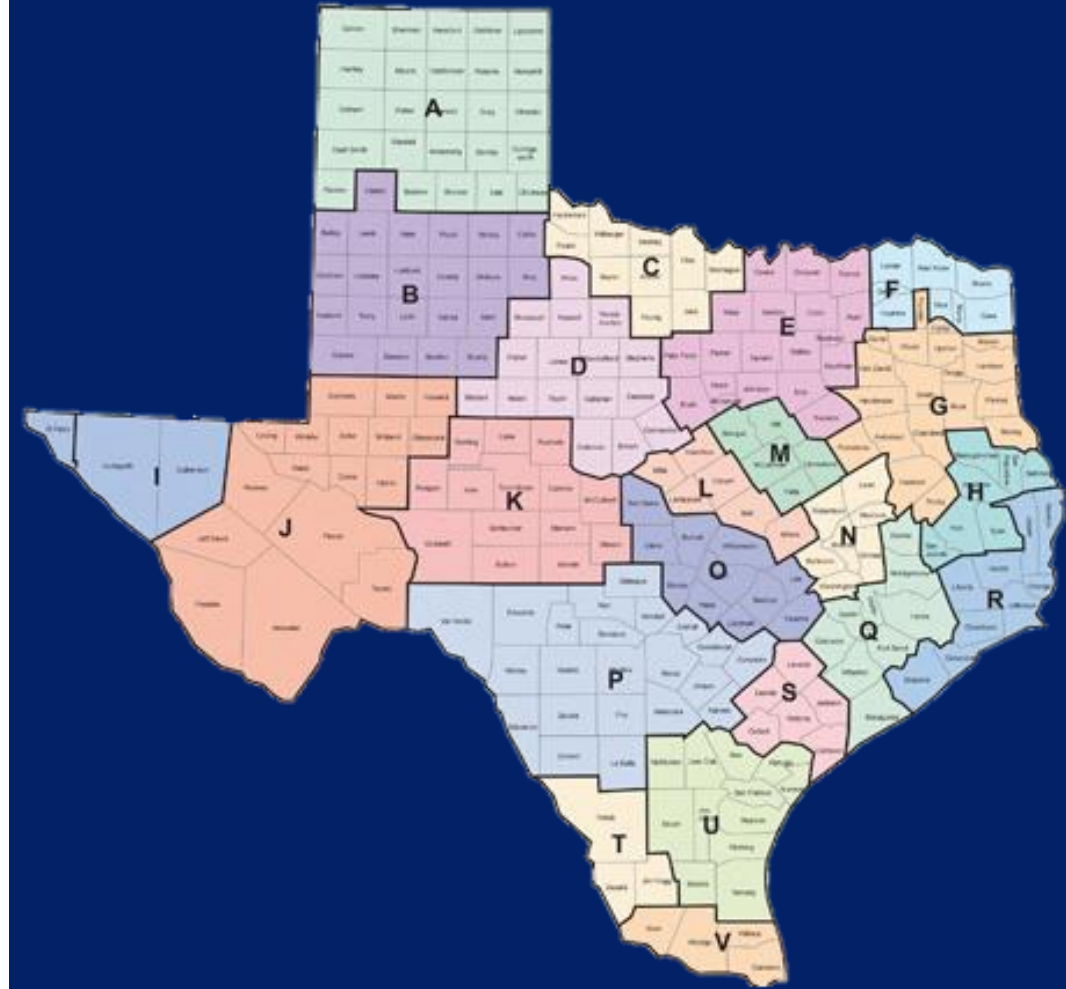
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Severe Maternal Morbidity Among Preeclampsia Cases, Texas, 2016-2019

By Perinatal Care Region (PCR)

PCR A	0.1%-9.1% (at or below state average)
PCR B	11.8%-14.6% (60% above state average)
PCR C	9.2%-11.8% (30% above state average)
PCR D	9.2%-11.8% (30% above state average)
PCR E	11.8%-14.6% (60% above state average)
PCR F	11.8%-14.6% (60% above state average)
PCR G	0.1%-9.1% (at or below state average)
PCR H	11.8%-14.6% (60% above state average)
PCR I	0.1%-9.1% (at or below state average)
PCR J	0.1%-9.1% (at or below state average)
PCR K	0.1%-9.1% (at or below state average)
PCR L	0.1%-9.1% (at or below state average)
PCR M	0.1%-9.1% (at or below state average)
PCR N	9.2%-11.8% (30% above state average)
PCR O	0.1%-9.1% (at or below state average)
PCR P	0.1%-9.1% (at or below state average)
PCR Q	0.1%-9.1% (at or below state average)
PCR R	0.1%-9.1% (at or below state average)
PCR S	9.2%-11.8% (30% above state average)
PCR T	9.2%-11.8% (30% above state average)
PCR U	0.1%-9.1% (at or below state average)
PCR V	0.1%-9.1% (at or below state average)





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Health Services**

Making Healthcare Safer for EVERY Mother

Lisa M. Hollier, MD, MPH, FACOG

12/8/2020

Pregnancy-Related Death Case Review Findings



Pregnancy-Related Deaths

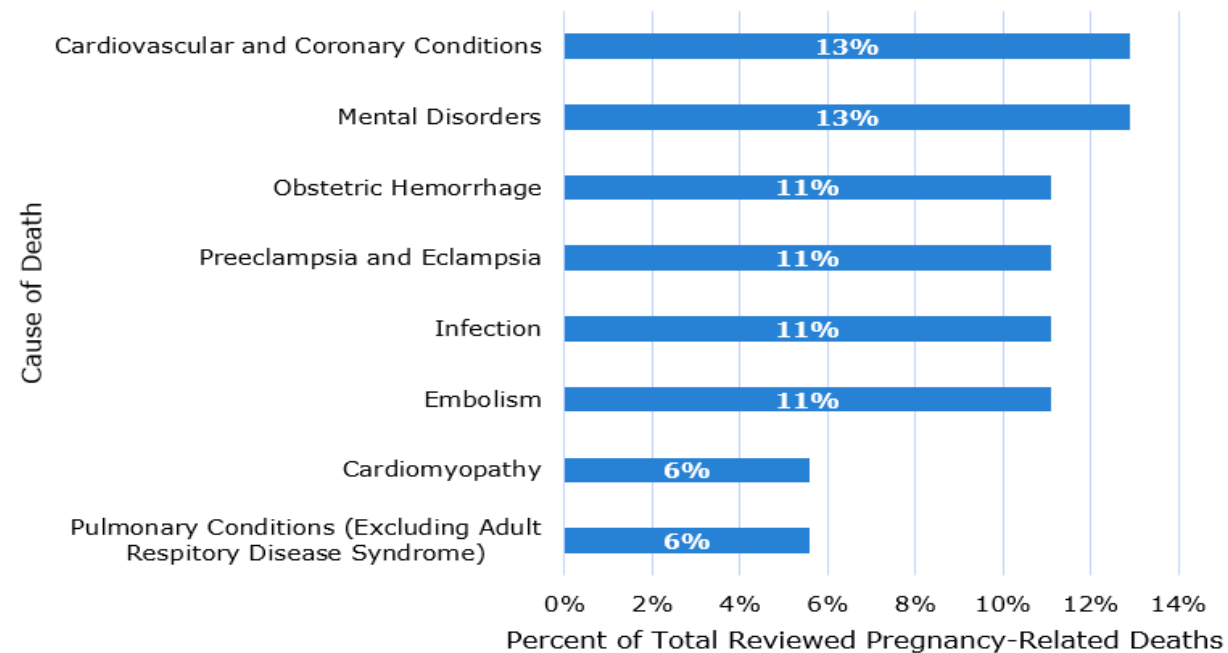
Nearly 40 percent of the reviewed 2013 pregnancy-associated cases were identified as being *pregnancy-related*.

A *pregnancy-related death* is the death of a woman during pregnancy or within one year of the end of pregnancy **from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.**

Top Causes of Death

Eight underlying causes of death accounted for 82 percent of all pregnancy-related death among reviewed 2013 cases.

Chart F-1: Leading Underlying Causes of Reviewed Pregnancy-Related Deaths, Texas, 2013 (N=44 of 54 Reviewed Pregnancy-Related Deaths)ⁱ

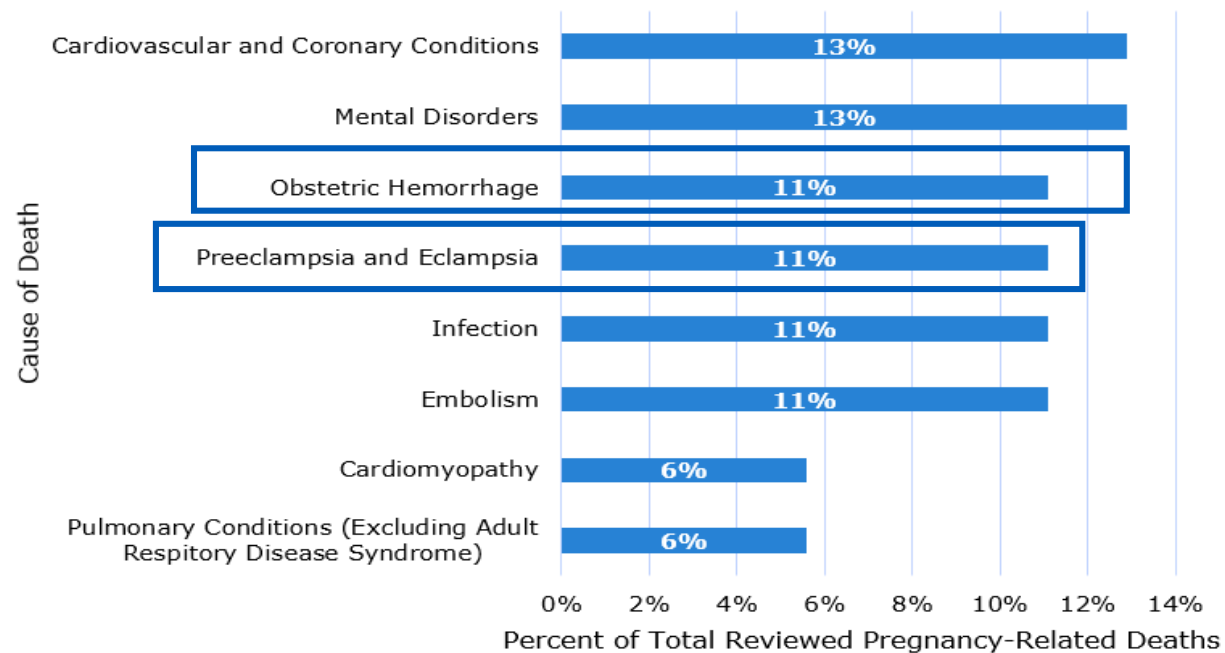


PREPARED BY: Healthy Texas Mothers and Babies Branch, Maternal & Child Health Unit, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Top Causes of Death

Eight underlying causes of death accounted for 82 percent of all pregnancy-related death among reviewed 2013 cases.

Chart F-1: Leading Underlying Causes of Reviewed Pregnancy-Related Deaths, Texas, 2013 (N=44 of 54 Reviewed Pregnancy-Related Deaths)ⁱ



PREPARED BY: Healthy Texas Mothers and Babies Branch, Maternal & Child Health Unit, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Disparity in Mortality

Disparities persist in maternal mortality. Non-Hispanic Black women are disproportionately impacted.

