Improving Postpartum Access to Care (IPAC) Launch Call

May 20, 2019
12:00 – 1:00 PM
Introductions

- Please enter for yourself and all those in the room with you viewing the webinar into the chat box your:
  - Name
  - Role
  - Institution
- If you are only on the phone line, please be sure to let us know so we can note your attendance.
Overview

• Why IPAC?
• ILPQC Structure and Supports
• Initiative overview
• Team Talk- Kelli Lewis, RN
• Getting Started with IPAC
• Upcoming Events & Next Steps
WHY IPAC?
Redefining Postpartum Care

ACOG Committee Opinion #736:

• To **optimize** the health of women and infants, postpartum care should **become an ongoing process**, rather than a single encounter.

• **All women** should ideally have contact with maternal care provider **within the first 3 weeks postpartum**
  - Blood pressure checks
  - Breastfeeding support
  - Mental health well-being
  - Contraception

• Initial assessment should be followed up with **ongoing care as needed**

• Conclude with a **comprehensive** postpartum visit **NO LATER than 12 after birth**
REVIEW OF MMRC REPORT
MMRC Report Overview

• IL is first state to release a **statewide maternal morbidity and mortality report**
• Identified statewide trends in maternal mortality and provided recommendations to prevent maternal mortality
• Key Findings:
  • Avg of 73 women per year died within one year of pregnancy 2008-2016 (Total of 655 women)
  • Non-Hispanic Black women are 6x as likely to die of a as non-Hispanic White women
  • 72% of pregnancy-related deaths and 93% of violent pregnant-associated deaths (includes overdoses) were deemed preventable

24% of pregnancy associated deaths 0-42 days  
53% of pregnancy related deaths 0-42 days  
Before the 6 week visit
Key Recommendations from the MMRC report

• For Providers:
  • Providers should adopt the recent recommendation from the American College of Obstetricians and Gynecologists (ACOG) for early postpartum visit in addition to traditional 6 week visit

• For Hospitals:
  • Birthing hospitals should ensure that women are connected with a primary care or obstetrical provider and scheduled for a postpartum visit prior to hospital discharge

• For Health Plans:
  • Illinois should expand Medicaid eligibility for the postpartum period from 60 days to one year after delivery and health insurance plans should cover case management and outreach for postpartum high-risk women for up to one year after delivery
  • Health insurance plans should separate payment for visits in the postpartum period from labor and delivery (unbundle postpartum visit services from labor and delivery)

Maternal Morbidity in the Early Postpartum Period

- 50% of postpartum strokes occur within 10 days of discharge
- 20% of women discontinue breastfeeding before the first 6-weeks
- Up to 40% of women do not attend the 6-week postpartum visit
- As many as 1 in 5 women experience a postpartum mental health disorder
New Postpartum Care Continuum

An early postpartum visit (within 2 weeks of delivery) provides women with essential maternal safety checks such as blood pressure evaluation, wound/perineum evaluation, breastfeeding support, mental health well-being, and family planning, among other essential health services.
Components of the Early Postpartum Visit

• Blood pressure / preeclampsia symptoms check
• Wound/ perineum healing check
• Assess postpartum bleeding
• Mood check/depression screening
• Breastfeeding support
• Family planning/contraception options
• Linkage to health / community services (ie. WIC, breastfeeding support, home visits)
• Check in on medical / pregnancy complications or any SUD/OUD risks and link to needed follow up care
• Review risk reduction strategies for future pregnancies (aspirin/preeclampsia, 17OHP/preterm delivery)
ILPQC STRUCTURE AND SUPPORTS
Illinois Perinatal Quality Collaborative (ILPQC)

- Multi-disciplinary, multi-stakeholder Perinatal Quality Collaborative with 119 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