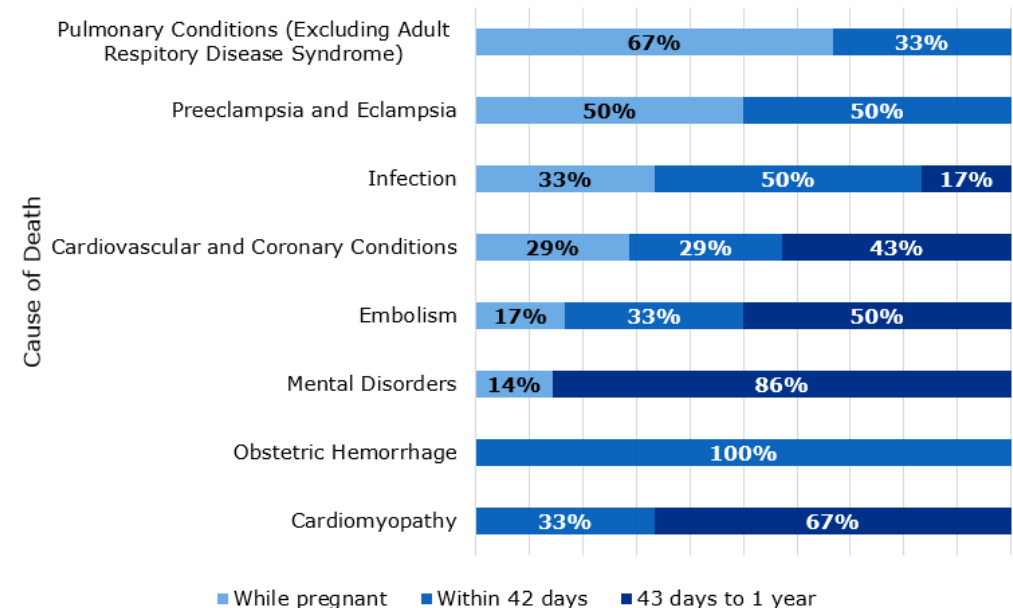
Race/Ethnicity	Racial/Ethnic Distribution of Reviewed Pregnancy-Related Deaths in 2013	Racial/Ethnic Distribution of Live Births in 2013
Non-Hispanic Black Women	31%	11%
Hispanic Women	26%	48%
Other Races/Ethnicities	2%	6%
Non-Hispanic White Women	41%	34%

Timing of Maternal Death

Timing of death in relation to pregnancy varies across leading underlying causes of pregnancy-related death.



Chart F-2: Top Underlying Causes of Reviewed Pregnancy-Related Deaths by Timing of Death in Relation to Pregnancy, Texas 2013 (N=44 of 54 Reviewed Pregnancy-Related Deaths)¹



PREPARED BY: Healthy Texas Mothers and Babies Branch, Maternal & Child Health Unit, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Graphic source: : Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

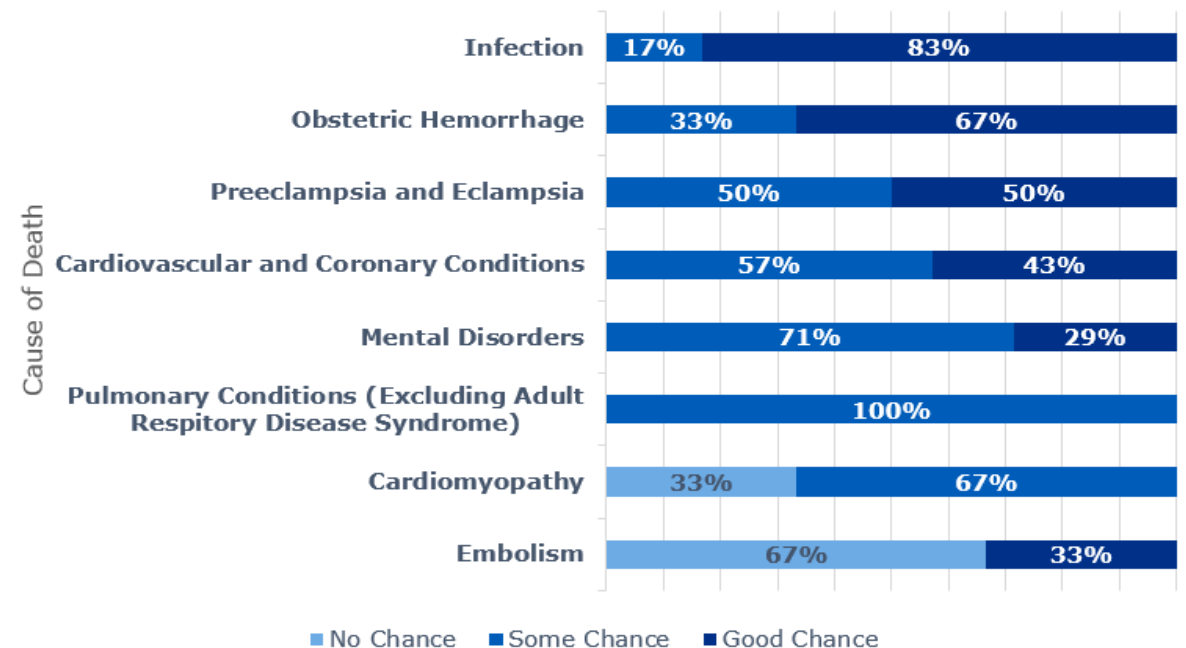
Preventability

Most pregnancy-related deaths were preventable.

89 percent of the reviewed pregnancy-related deaths in 2013 were **preventable**.

A death is considered *preventable* if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, community, provider, or systems factors.

Chart F-3: Degree of Preventability for Top Underlying Causes of Reviewed Pregnancy-Related Deaths by Rating of Chance to Alter Outcome, Texas, 2013 (N=44 of 54 Reviewed Pregnancy-Related Deaths)ⁱ



PREPARED BY: Healthy Texas Mothers and Babies Branch, Maternal & Child Health Unit, Division for Community Health Improvement, the Department of State Health Services (DSHS).

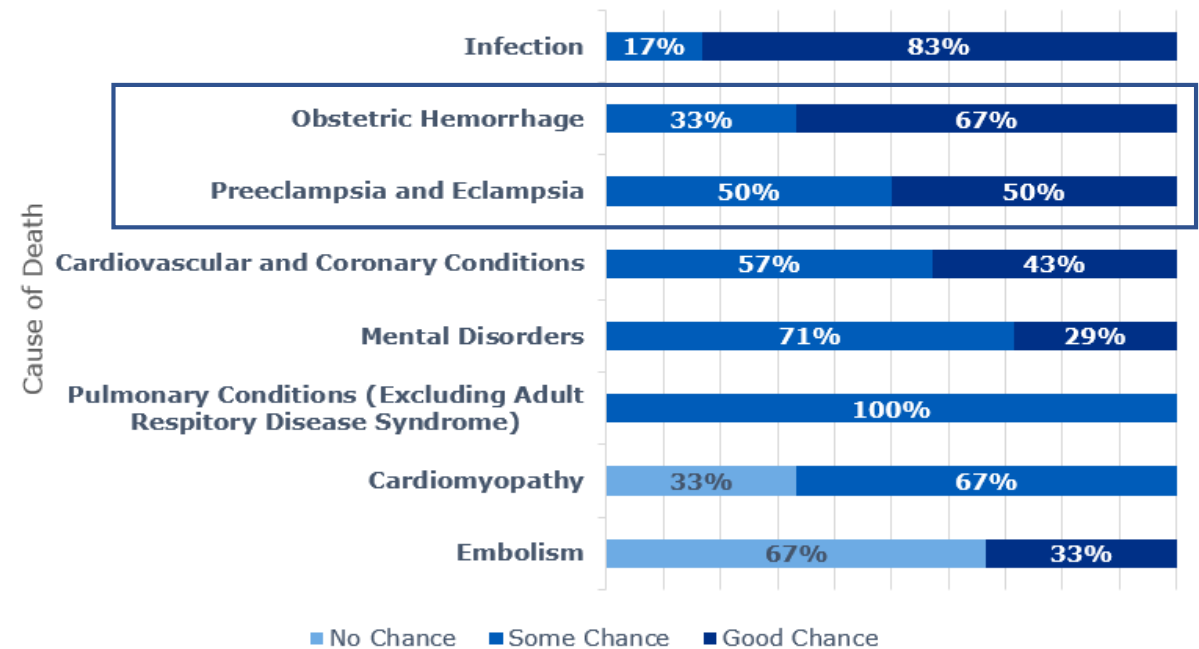
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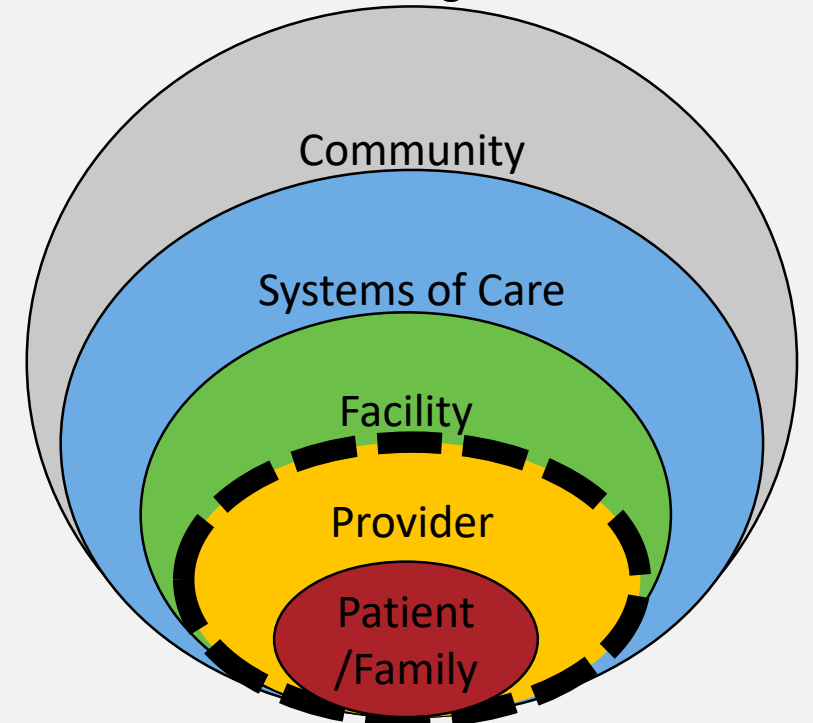


Contributing Factors

Top Contributing Factors Identified by the Texas Maternal Mortality and Morbidity Review Committee: **Provider Domain (24%)**

1. Clinical Skill/Quality of Care (22%)
2. Lack of Continuity of care (14%)
3. Delay - referring for care, treatment, or follow up care/action (13%)
4. Knowledge- inadequate education, knowledge or understanding (14%)
5. Failure to screen/inadequate assessment of risk (13%)

Domains of Contributing Factor Themes in a Social-Ecological Model

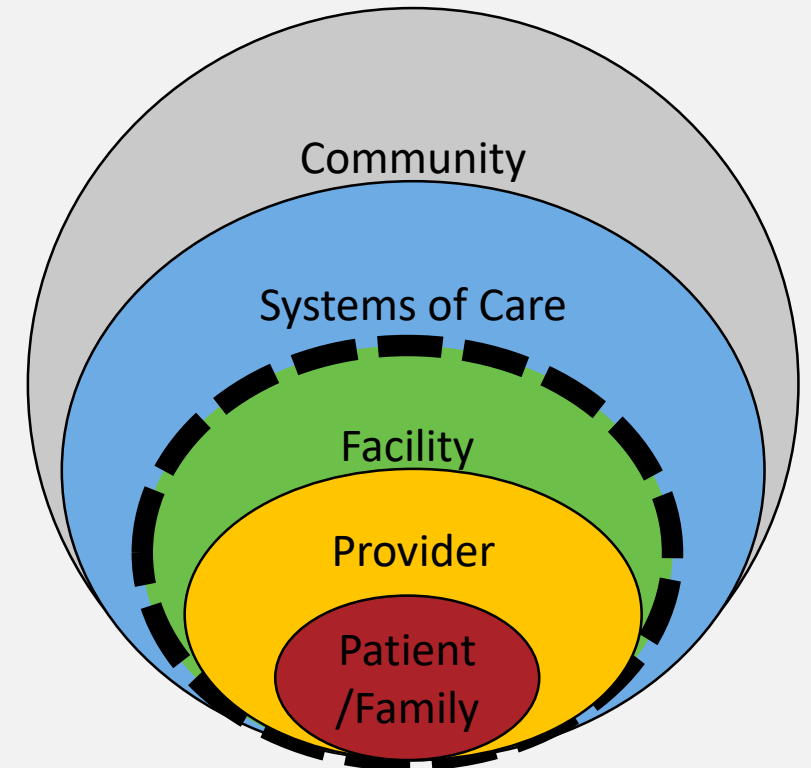


Contributing Factors

Top Contributing Factors Identified by the Texas Maternal Mortality and Morbidity Review Committee: **Facility Domain (17%)**

1. Lack of Continuity of Care (17%)
2. Clinical Skill/ Quality of Care (14%)
3. Delay (13%)
4. Lack of Standardized Policies and Procedures (11%)
5. Lack of knowledge regarding the importance of the event or of treatment or follow-up (10%)

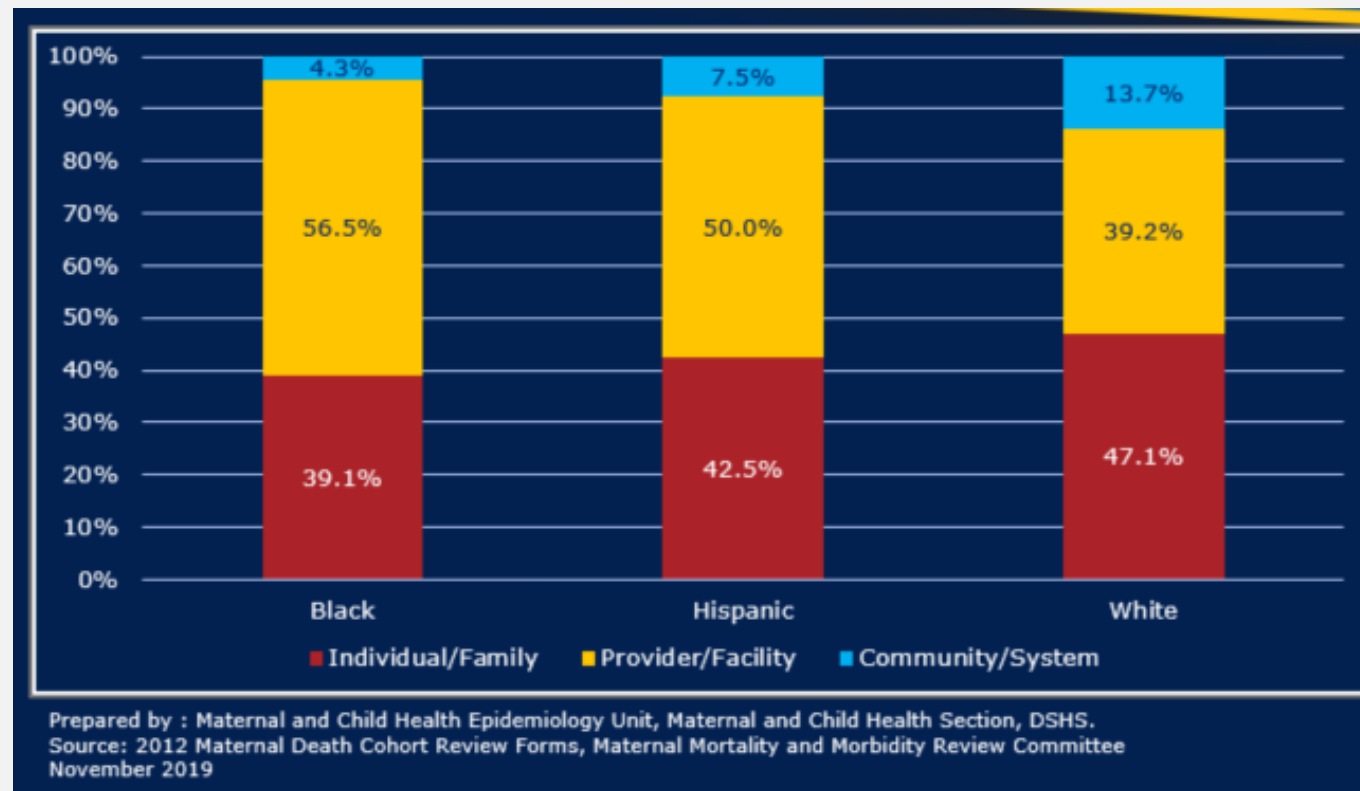
Domains of Contributing Factor Themes in a Social-Ecological Model



Contributing Factors

A complex interaction of factors contributed to disparities in maternal mortality and morbidity.

Contributing Factor Domains by Race/Ethnicity Among Pregnancy-Associated, Pregnancy-Related Deaths, 2012 (n=154)



Texas Maternal Mortality and Morbidity Review Committee Recommendations



Recommendation

Implement statewide maternal health and safety initiatives to reduce maternal mortality and morbidity.

Recommendation

Engage Black communities and apply health equity principles in the development of maternal and women's health programs.

Recommendation

Support coordination between emergency and maternal health services, and implement evidence-based, standardized protocols to identify and manage obstetric and postpartum emergencies.

Recommendation:

Improve postpartum care management and discharge education for patients and families.

Thank you!

Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services:
2020 JOINT BIENNIAL REPORT

Email: maternalhealth@dshs.texas.gov

Session 3: Q&A

Manda Hall, MD

Facilitator



TEXAS
Health and Human
Services

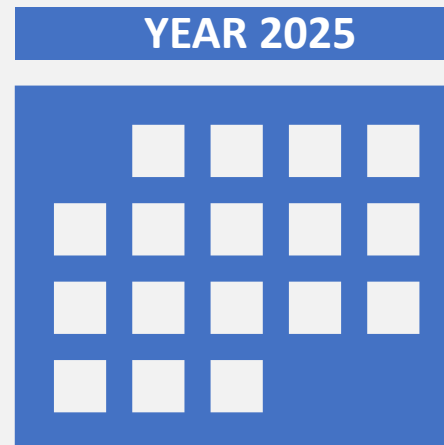
Texas Department of State
Health Services

End of Session 3-Stretch!



Ice Breaker

If you could travel forward in time five years into the future, what you would like to read in a headline for maternal health news in your city?





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Services

**Texas Department of State
Health Services**

TexasAIM Celebration of Teams

TexasAIM 2020 Virtual Summit
December 8-9, 2020



KickOff

- Hospital CEOs signed participation and data use agreements
- 167 Hospitals enrolled



Learning
Session 1



Action
Period 1



Learning
Session 2



Learning
Session 3



Action
Period 2

Learning
Session 1



Action
Period 1



- Introduction to the bundle and breakthrough series framework
- 203 Hospitals enrolled – 90%



B LYNCH COMPRESSION SUTURE

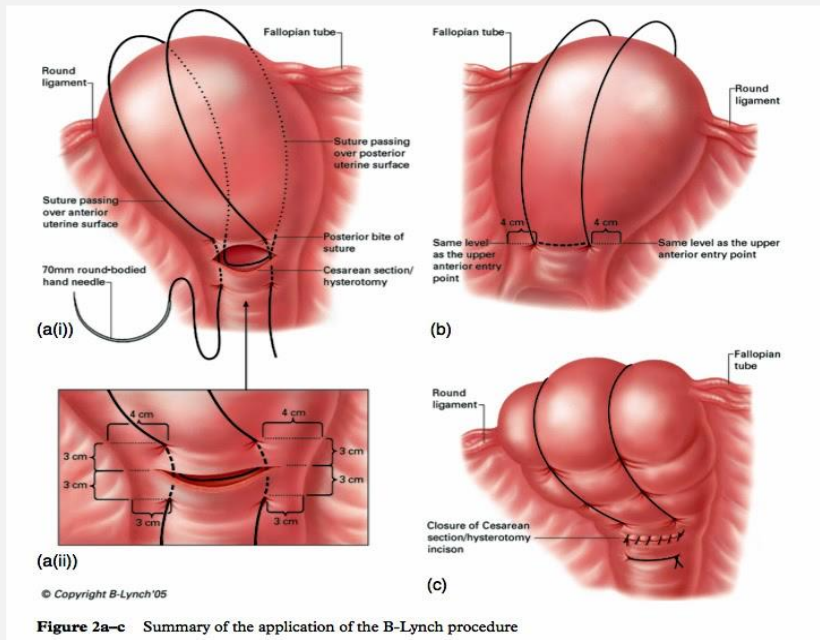
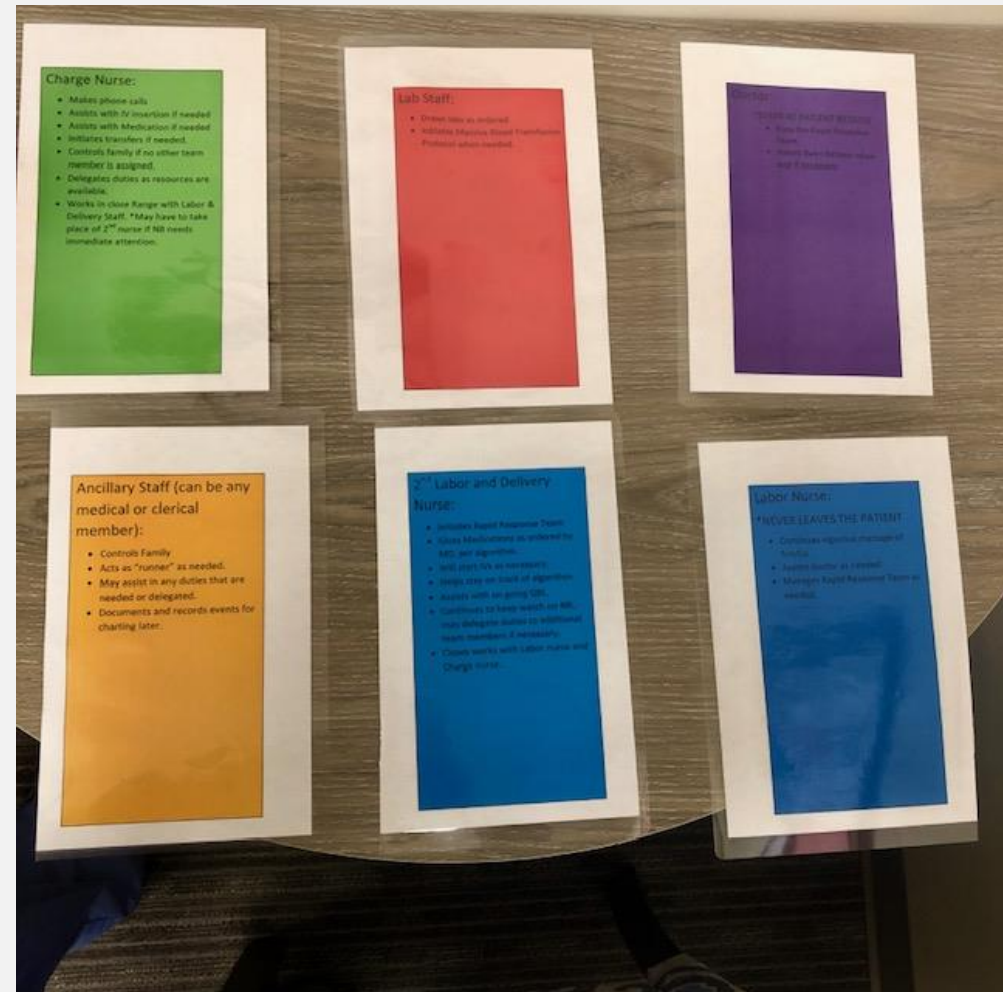


Figure 2a-c Summary of the application of the B-Lynch procedure

Primary Nurse-Team Leader makes Assignments		
RN1	RN2	RN3
Team Leader	Maternal VS/P.O. (q2minute BPs)	Call MD Hem cart (IU Balloon) Scribe
↑ IV fluids	2 IVs (16 or 18 g)	Weigh pads
Fundal message	Draw STAT labs: (CBC, PT/PTT, Fibrinogen)	Call & Prepare OR
Lower HOB	Administer Medications Pitocin, methergine, hemabate, txa	Call Blood Bank – place bb number on card