>99% of IL births
**Key Stakeholders**
- Illinois Department of Public Health
- Illinois Department of Healthcare and Family Services
- Illinois Department of Human Services
- Illinois Hospital Association
- Illinois Public Health Association
- March of Dimes
- EverThrive Illinois
- ACOG
- ACNM
- ICAAP
- AWHONN
- AAFP
- Midwest Business Group on Health
- Illinois Association of Medicaid Health Plans
- Private Payers

**Leadership Team**
- Ann Borders, MD, MSc, MPH
  Northshore University HealthSystem
- Patricia Lee King, PhD, MSW
  Northwestern University, Illinois Perinatal Quality Collaborative
- Leslie Caldarelli, MD
  Prentice Women’s Hospital – Northwestern Medicine
- Justin Josephsen, MD
  SSM Health Cardinal Glennon Children’s Hospital – St. Louis University
- Terry Griffin, MS, APN, NNP-BC
  St. Alexius Medical Center
- Shannon Lightner, MSW, MPA
  Illinois Department of Public Health
- Abigail Holicky, MPH
  Illinois Department of Public Health
- Amanda Bennett, PhD
  Illinois Department of Public Health
- Cindy Mitchell, RN, BSN, MSHL
  St. John’s Perinatal Center
- Stephanie Bess
  Illinois Department of Human Services
- Arvind Goyal, MD
  Illinois Department of Health and Family Services
- Scott Matthews, MSW, MHA
  March of Dimes, Midwest Region
- Helga Brake, PharmD, CPHQ, CPPS
  Illinois Health and Hospital Association
- Ashley Frederick, BSN, RN, CPHQ, CPPS
  Illinois Health and Hospital Association
- Kirbi Range, MS
  EverThrive Illinois

**ILPQC Central**
- Danielle Young, MPH
  Northwestern University, Illinois Perinatal Quality Collaborative
- Autumn Perrault, RN, BSN, LCCE
  Northshore University HealthSystem, Illinois Perinatal Quality Collaborative
- Dan Weiss, MPH
  Northshore University HealthSystem, Illinois Perinatal Quality Collaborative

**ILPQC Data Team**
- Satyender Goel, PhD
  Northwestern University Feinberg School of Medicine
- Zahra Hosseinian, MA
  Northwestern University Feinberg School of Medicine

**Key Advisors**
IDPH Office of Women’s Health & Family Services
Title V MCH Programs
- Regionalized Perinatal Program
- Perinatal Advisory Committee
- State Quality Council
- MCH Epidemiology Programs, School of Public Health, UIC

**Patient/Family Advisors**
- Jennifer Heiniger
- Valerie Krasnoff
- Tracy Patton
- Stacey Porter
- Tamela Milan, MPPA

**Legislative Advisory Workgroup**

**Obstetric Advisory Workgroup**

**Obstetric Hospital Teams**

**Neonatal Advisory Workgroup**

**Neonatal Hospital Teams**
ILPQC Central Team

Ann Borders
ILPQC Executive Director, OB Lead

Leslie Caldarelli & Justin Josephsen
Neonatal Leads

Patricia Lee King
State Project Director

Daniel Weiss & Danielle Young
Project Coordinators

Autumn Perrault
Nurse Quality Manager

info@ilpqc.org OR www.ilpqc.org
ILPQC: Three Pillars Support Quality Improvement Success
What is Quality Improvement?

Hospital QI Work:
What changes can you make to your process/system and test with a PDSA cycle to reach initiative goals?
ILPQC Provides Responsive QI Services to Hospital Teams

**Webinars/ Calls**
- Monthly collaborative learning calls
- Quarterly QI support calls to individual teams
- Small group QI topic calls as needed

**Face to Face**
- Spring Face-to-Face Meeting breakouts
- Annual Conference breakouts
- Key Player site visits
- Grand Rounds presentations

**ILPQC Resources**
- Paper/online QI toolkits
- Patient-education materials
- Monthly e-newsletters
- Webinar recordings

**ILPQC Data**
- Rapid response data system
- Real-time reports for teams to compare data across time & hospitals
- Data system training calls

**Quality Improvement Support Services**
Improving Postpartum Access to Care (IPAC)

INITIATIVE OVERVIEW
Aim: Within 11 months of initiative start, ≥80% of participating hospitals will be documenting and offering a universal two-week early postpartum visit.

To optimize the health of women by increasing access to early postpartum care within the first two weeks postpartum to facilitate follow-up as an ongoing process, rather than a single 6-week encounter and provide an opportunity for a maternal health safety check and link women to appropriate services.

Key Goals:
• Increase % of women with an early postpartum visit scheduled with an OB provider within the first two weeks after delivery
• Increase % of women receiving focused postpartum education prior to discharge after delivery
• Increase % of providers / staff receiving education on optimizing early postpartum care
• Achieve GO LIVE goal to provide IPAC for ≥80% participating hospitals by May 2020
Timeline for IPAC

- Initiative Development and Pilot with St. Anthony Hospital: April – December 2018
- Recruitment for IPAC Teams: Winter/Spring 2019
- IPAC Kick-Off Call: May 20, 2019
- Wave 2 Launch Face-to-Face Meeting: May 29, 2019
- Monthly Team Webinars / Active QI Period
- 3rd Monday of month, 11-12pm 2019-2020
- Go LIVE goal by May 2020
ILPQC Improving Postpartum Access to Care (IPAC) Key Driver Diagram

**Primary Key Drivers**
- Utilize provider outpatient packet to engage OB providers and outpatient care sites to help plan for early pp visit scheduling, obtain buy-in from providers, and share options for billing and coding.
- Implement process flow to facilitate universal scheduling of early pp visits prior to hospital discharge.
- Implement provider and nurse education on risks of the postpartum period, benefits of early pp visit, and key components of maternal health safety check.
- Standardize system to provide patient education prior to hospital discharge on the benefits of early pp visit, early pp warning signs, and benefits of pregnancy spacing and options for (outpatient) family planning.

**Secondary Key Drivers**
- Obtain buy-in from OB providers and outpatient care sites on national recommendations and benefits for an early pp visit within 2 weeks.
- Provide billing and coding information to OB providers and outpatient care sites for the early pp visit within 2 weeks.
- Create a hospital specific process flow to help facilitate scheduling of an early pp visit within 2 weeks prior to discharge.
- Revise policies and procedures to ensure scheduling for an early pp visit within 2 weeks.
- Develop strategy to educate inpatient and outpatient providers and staff using IPAC slide set, OB Provider Packet, and/or didactic education.
- Plan in place for ongoing and new hire education.
- Determine standard education about the benefits of early pp visits and components of maternal health safety check.
- Provide AWHONN’s early warning signs for all patients before delivery discharge.
- Determine standard education that includes benefits of pregnancy spacing and options for outpatient family planning.
- Develop a system change to ensure that all patients receive recommended postpartum education with documentation prior to hospital discharge, consider IT/EMR updates as needed.

**AIM**
Within 11 months of initiative start, ≥80% of participating hospitals will implement universal early postpartum visits (within 2 weeks) and be able to facilitate scheduling prior to hospital discharge.
Utilize provider outpatient packet to engage OB providers and outpatient care sites to help plan for early pp visit scheduling, obtain buy-in from providers, and share options for billing and coding.

Implement process flow to facilitate universal scheduling and patient education, prior to hospital discharge, of early pp visits / maternal health safety check within 2 weeks.

Implement provider and nurse education on risks of the postpartum period, benefits of early pp visit, and key components of maternal health safety check.

Standardize system to provide patient education prior to hospital discharge on the benefits of early pp visit, early pp warning signs and how to seek care (ie AWHONN resource), and benefits of pregnancy spacing and options for (outpatient) family planning.
## Overall Initiative Aim

Within 11 months of initiative start, ≥80% of participating hospitals will implement universal early postpartum visits (within 2 weeks) and be able to facilitate scheduling prior to hospital discharge.