- Peer Learning
- Team PDSA Cycle activities
- 206 Hospitals enrolled – 92%

Learning
Session 2

Action Period 2





Learning Session 3



- Completely team led
- Started to talk about sustainability
- Worked on teamwork
- Simulated case review and corrective action plan
- 216 Hospitals enrolled – 96%

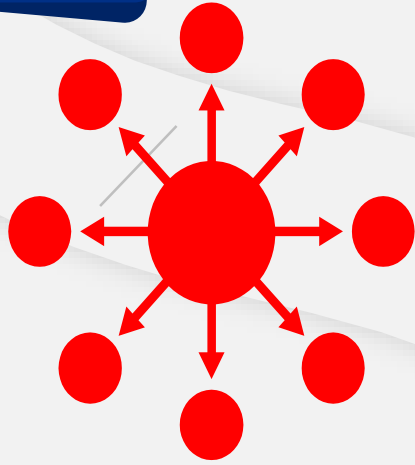


Simulation

- Texas is the FIRST state to do statewide simulation with AIM bundles
- 120 hospitals and 297 attendees
- The majority of participants trained 20-50 colleagues in their hospitals



COVID Calls



- First webinar March 20,2020
- Average of more than 250 attendees each week
- Currently 1231 health professionals from 219+ hospitals have access to TexasAIM OB Care & COVID19 Basecamp Site
- TexasAIM Bi-weekly Bulletin: 1,504 subscribers

Coronavirus Disease 2019 (COVID-19)

Readiness

Every Hospital¹

- [Assess Preparedness](#) and ensure staff are trained, equipped and capable of practices needed to:
 - Prevent the spread of respiratory diseases including COVID-19 within the facility
 - Promptly identify and isolate patients with possible COVID-19 and inform the correct facility staff and public health authorities
 - Care for a limited number of patients with confirmed or suspected COVID-19 as part of routine operations
 - Potentially care for a larger number of patients in the context of an escalating outbreak
 - Monitor and manage any healthcare personnel that might be exposed to COVID-19
 - Communicate effectively within the facility and plan for appropriate external communication related to COVID-19
 - Obtain the appropriate PPE for possible triage, vaginal delivery and cesarean delivery scenarios

Every Unit²

- Establish systems for prehospital notification of confirmed COVID-19 patients or Persons Under Investigation (PUIs)
 - Coordination with admitting providers
 - Review of local or regional transport protocols include notification for patients arriving via EMS transport (refer to [Interim Guidance for Emergency Medical Services \(EMS\) Systems and 911 Public Safety Answering Points \(PSAPs\) for COVID-19 in the United States](#))
- Create communication channels to disseminate information and changes in clinical management/protocols
- Develop unit surge capacity models to potentially cohort COVID-19 patients or identify triggers for when to transfer out of the facility
- Develop strategies for outpatient prenatal care during the pandemic including telemedicine, monitoring of those at highest risk, and telephone triage
- Align unit staffing models to minimize employee exposure and balance workforce fatigue
- Unit education on [recommendations for COVID-19 infection prevention and control in health care settings](#) and on protocols
- Unit based drills (with post-drill debriefs)

Recognition

Every Patient³

- Assess all patients for signs and symptoms of COVID-19
- Be aware of your geographic region and facilities testing guidelines
- Assess illness severity in symptomatic patients
- Assess clinical and social risks

Response

Every patient with suspected or confirmed COVID-19

- Activate COVID-19 Infection Prevention and Control precautions using unit-standard protocols that include/address:
 - Process for rapidly identifying and isolating patients with confirmed or suspected COVID-19
 - Patient placement
 - Transmission-Based Precautions
 - Movement of patients within the facility
 - Hand hygiene
 - Environmental cleaning
 - Monitoring and managing health care personnel
 - Visitor access and movement within the facility
 - Regular situation monitoring
- Perform triage and testing per unit specific guidelines
- Isolate infants according to the [Infection Prevention and Control Guidance for PUIs](#) until the mother's and infant's transmission-based precautions are discontinued.
- Support and facilitate establishment of lactation, breastmilk feeding of the newborn, and post-illness support of breastfeeding for mothers who wish to breastfeed in accordance with CDC's [Interim Guidance on Breastfeeding for a Mother Confirmed or Under Investigation for COVID-19](#)
- Prepare for discharge postpartum women according to recommendations described in the [Interim Considerations for Disposition of Hospitalized Patients with COVID-19](#).
- Support patient, families and staff experiencing exposure to COVID-19⁴.

Reporting/Systems Learning

Every Unit

- Establish a culture of briefs, huddles, and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of COVID-19 associated severe maternal morbidities for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement committee

TexasAIM OB Care and COVID-19 Weekly Webinars

- Weekly Literature Updates
- Simulation (x2)
- Management with Blood Shortages
- PPE on L&D
- Transport
- Outpatient Strategies
- Rural Hospital Strategies
- Mental Wellness
- Implications for The Newborn
- OB Anesthesia Management
- Lessons from the ICU
- COVID-19 Q&A Panel (X2)
- Surge Planning
- Case Studies and Lessons Learned
- Rural Hospitals Response to COVID-19
- Strategies for Reopening
- Disparities and COVID-19

Quotes

Learning Sessions:

“During collaborative problem-solving, our team met a team with had already solved our problems and we had already solved theirs at our respective facilities. It was like we were meant to work together.”

COVID Calls:

- “Sharing the information from all of the resources you have - it helps to remember we are not the only ones writing this book”
- “I have greatly appreciated the COVID Webinars and collaboration. It has greatly helped me in advocating for things like universal testing knowing that other hospitals in the area were implementing them.”

Simulation Couse:

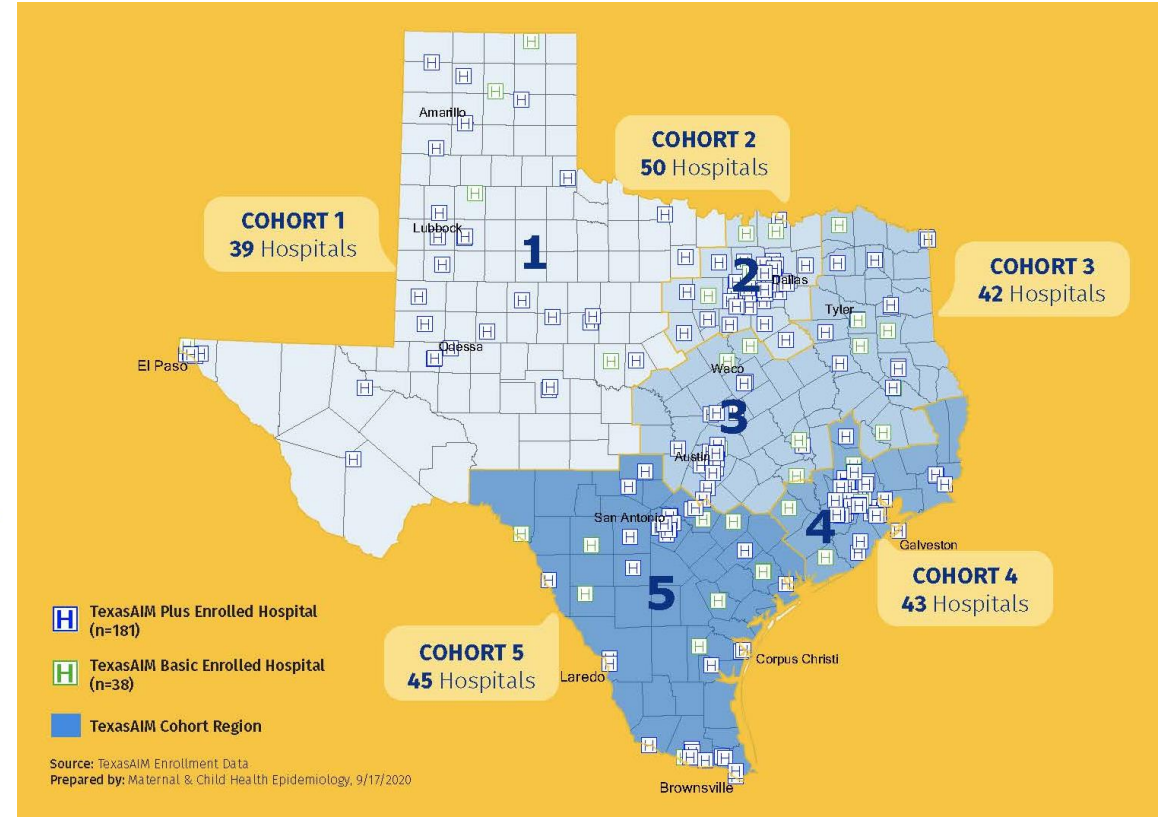
“Excellent, feel as if we were more prepared and able to assess the situation and act appropriately to stabilize the patient. Had a good outcome that could have ended very different had we not been prepared.”

TexasAIM Enrollment by the Numbers

Hospitals participating in TexasAIM serve:



Hospital Enrollment:



DSHS TexasAIM Ops Team



John Hellerstedt, MD, DSHS
Commissioner



Manda Hall, MD Associate Commissioner
Community Health Improvement Division, DSHS



Jeremy Triplett
Director, Maternal & Child Health Section, DSHS



Michael Spencer, LMSW
Director, Maternal & Child Health Unit, DSHS



Julie Stagg, MSN, RN, IBCLC
Healthy Texas Mothers & Babies Branch Manager, DSHS



Ashley Steenberger MPH, CHES
Maternal Health & Safety Coordinator



Megan Coulter, MPH
Maternal Health & Safety Coordinator, TexasAIM Data Lead



Laura Wando, MPH
Maternal Health & Safety Coordinator



Rosa-Maria DiDonato, RNC-OB, C-EFM
Maternal Health & Safety Nurse Consultant



Aliyah Abdul-Wakil, MPH
Maternal & Child Health Epidemiologist

TexasAIM OBH Faculty



Carey Eppes, MD, MPH
TexasAIM Faculty Chair



Carlos Carreno,
MD



Carroll Deighton,
MSN, RNC-OB, C-EFM



Jamie Morgan,
MD



Karin Fox,
MD, M.Ed.



Kendra Folh,
BSN, RNC-OB



Linda H. Beaverstock,
BSN, RNC-OB, C-EFM



Rakhi Dimino,
MD, MMM, FACOG



Renee' Jones,
DNP, RNC-OB, WHNP-BC



Suzanne Lundeen,
PhD, RNC-OB, NEA-BC

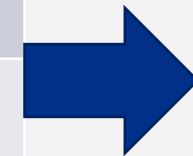


Patricia Heale,
DNP, RNC-OB, C-EFM



Alignment of State and National Priorities

Bundle Element	Texas LoMC	AIM	Joint Commission
Hemorrhage Risk Assessment		✓	✓
Stage-based management plan of PPH	✓	✓	✓
Hemorrhage supply kit with medications	✓	✓	✓
Role-specific education to all staff and providers for PPH	✓	✓	✓
Conduct annual simulation for PPH	✓	✓	✓
Multi-D Case review of PPH/HTN cases	✓	✓	✓
Educate and support patients regarding PPH	✓	✓	✓



**HHS Maternal
Action Plan**

End of Session 4-Celebrate!



This group has so much to be proud of!

Type in a kudos for someone who helped make change happen in your hospital. Tell us who they are and what they did that was GREAT!