## Structure Measures

- IPAC protocol/process flow in place for facilitating scheduling of early postpartum visits with affiliated outpatient care sites and OB providers prior to discharge.
- Communicate recommendation/strategy for early postpartum visit and obtain buy-in with OB providers/outpatient care sites (ie, share ILPQC OB provider/outpatient care site packet).
- Implement standard postpartum education prior to discharge after delivery regarding:
  - a) benefits of early postpartum care
  - b) postpartum early warning signs and how to seek care
  - c) benefits of pregnancy spacing and options for (outpatient) family planning

## Process Measures

- Educate all providers and staff on optimizing early postpartum care including:
  - a) maternal safety risks in the postpartum period
  - b) benefits of early postpartum care/maternal health safety check
  - c) protocol for facilitating scheduling early postpartum visit prior to discharge
  - d) documentation and billing for early postpartum visit
  - e) components of early postpartum visits/maternal health safety check

## Outcome Measure

- Increase % of women with documentation of an early postpartum visit/maternal health safety check encounter scheduled within the first 2 weeks of delivery.
- Increase % of patients who receive standardized pp patient education prior to discharge.
IPAC Clinical Leads

- Clinical Leads:
  - Michelle Bucciero, St. Anthony Hospital
  - Jeanne Goodman, Loyola University Medical Center
  - Kelli Lewis, Franciscan Health Olympia Fields
  - Lisa Masinter, Erie Health Center

- Clinical leads work with ILPQC to develop and refine data project aims/measures, data collection, scope, etc.
IPAC Teams to Date

- AMITA Alexian Brothers Women’s and Children’s Hospital – Hoffman Estates
- AMITA Alexian Brothers Hospital – Elk Grove Village
- AMITA Resurrection Medical Center - Chicago
- Loyola University Medical Center - Maywood
- FHN Memorial Hospital - Rockford
- Franciscan Health Olympia Fields - Olympia Fields
- Touchette Regional Hospital – East St. Louis
- SSM St. Mary’s – St. Louis
- St. Joseph Hospital – Chicago
- Morris Hospital & Healthcare Centers - Morris
Creating your IPAC Team

- **Required**
  - OB provider champion
  - OB nurse champion
  - Team Lead (can be OB or Nurse champion)

- **Recommended**
  - Outpatient representative*
  - Patient/family member
  - Lactation consultant
  - Social work
  - QI professional

*Highly recommended given need to schedule postpartum visits prior to discharge.
IPAC Team Rosters

- Developing your QI team and submitting your team roster to ILPQC are key first steps to get started
- Your team will be essential to your success, plan to meet at least monthly
- If you have not submitted a team roster yet, please do so as soon as possible
- Contact info@ilpqc.com if you need assistance developing your team or submitting your roster
Structure Measures help you track your implementation of systems/capacity changes

- Communicate recommendation/strategy for early postpartum visit and obtain buy-in with OB providers/ outpatient care sites (ie. share ILPQC OB provider/outpatient care site packet)
- System in place for facilitating scheduling early postpartum visits with affiliated prenatal care sites before hospital discharge
- Patient education materials selected with system to provide/review with patients before hospital discharge
- Reports will display your progress in red/yellow/green (not started, started, completed)
Process Measures
help you track your implementation of clinical practices towards culture change

- % of Physician and midwife educated on IPAC
- % of Nurse, lactation consultant, and social worker educated on IPAC

Outcome Measures
help you track your progress towards changing the health status of patients

- # of deliveries for the month
- Random sample of 10 deliveries report
  - # early postpartum follow-up plan/counseling documented prior to hospital discharge
  - # early postpartum visits scheduled and documented prior to hospital discharge
  - # patient with documentation of standardized postpartum patient education prior to hospital discharge
### Short Monthly Data Form to drive QI change at your hospital