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**Texas Department of State
Health Services**

Holding & Building on the Gains



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Services

Texas Department of State
Health Services



David Lakey, MD
The University of
Texas System



Ann Borders, MD,
MSc, MPH
NorthShore
University Health
System,
Illinois



Veronica Gillispie-
Bell, MD, MAS
Ochsner Baptist
Hospital,
Louisiana



Amy Ladley, PhD
Louisiana
Perinatal Quality
Collaborative

Welcome and Introductions






IL Perinatal Quality Collaborative: Holding & Building on the Gains

Ann Borders, MD, MSc, MPH
Executive Director and OB Lead Illinois
Perinatal Quality Collaborative,
Maternal Fetal Medicine, NorthShore
University HealthSystem, Evanston, IL

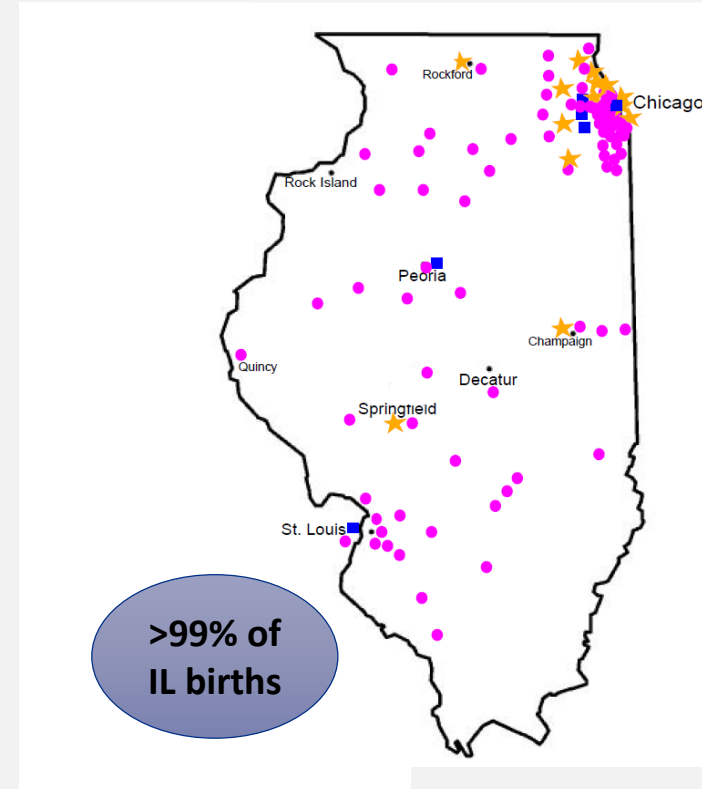
Overview



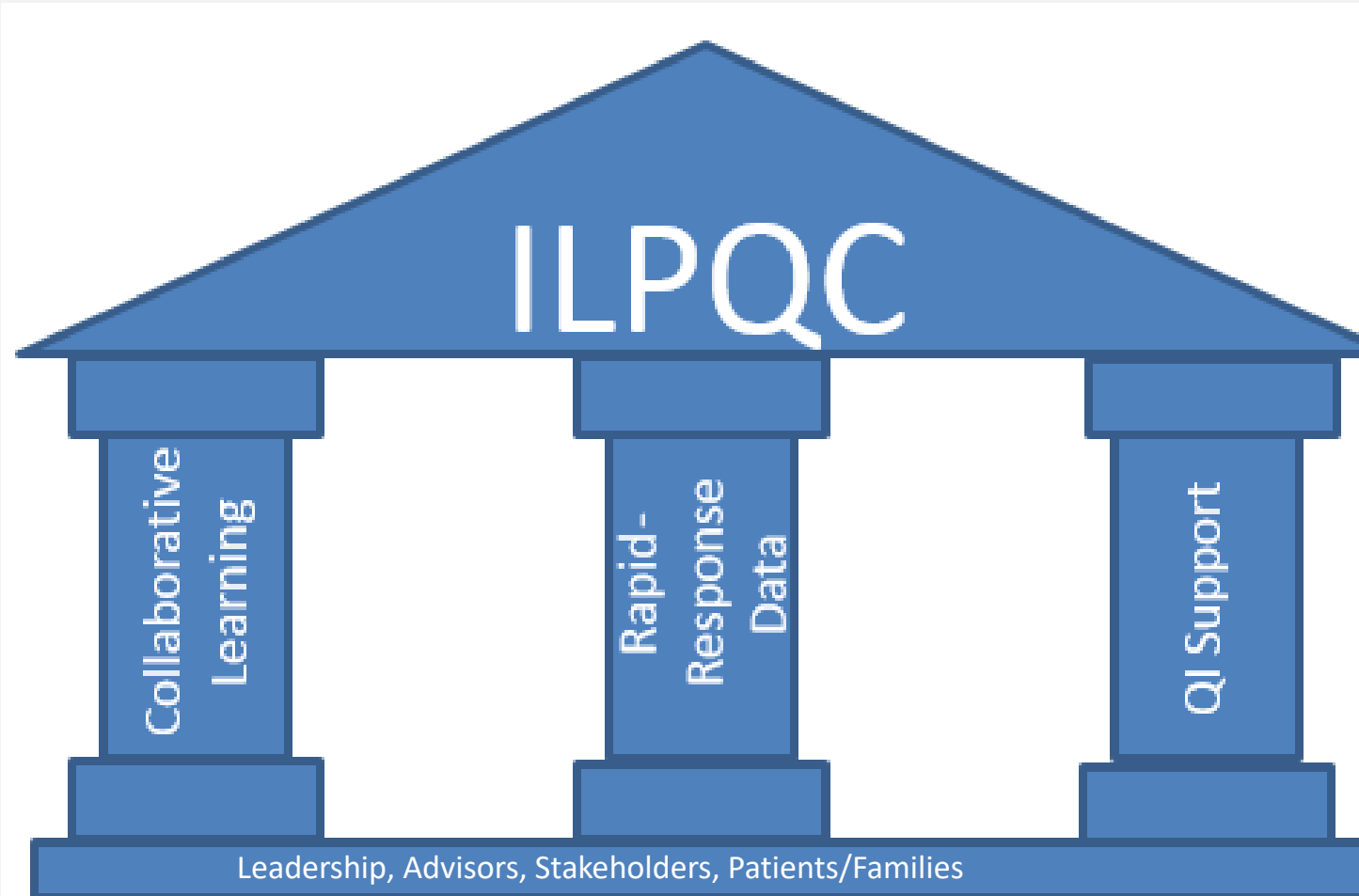
- ILPQC Overview & QI Initiative Life Cycle
 - Crossing the Finish Line and Achieving Sustainability Success
 - ILPQC examples: supporting hospitals achieving sustainability success while transitioning to next initiative
 - Severe HTN Initiative → MNO
 - Mothers and Newborns affected by Opioid (MNO) Initiative → Promoting Vaginal Birth
- 

Illinois Perinatal Quality Collaborative (ILPQC)

- Multi-disciplinary, multi-stakeholder Perinatal Quality Collaborative with 107 Illinois hospitals participating in 1 or more initiative
- Support participating hospitals' implementation of evidenced-based practices using quality improvement science, collaborative learning and rapid response data



ILPQC: Using QI to Build Hospital Capacity to Drive Systems & Culture Change



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?



© 2012 Associates in Process Improvement

Initiative Lifecycle



- Collaborative selection of a QI initiative
 - Development (6-9 months): Includes creation of aim, measures, data collection/reporting process, toolkit, collaborative learning webinar schedule, etc.
 - Wave 1 (3 months): Subset of site QI teams test data collection process and form
 - Statewide launch (18-24 months): QI work begins with all teams (active QI), monthly webinars, 2x/yr in-person
 - Sustainability (12-18 months): Teams develop sustainability plans, collaborative learning webinars at reduced frequency, select data reporting/compliance monitoring, QI support continues as needed
- 

Successful Transitions

- Provide hospitals draft sustainability plans, they complete a hospital specific plan and submit
 - Incorporate data compliance monitoring into ongoing QI system with benchmarks
 - New hire and ongoing education for staff
 - Maintain system changes that promote optimal care
- Provide quarterly sustainability webinars to review sustainability data, support crossing the finish line, teams share sustainability plan progress
- Support QI teams to cross finish line and then shift QI focus to next active phase initiative with flexible timeline





Supporting hospitals achieving
sustainability success while
transitioning to next initiative

HTN → MNO

MNO → PVB



ILPQC Maternal Hypertension Initiative

Aim: Reduce the rate of severe morbidities in women with severe preeclampsia, eclampsia, or preeclampsia superimposed on pre-existing hypertension by 20% by December 2017

Approach: 4 key goals

- 1. Reduce time to treatment**
- 2. Improve postpartum patient education**
- 3. Improve postpartum patient follow up**
- 4. Improve provider & RN debrief**



- 110 hospital teams - May 2016 kick off to December 2017
- 106 Hospitals submitted data for over 17,000 women who experienced severe maternal HTN across the initiative
- Sustainability started January 2018
- 86 teams have submitted sustainability data

Severe HTN Initiative Timeline




- Jan-April 2015 Wave 1 Teams evaluated data form, trialed data collection strategies, provided feedback
- April 2015 kick-off 2 hour webinar to introduce HTN Initiative to teams statewide
- May 2015 Face to Face Meeting Springfield: storyboards, toolkit launch, patient education materials, breakout sessions, leaders from other state PQC's share strategy
- June 2015 Monthly team webinars started: education, data review, clinical / QI leaders other states, Team Talks
- Baseline data collection 4th quarter 2015
- July 2015 – December 2017 Teams submitted monthly data & participate in monthly collaborative learning webinars, ILPQC provided quarter QI support
- January 2018 – December 2018 Teams completed sustainability plans and participate in quarterly sustainability webinars. ILPQC provided support for hospital teams to cross the finish line

QUALITY IMPROVEMENT RECOGNITION AWARDS

ILPQC SEVERE MATERNAL HYPERTENSION INITIATIVE

GOLD

- ✓  Structure Measures
- +
- ✓ All 4 Process
- Measure goals met

SILVER

- ✓ Structure Measures
- +
- ✓ 3 of the 4 Process
- Measure goals met

BRONZE

- ✓ Structure Measures
- +
- ✓ 2 of the 4 Process
- Measure goals met

DETERMINED BY DATA* FOR QUARTER 3 OF 2017**

(PLEASE SUBMIT NO LATER THAN NOVEMBER 15TH)

TO BE AWARDED AT 5TH ANNUAL ILPQC CONFERENCE: DECEMBER 19, 2017

**SEVERE HTN DATA, AIM QUARTERLY MEASURES, & IMPLEMENTATION CHECKLIST*

***QUARTER 3 INCLUDES JULY, AUGUST, SEPTEMBER & OCTOBER 2017*

PROCESS MEASURES WILL BE EVALUATED BASED ON OCTOBER 2017 DATA

HTN Initiative Sustainability Plan



Compliance Monitoring in ILPQC Data System



- Time to treatment severe HTN < 60 minutes
- Magnesium provided
- Early follow up for BP check within 7-10 days
- Patient discharge education

Building HTN Sustainability Post-Initiative:

All teams submit a Severe HTN Sustainability Plan

1. Compliance tracking for all cases severe HTN in ILPQC Data System, plan for monitoring & response
 - Time to treatment severe HTN under an hour
 - Magnesium provided
 - Early follow up for BP check within 7-10 days
 - Patient education at discharge
2. Ongoing education for providers and nurses (drills, simulations, e-modules)
3. Education plan for new hires

ILPQC Maternal Hypertension Initiative: Sustainability Plan

Compliance Monitoring of key process measures:

1. Time to treatment for severe HTN <60 minutes
2. Magnesium provided
3. Early follow-up for BP check within 7-10 days
4. Patient discharge education
5. Demographic and basic descriptive information including BP

How will measures be collected? _____

Will you continue to track additional data internally? Yes No

Team member(s) in charge of reporting in REDCap: _____

How often will your QI team meet to review hospital data reports via REDCap and develop and implement PDSA cycles if compliance on measures starts to slip?:

Weekly Monthly Quarterly Other

New Hire Education for all new hires

What education tool(s) will you use for new hires?

AIM e-modules / webcast ILPQC Grand Rounds Slide Set ILPQC Severe Maternal HTN Toolkit Binder

Other: _____

How will you incorporate Severe Maternal Hypertension education and hospital identification, treatment, and discharge workflows and protocols into hospital new hire education?

Ongoing Education for all providers and nurses

What education tool(s) will you use for ongoing education for all nurses and providers?

Drills Simulations Laminated protocols Algorithms Active debrief AIM e-modules /webcast

Other: _____

How will you incorporate Severe Maternal Hypertension education and hospital identification, treatment, and discharge workflows and protocols into ongoing education?

Nursing Champion(s): _____ Provider Champion(s): _____

Drafted Date: _____ Quarterly Review Dates: _____

Hospital Name: _____

Steps for sustainability success



- All teams submit a *HTN Sustainability Plan* using ILPQC sustainability plan template
- Transition to *HTN Compliance Data Form* after final December 2017 data is submitted (January 30, 2018)
- Facilitate collaborative team calls for HTN sustainability – Every other month for first quarter then move to quarterly (January, March, Q2, Q3, Q4)
- Leverage Perinatal Network Meetings for ongoing sustainability discussions

Mothers and Newborns affected by Opioids- OB Initiative

Aim: $\geq 70\%$ women with OUD receiving MAT; $\geq 80\%$ connected to Behavioral Health Counseling/Recovery Services prenatally or by delivery discharge

Benchmarks:

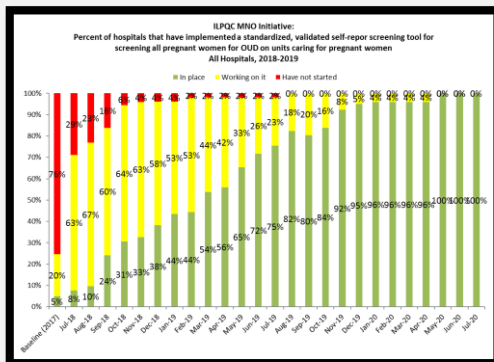
- $\geq 80\%$ all pregnant women screened with a universal validated screener during prenatal period among all deliveries
- $\geq 80\%$ all pregnant women screened with a universal validated screener during L&D admission among all deliveries
- $\geq 70\%$ women with OUD with an OUD clinical care checklist completed prenatally or during delivery admission
- $\geq 70\%$ women with OUD receiving: Narcan, Hep C, contraception, behavioral health/ social work consult prenatally or during delivery admission
- $\geq 70\%$ women with OUD receiving pediatric / neonatal consult on NAS and role in newborn care prenatally or during delivery admission
- $\geq 80\%$ women with OUD receiving OUD/NAS education prenatally or during delivery admission
- 101 hospitals participating in the MNO OB Initiative
- Since Spring 2018, 92 MNO-OB teams have cared for over 2,384 pregnant/postpartum women with Opioid Use Disorder, averaging 71 women per month



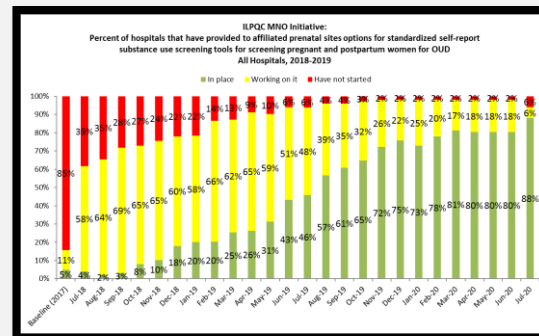
MNO-OB Timeline

- Jan-April 2018 Wave 1 Teams evaluated data form, trialed data collection strategies, provided feedback
- April 2018 kick-off 2 hour webinar to introduce MNO Initiative to teams statewide
- May 2018 Face to Face Meeting Springfield: > 300 participants, > 100 hospital teams, storyboards, toolkit launch, patient education materials, breakout sessions, leaders from other state PQC's share strategy
- June 2018 Monthly team webinars start: education, data review, clinical / QI leaders other states, Team Talks
- Baseline data collection 4th quarter 2017 due 8/15/18
- July 2018 – December 2020 Teams submit monthly data & participate in monthly collaborative learning webinars, ILPQC provides quarter QI support
- January 2021 – December 2021 Teams will complete sustainability plans and participate in quarterly sustainability webinars. ILPQC provides support for teams to cross the finish line

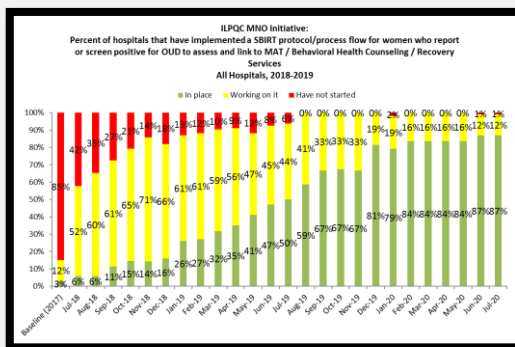
Making Systems Change Happen



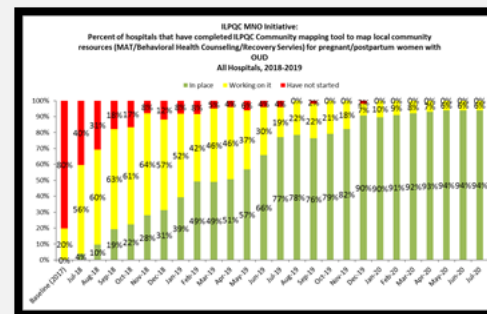
100% of teams have a validated screening tool in place on L&D



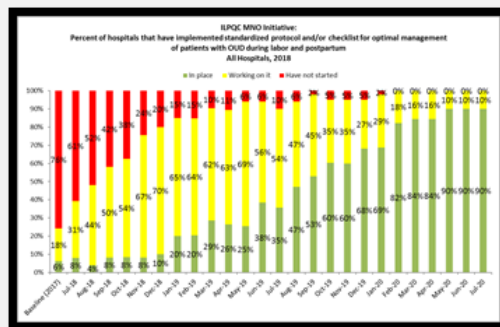
88% of teams have a validated screening tool in place prenatally



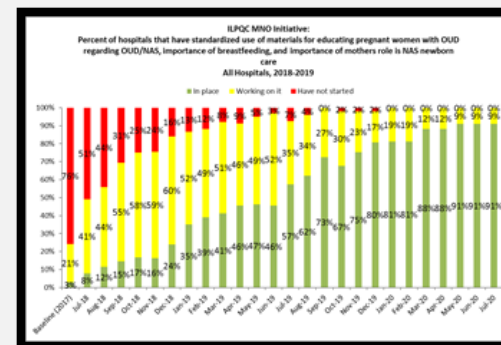
87% of teams have a SBIRT protocol/algorithm in place on L&D



94% of teams have mapped community resources for women with OUD



90% of teams have implemented an OUD Clinical Care Checklist on L&D



88% of teams have implemented standardized patient education on L&D

MNO-OB Excellence Award Criteria for Optimal OUD Care



✓ **All Data Submitted**

+

✓ **6 Structure Measures In Place**

(Screening Prenatal, Screening L&D, SBIRT/OUD Protocol, Mapping, Checklist, Patient Education)

+

✓ **All Process Measure goals met**

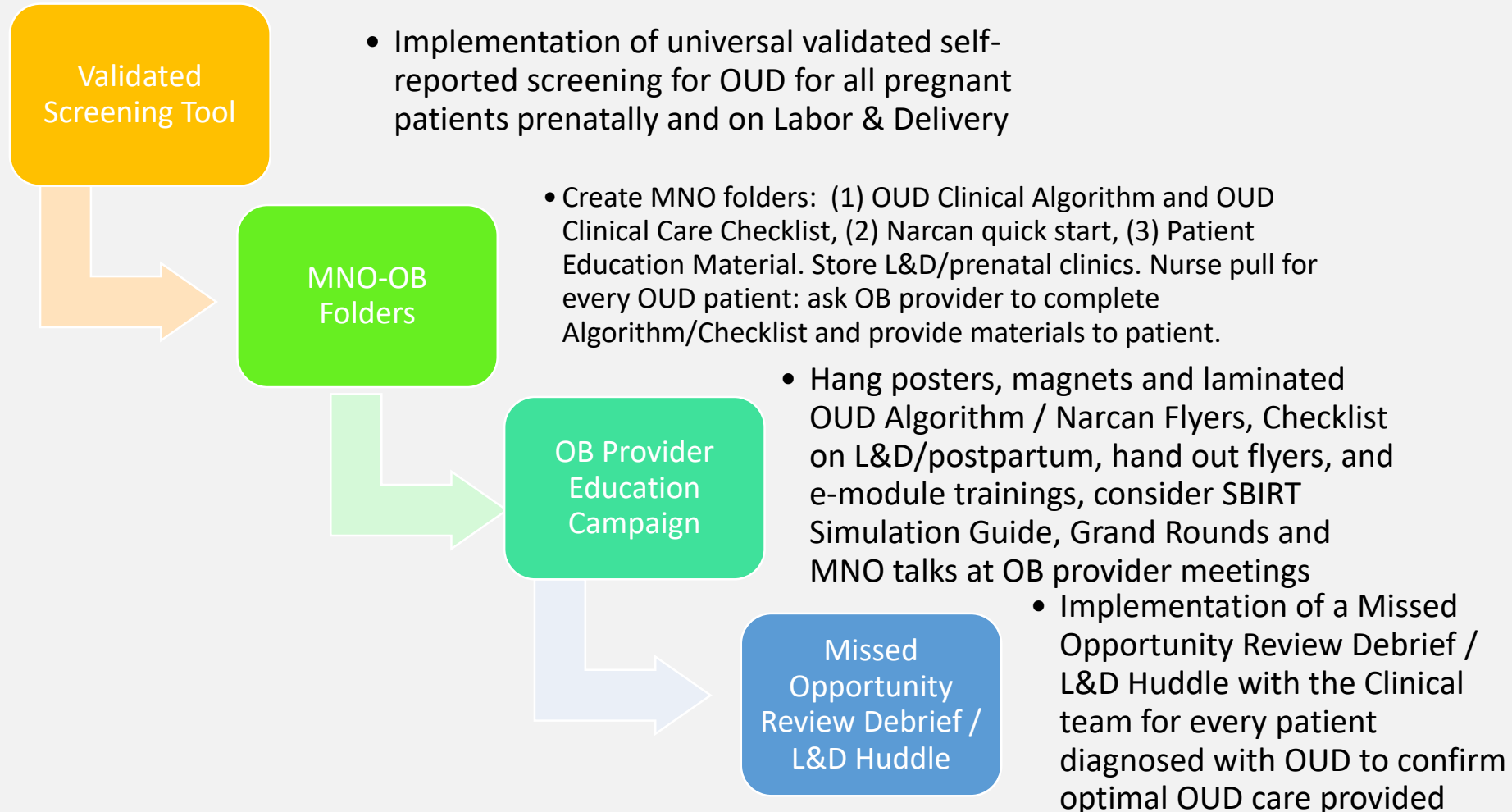
>70% MAT, >70% Recovery Treatment Services

>60% Narcan, >70% Hep C

>70% Patient Education, >50% Prenatal Screening



Key Strategies for MNO Success



MNO Education for all OBs & RNs

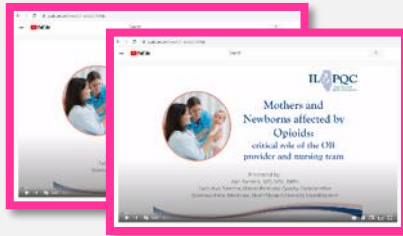
Stigma & bias education



- [Words Matter e-Module](#) from ILPQC AC Conference
- [CDC Opioid Use and Pregnancy e-Module](#)

Implement stigma & bias education

Provider & RN e-Modules



- [MNO-OB Provider eModule](#)
- [MNO-OB Nursing eModule](#)

Shares key strategies for caring for pregnant and pp women with OUD

Provider & RN education campaign



- [MNO-OB Education Flyers](#)

Post & distribute in clinical areas including prenatal sites

SBIRT Simulations Guide and e-training



- 1hr SBIRT IRETA [Training e-Module](#)
- ACOG District II SBIRT Training [6 Min Video](#)

Train providers to talk to patients about readiness for MAT & linking to recovery treatment services.

Sustainability Plan



What systems do you have in place to ensure your QI work is continuously integrated into your clinical culture?