#### ILPQC IPAC Data Collection Form

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers/Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. For which month are you reporting? [month]</td>
<td>Month/year:</td>
</tr>
<tr>
<td><strong>Structure Measures</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 2. What stakeholders do you have on your hospital QI team to date? (check all that apply) | 1. Administration  
2. Nursing  
3. OB provider champion  
4. Postpartum care site liaison  
5. Social Work  
6. Other:         |
| 3. Communicate recommendation/strategy for early postpartum visit and obtain buy-in with OB providers/outpatient care sites (e.g., share ILPQC OB provider/outpatient care site packet) | a. Have not started  
b. Working on it  
c. In place |
| 4. Does your team have a system in place to facilitate scheduling early postpartum visits with affiliated prenatal care sites prior to hospital discharge | a. Have not started  
b. Working on it  
c. In place |
| 5. Does your team have patient education materials selected/created to disseminate to patients prior to hospital discharge? | a. Have not started  
b. Working on it  
c. In place |
| a. Benefits of early postpartum care                                     |                |
| b. Postpartum early warning signs and how to seek care                   |                |
| c. Benefits of pregnancy spacing and options for outpatient family planning |                |
| 6. Does your team have a system in place for educating inpatient providers and nurses on the benefits of early pp visit/maternal health safety check and strategies to facilitate scheduling early pp visit prior to hospital discharge? | a. Have not started  
b. Working on it  
c. In place |
| 7. Does your team have a system in place for communication with all affiliated obstetric providers and outpatient care sites the benefits of maternal health safety check and education on billing and coding for this visit? | a. Have not started  
b. Working on it  
c. In place |
| **Process Measures**                                                     |                |
| 8. % of providers educated on optimizing early postpartum care            | a. 10%  
b. 20%  
c. 30%  
d. 40%  
e. 50%  
f. 60%  
g. 70%  
h. 80%  
i. 90%  
j. 100% |
ILPQC Data System

Collect data at your hospital

Enter data into data system

Review your progress in web-based reports to compare across time and across participating hospitals

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**ILPQC IPAC Data Collection Form**

<table>
<thead>
<tr>
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<th>Answer/Format</th>
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</thead>
<tbody>
<tr>
<td>1. For which month are you reporting? (Month)</td>
<td>Month/Year</td>
</tr>
<tr>
<td>2. What stakeholders do you have on your hospital’s team? (check all that apply)</td>
<td></td>
</tr>
<tr>
<td>3. Does your team have a system in place for scheduling early postpartum visits with affiliated prenatal care sites prior to hospital discharge?</td>
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</tr>
<tr>
<td>4. Does your team have patient education materials selected/created to disseminate to patients prior to discharge from L&amp;D/Mother/Baby?</td>
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<tr>
<td>5. Does your team have a system in place for educating inpatient providers and nurses on the benefits of early PP visit and key components of the visit?</td>
<td></td>
</tr>
<tr>
<td>6. Does your team have a system in place for communication with outpatient provider sites on education on billing/coding, benefits of early PP visit and key components of the visit?</td>
<td></td>
</tr>
<tr>
<td>7. % of providers educated on optimizing early</td>
<td>a. 10%</td>
</tr>
</tbody>
</table>

**ILPQC Process Measures:**

**Cumulative Percent of Nurses, Lactation Consultants, and Social Workers Trained on Evidence and Protocols**

- Cumulative Percent of Nurses, Trained 2018-2019
- Evidence and Protocols,
Team baseline evaluation

- All teams have opportunities for quality improvement to achieve IPAC AIMS regardless of where you are in implementation process.
- Baseline evaluation of needs, successes, challenges and where your team is in the process will help establish your team goals and work plan.
- Each team will create a 30, 60 and 90 day plan for success to be shared in a team story board at May 29 Face-to-Face Meeting in Springfield.
How will ILPQC help?