Strategies for Sustainable Change

Compliance Monitoring

Monitor prenatal screening and on LD

Monitor MAT and Behavioral Health/Recovery Treatment

Monitor Narcan counseling and prescribing

New Hire & Ongoing Education

Plan for training residents, new providers on optimal OUD care

Plan for training new nursing hires on optimal OUD care

Plan for ongoing education for inpatient and outpatient clinical staff

Maintain Systems Changes

Identify who will be responsible for maintaining MNO-OB Folders

QI team to continue with MNO Missed Opportunity Review forms and provide feedback

QI team will create a plan to monitor compliance and engagement with OUD L&D huddles

ILPQC MNO-OB Initiative: Sustainability Plan

Sustained Improvement Tracking of key process measures:

1. SUD/OD Prenatal and LD Screening documented
2. Medication Assisted Treatment (MAT) Prenatally or by Delivery Discharge
3. Linkage to Behavioral Health Counseling / Recovery Treatment Services Prenatally or by Delivery Discharge
4. Narcan Counseling & Prescription Offered Prenatally or by Delivery Discharge
5. Hepatitis-C Screening Prenatally or by Delivery Discharge

How will measures be collected? _____

Team member(s) in charge of monthly reporting in REDCap: _____

How often will your QI team meet to review hospital data reports via REDCap and develop a response if compliance on measures are below the goal? Monthly Quarterly Other: _____

Ongoing Education for all providers and nurses

What education tool(s) will you use for ongoing education for all nurses and providers?

- ILPQC Provider eModule ILPQC RN eModule Missed Opportunity Review form ILPQC SBIRT Simulations
 SBIRT/OD Clinical Algorithm MNO-OB Toolkit Provider Education Materials RN Workflow Other: _____

How will you incorporate MNO-OB education and clinical care policies and protocols into ongoing education?

How often will you provide ongoing education? Biannually Annually Other? _____

New Hire Education for all new hires

What education tool(s) will you use for new hires (see above)?

How will you incorporate MNO-OB education and clinical care policies and protocols into hospital new hire education?

Sustained System-level Changes

What system-level changes have you put into place to sustain providing optimal care for every patient with OUD?

- LD Admission Huddles Prenatal Care Conference MNO-OB Folders MNO OUD Order Sets
 Missed Opportunity review with clinical team feedback Validated Screening tool in EMR Other: _____

How will you sustain these efforts, such as how will you ensure that MNO-OB Folders are replenished and updated? How will you confirm OUD Admission Huddles are being completed for all patients with OUD?

Community Resources: How often will you update your local map of resources to connect pregnant/postpartum patients to MAT & Behavioral Health/Recovery Treatment Services? Bi-annually Annually

Whose job is it to update the MNO- OB folders? _____

Whose job is it to update local map of resources to MAT & Behavioral Health/Recovery Services? _____

Nursing Champion(s): _____ Provider Champion(s): _____

Drafted Date: _____ Quarterly Review Dates: _____

Hospital Name: _____

ILPQC MNO-OB Sustainability Plan

- Helps capture QI team's plan for MNO sustainability

PVB Smart AIM

TO SUPPORT VAGINAL BIRTH AND REDUCE PRIMARY CESAREANS TO REACH THE HEALTHY PEOPLE GOAL FOR LOW RISK CESAREAN SECTION TARGET RATE OF 24.7% BY DECEMBER 2021

3 Key QI Strategies

1

Facilitate clinical culture change that promotes and supports vaginal birth



2

Develop standardized processes for induction and labor support



3

Develop standardized protocols for identification and response to labor challenges / abnormalities



Summary

- Goal is for very team to cross the finish line to achieve initiative aims and have systems in place to sustain the gains
 - ILPQC provides ongoing support and recognition as needed into sustainability
- Teams complete Sustainability Plan to establish:
 - Compliance monitoring and benchmarks
 - New Hire Education / Ongoing staff education
 - Maintain systems to provide optimal care
- Transition to new initiative
 - Start with baseline data collection
 - Easy to achieve systems changes track progress with structure measures
 - Flexible timeline to shift focus to new initiative





THANKS TO OUR
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JB & MK PRITZKER

Family Foundation

Email info@ilpqc.org
Visit us at www.ilpqc.org

Thank you!

IL Perinatal Quality Collaborative: Holding & Building on the Gains

Ann Borders

info@ilpqc.org

Lessons Learned from Louisiana

Amy Ladley, PhD, State Perinatal Quality Program Manager



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Disclosures

I have no financial interests or relationships to disclose.

Implementation Background

- Implement AIM bundles through the Louisiana Perinatal Quality Collaborative.
- We bundle our bundles.
- Zucchini bread approach to implementation.
- Administrative stuff happens behind the scenes.

Lesson 1

There's **no singular path** to improvement and implementation.

Lesson 2

Emphasize improvement science to **make change small** and eliminate "bad habits."

Lesson 3

Manage setbacks by shifting perspective – improvement science tells us the **process** is important.

Lesson 4

Create opportunities to celebrate wins and build confidence.

Thank you!

Lessons Learned from Louisiana

amy.ladley@la.gov

Implementing Quality Improvement Initiatives

Boots on the Ground - Lessons Learned

Veronica Gillispie-Bell, MD, MAS, FACOG

Medical Director of Quality, Women's Services

Ochsner Health

Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review

Louisiana Department of Health

Disclosures

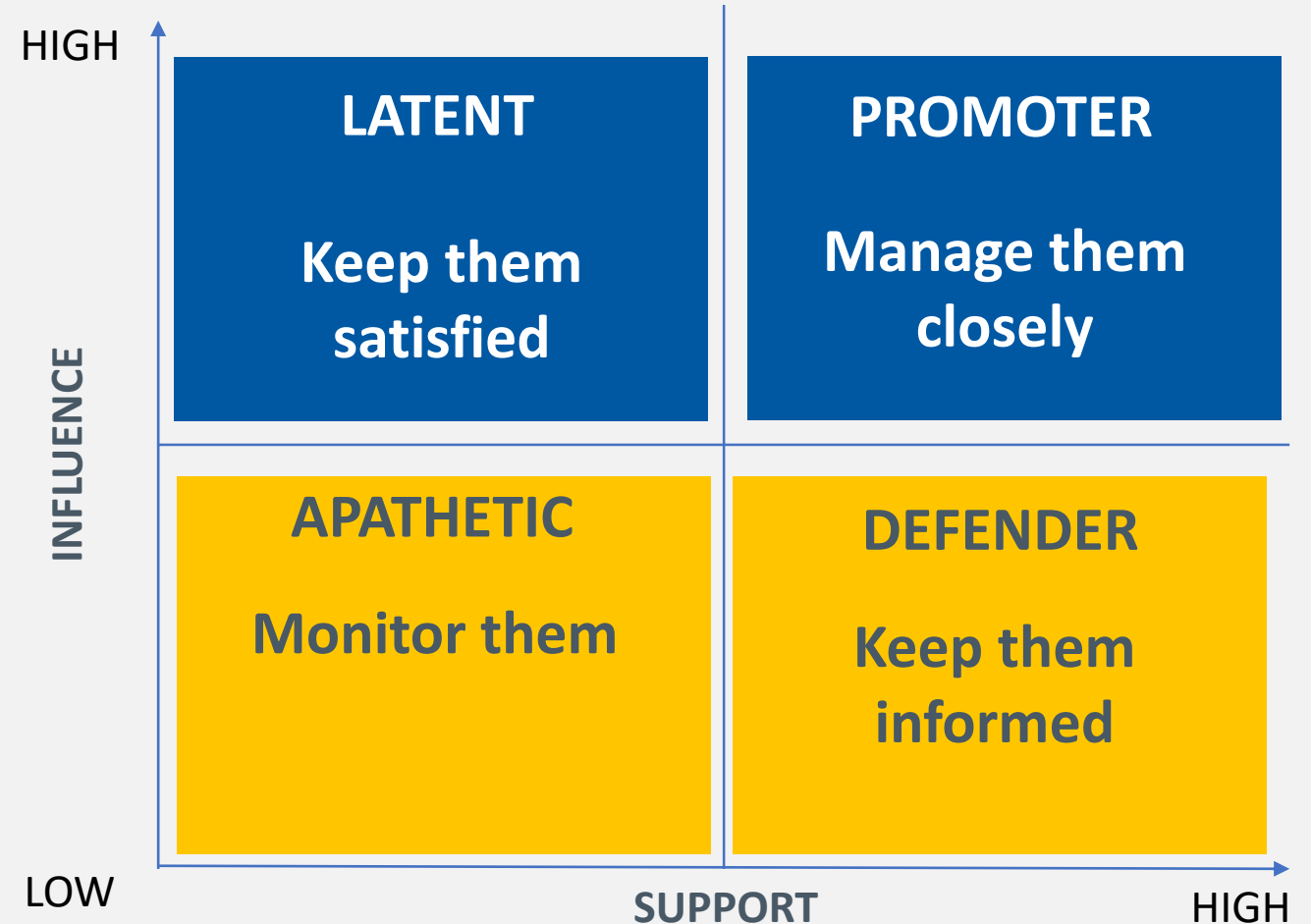
- Consultant and Speaker's Bureau for Abbvie, Inc for heavy menstrual bleeding
- Royalties from Lecturio for intellectual property related to USMLE Step 2
- I have no conflicts of interested related to today's content

Lesson One: Choose a Good QI Team



Who Should be on the QI Team?

- Things to consider when choosing your QI Team
 - Who will be affected by your change?
 - Make sure those disciplines are represented on your QI Team
 - Always have a physician and nursing dyad to lead the initiative
 - Who will influence your change – Stakeholder analysis?
 - Know how to engage and manage them