- IPAC Toolkit available online today and each team will receive a printed materials at Face-to-Face meeting on 5/29
- Monthly team webinars with education, data review and Team Talks
- ILPQC Data System each team will have secure access to the REDCap portal and live reports that can be shared at your hospital to support your teams efforts
- QI support coaching calls to teams to problem solve

Face-to-Face Launch Meeting, May 29, Springfield

Registration Closes Today!!!
IPAC Toolkit

- Introduction
- Initiative Resources
- Communicating and obtaining buy-in regarding need for early postpartum visit
- Tools for implementing universal early postpartum visits scheduled prior to hospital discharge
- Tools for outpatient providers to optimize early pp visit/maternal health safety check
- Billing/coding strategies for reimbursement of IPAC
- Resources for provider/nurse education
- Resources for patient education regarding IPAC
How long should you wait before getting pregnant again?

For most women, it’s best to wait at least 18 months between giving birth and getting pregnant again. This means your baby will be at least 1½ years old before you get pregnant.

Too little time between pregnancies increases your risk of premature birth. Premature birth is when your baby is born too soon. Premature babies are more likely to have health problems than babies born on time. The shorter the time between pregnancies, the higher your risk for premature birth.

Your body needs time to fully recover from your last pregnancy before it’s ready for your next pregnancy. Having at least 6 months between pregnancies may help reduce your risk for premature birth in your next pregnancy. Use this time to talk to your healthcare provider about things you can do to help reduce your risk. To learn more, go to marchofdimes.org/pretermbirth.

What you can do:
- Wait 18 months or more after having a baby before getting pregnant again.
- If you’re younger than 20 or had a miscarriage or stillbirth, talk to your provider about how long to wait.
- Use effective birth control until you’re ready to get pregnant.
- Talk to your healthcare provider about birth control options.

Waiting at least 18 months doesn’t mean you won’t be able to get pregnant, but it can help.

TAKING ACTION

Get your 18 months.

Fill this out with your provider so you know when you can start trying to get pregnant again.

Example:
- Date your baby was born: May 16, 2017
- Add 1 year and 6 months: Nov. 16, 2018

Now you try:
- Date your baby was born
- Add 1 year and 6 months

SAVE YOUR LIFE!

Get Care for These POST-BIRTH Warning Signs

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

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

Call 911 if you have:

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

Tell 911 or your healthcare provider:

“I gave birth on ______ and I am having ______.”

These post-birth warning signs can become life-threatening if you don’t receive medical care right away because:
- Pain in chest: A heart attack or breathing problems
- Bleeding: You may have a blood clot
- Seizures: You may have a fever or low blood sugar
- Thoughts of hurting yourself or someone else: You may have postpartum depression
- Headache: You may have a brain bleed

Your healthcare provider can help you identify any risk factors you may have and how to handle them.

GET HELP

My Healthcare Provider/Office:
- Hospital:
- Phone Number:
- Email:
# Early Postpartum Visit/ Maternal Health Safety Checklist

<table>
<thead>
<tr>
<th>Checklist Element</th>
<th>Discussed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Blood Pressure Check</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal blood pressure check and assess signs/symptoms of preeclampsia and when to seek care</td>
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<td></td>
</tr>
<tr>
<td>Wound and Perineum Complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess wound incision or perineum for appropriate healing and provide guidance on signs / symptoms to seek care</td>
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<tr>
<td>Postpartum Bleeding Assessment</td>
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<tr>
<td>Assess postpartum bleeding resolution and when to seek care</td>
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<td></td>
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<tr>
<td>Signs of infection</td>
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<td></td>
</tr>
<tr>
<td>Review with patient signs of infection and importance of seeking care</td>
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<tr>
<td>Breastfeeding Support</td>
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<tr>
<td>Discuss infant feeding; provide breastfeeding support and evaluate any concerns with breasts or breastfeeding; link to lactation support and where to call with questions</td>
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<tr>
<td>Mood and Depression Screening</td>
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<td></td>
</tr>
<tr>
<td>Assess mood; provide depression screening; review signs and symptoms of postpartum depression and when to seek care, link to follow up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and Pregnancy Complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check in on any medical/pregnancy complication and need for follow-up care; help navigate need follow up referrals / appointments</td>
<td></td>
<td></td>
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<tr>
<td>Other points of discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss risk reduction strategies for future pregnancies (e.g., OEP for preterm birth, aspirin for preeclampsia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other linkage to health/community resources as needed (e.g., WIC, home visiting, social work, lactation support groups, lactation counselor)</td>
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</tbody>
</table>
IPAC Toolkit Development