Lesson Two: Change is Uncomfortable

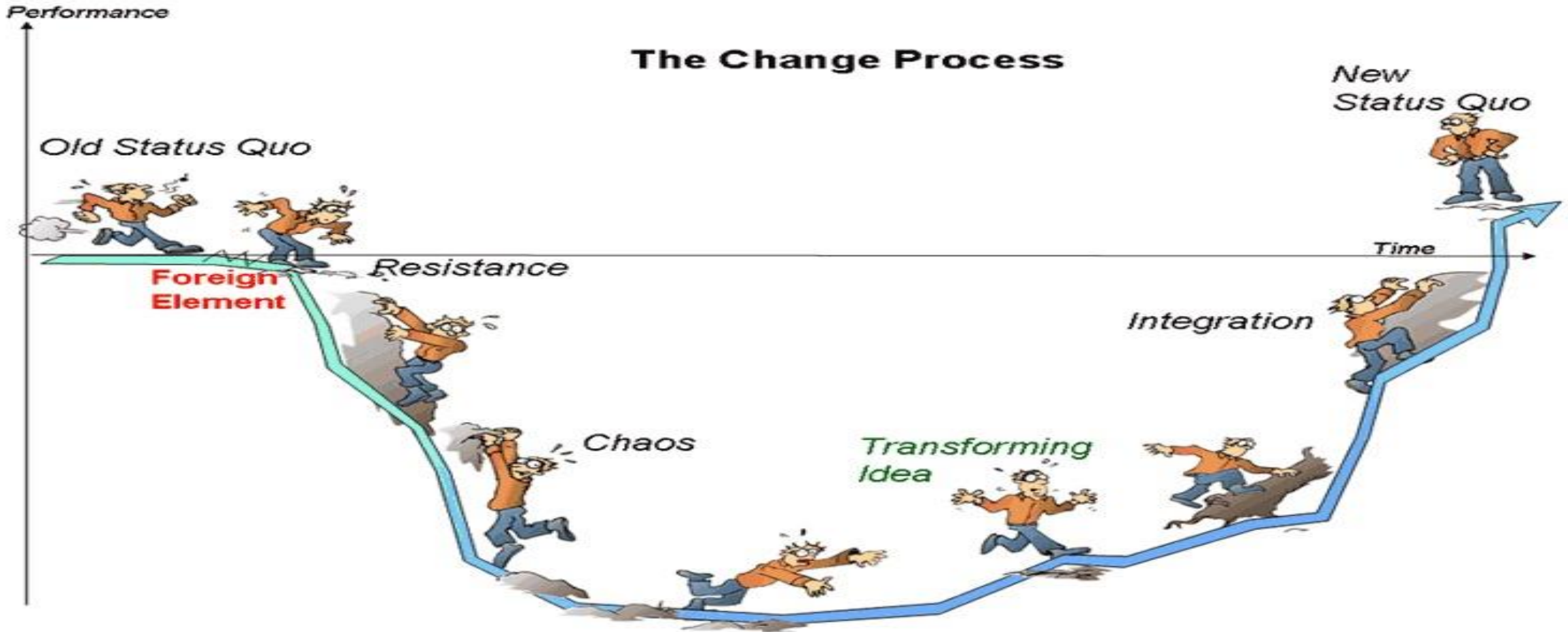
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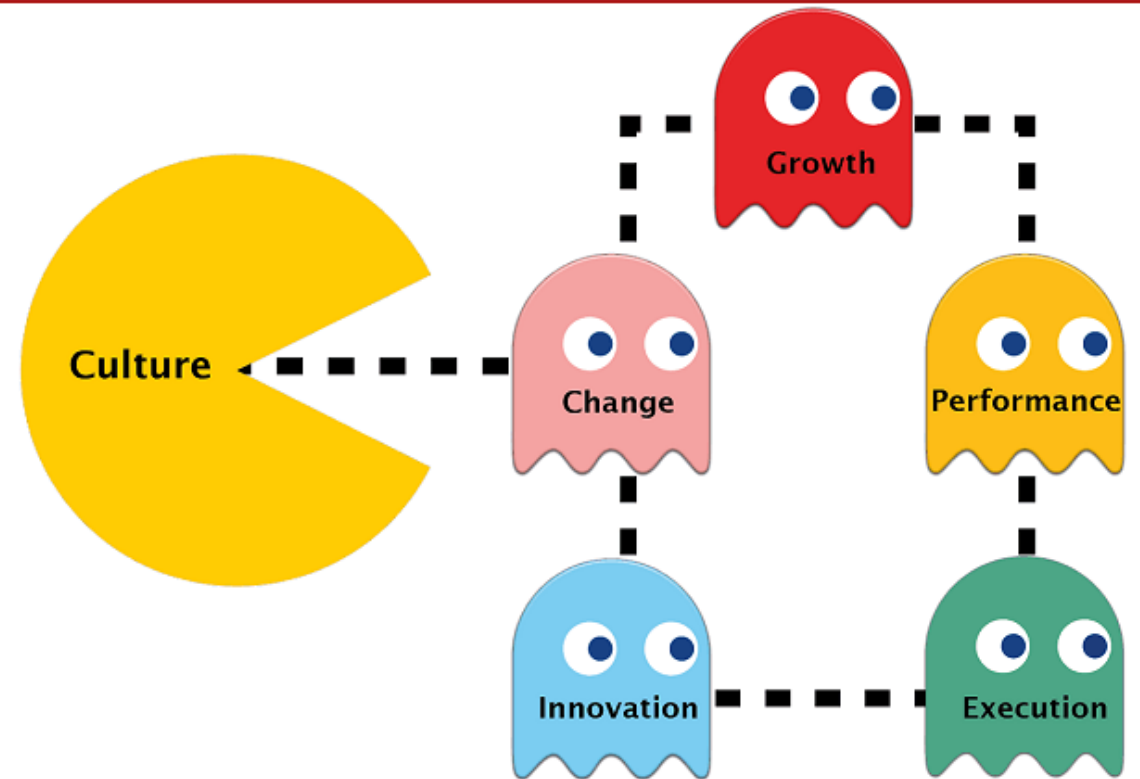
Change Management: Lewin Model



Why Change Fails?

- **70%** of organizational change efforts fail*
 - Level of resistance was underestimated
 - Pace of change was too fast
 - People felt the change was forced on them

Organizational culture eats strategy for breakfast, lunch and dinner



Torben Rick www.torbenrick.eu

*Kotter J. Leading Change: Why Transformation Efforts Fail. Change Management. Harvard Business Review. January 2007.

Kotter's Models of Change

1. Create a sense of urgency
2. Pull together the guiding team
3. Develop the change vision and strategy
4. Communicate for understanding and buy-in
5. Empower others to act
6. Produce short-term wins
7. Don't let up
8. Create a new culture



Lesson Three: Always Use Small Tests of Change

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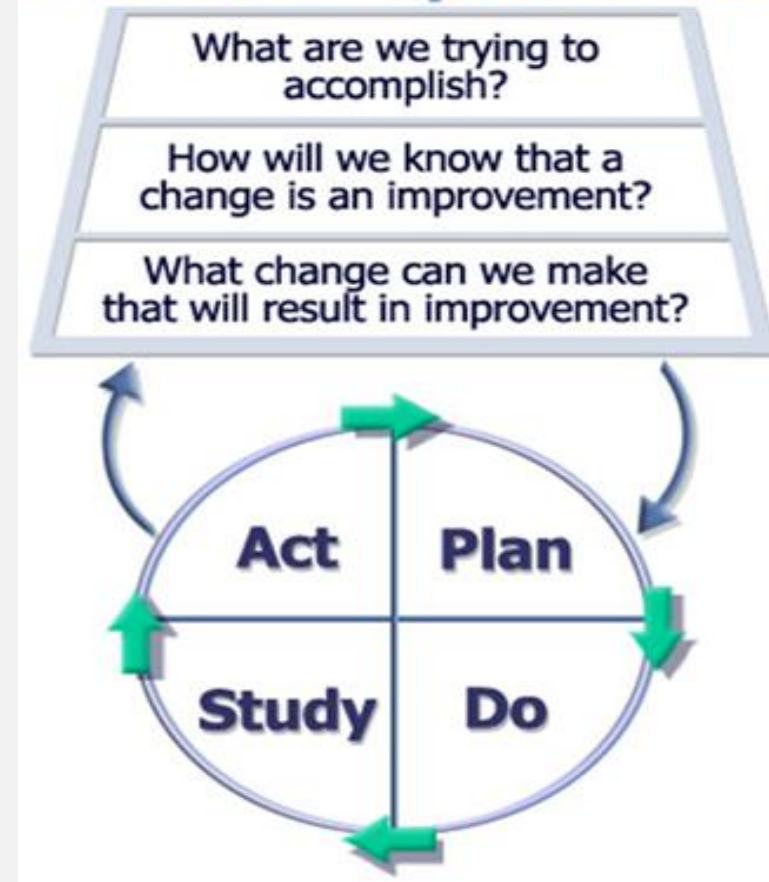
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Small Tests of Change

- Plan for a small test of change
 - One physician or one day of the week
- Make it easy to do the right thing and hard to do the wrong thing
 - Order sets
 - Provider level data

Model for Improvement



Lesson Four: Know Your Audience

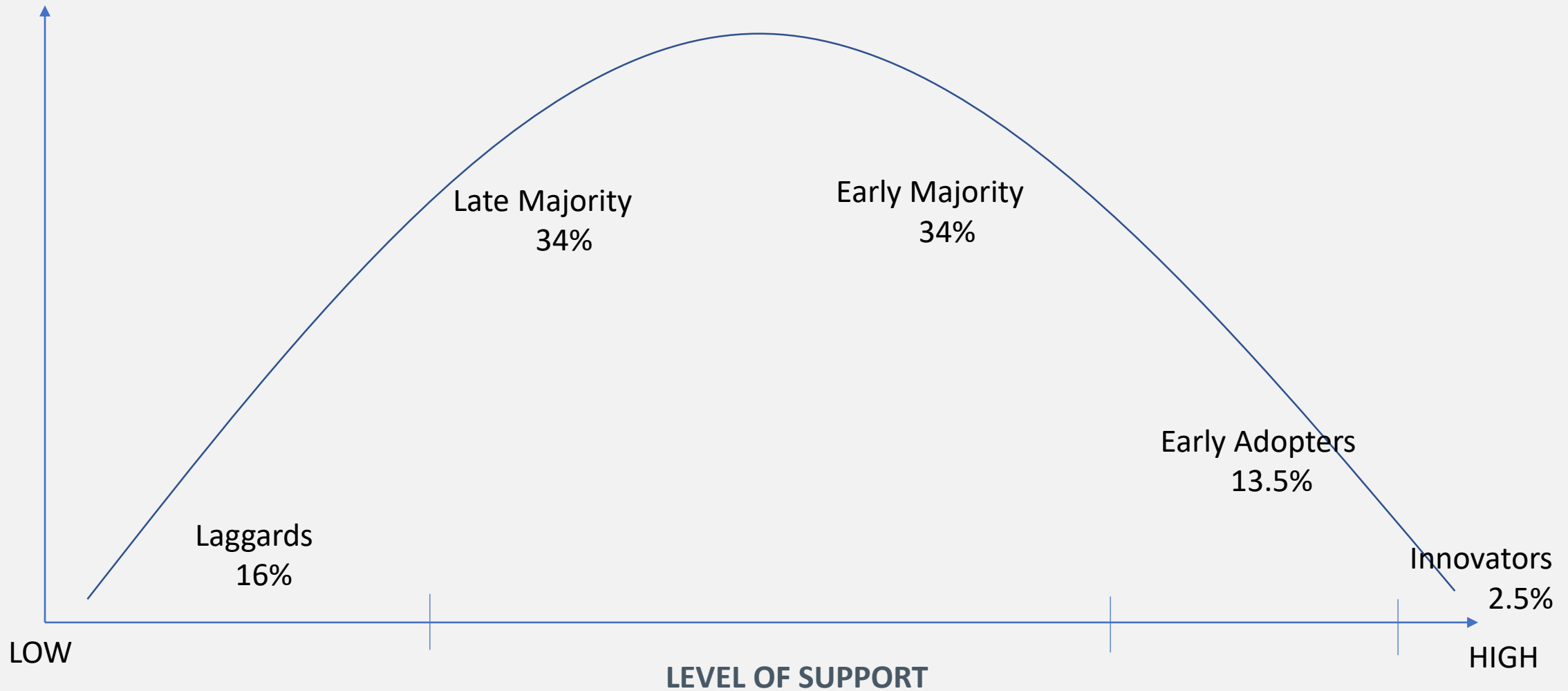
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Who Has Your Back?



Take Aways!

- Start with a QI team with all disciplines that will be affected by your change represented
- Change is uncomfortable. Resistance is not Rejection!
- *The best way to eat an elephant is one bite at a time.*
- *African Proverb*
- Identify those who are supporting you and promote them. Identify those who do not and manage them.



Thank you!

Veronica Gillispie-Bell, MD, MAS, FACOG

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Session 5: Panel Discussion

David Lakey, MD

Facilitator



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Closing Thoughts and Day Ahead

Julie Stagg, MSN, RN, IBCLC, RLC, CPHQ
TexasAIM Project Director, DSHS



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End of Day 1



TexasAIM Summit Day 1 Evaluation



TexasAIM Summit Day 1 (12/08) Evaluation

Thank you for attending TexasAIM Summit Day 1 (12/08). Please complete the brief evaluation survey below.

Please note that this is *not* the evaluation for continuing education credit hours. You will be receiving an email within the next few days including instructions on how to obtain credit hours and complete the continuing education evaluation.

* 1. Type of provider:

- | | |
|-------------------------------------------------|-----------------------------------------------|
| <input type="radio"/> Administrative Leader | <input type="radio"/> Nurse |
| <input type="radio"/> Advance Practice Provider | <input type="radio"/> Patient/Family Provider |
| <input type="radio"/> Certified Nurse Midwife | <input type="radio"/> Physician |
| <input type="radio"/> Community Representative | <input type="radio"/> N/A |
| <input type="radio"/> Health Educator | |

Other (please specify)

We want to hear from you!

- Please complete the brief TexasAIM Summit Day 1 Evaluation:

<https://tinyurl.com/TexasAIMDay1Eval>

- A link to the evaluation will be posted in the **Chat box**
- You will also receive the survey link in a **follow-up email** sent to you later today
- Please note that this is *not the evaluation for continuing education credits*