ILPQC 2019 Face-to-Face
Featuring Dr. Bucciero

**Key partner in development of IPAC toolkit**

Thank You

IPAC Panel Discussion – 11:00am

Dr. Michele Bucciero – St. Anthony Hospital
Kelli Lewis, RN

IPAC TEAM TALK
Improving Postpartum Access to Care (IPAC)

GETTING STARTED
Getting started with IPAC

• Form your QI team and find a monthly meeting time
• Submit team roster for team members if not completed
• Complete baseline survey and identify team goals
• Create a draft 30-60-90 day plan (QI plan for first 3 months)
• Draft a process flow diagram to assist providers in scheduling an immediate pp visit
• Plan first PDSA cycle to address 30-60-90 day plan
• Incorporate this work into Team Storyboard for Face-to-Face meeting on May 29 (goal share your team story and plan)

Register team for Face-to-Face Meeting and IPAC training in Springfield on May 29 / 30.
30-60-90 Day Plans or “Where should we start” Plan

- What are your **goals**?
- Where do you want to **start**?
- What would you like to accomplish in first 3 months of this initiative?
- Include plan for **1st small test of change** (PDSA cycle)
What is a Process Flow Diagram?

- Illustrates all of the activities involved - what really happens – in the OB process flow to facilitate scheduling early postpartum visits and provide patient education before discharge
  - Who is doing each activity, Where, Why, How?
  - The baseline process flow is a starting point for this work in progress document
- Involve everyone in the process to help your team understand
  - What steps are missing?
  - Where repetition is occurring?
  - Are the right people performing the right tasks?
  - What additional information / resources are needed?
Key questions to discuss with your team before getting started:

• What is the process for providing patients information on the importance of an early postpartum visit and documenting counseling?
• What is the process for facilitating scheduling and documenting an early postpartum visit?
• What is the process for communication between hospital and outpatient postpartum care sites for an early follow up appointment?
Process Flow Diagram Symbols

- Start or End of the process
- Task in the process
- Decision point in the process
Sample Process Flow:

Here is an example process flow to get started, can start from scratch or revise/add details to be more specific to your needs and workflow.
Plan-Do-Study-Act (PDSA) Cycle: Building Hospital-Level QI Capacity

Hospital QI Work:
What changes can you make to your process/system and test with a PDSA cycle to reach initiative goals?
Dr. Post, the outpatient provider champion, feels that provider buy-in should be a top priority. The team agrees and would like to do a small PDSA.

Team discusses strategies to assess outpatient providers’ understanding and readiness for implementation of a 2wk pp visit.

Team decides to do a PDSA with the ILPQC IPAC Outpatient Provider Packet along with suggested materials.

Team will measures understanding and readiness using a feedback tool that the team will create.
Sample PDSA:

- **Plan:**
  - **Objection:** Determine the effectiveness of utilizing the OB IPAC Outpatient Packet for engaging providers in the implementation of a 2wk pp check
  - **Prediction:** We think the packet will provide enough information and move providers to implementation of a universal 2wk pp visit
  - **Tool:** The QI team created a 2 question pre/post survey asking providers to rate (scale 1-10) their understanding and likeness of implementing a 2wk pp visit scheduled before the patient is discharged after her delivery
Sample PDSA cont.:

**Act**

Dr. Post will create a printed Outpatient Packet and will work with his office manager to disseminate the information to providers, and nurses and collect the post-survey.

**Plan**

IPAC QI team met and developed their plan for their first PDSA cycle (see previous slide)

**Do**

Dr. Post provided the pre-survey to his team at his office and collected the surveys the same day. After he collected the surveys he emailed the Outpatient Packets to everyone in the office. The email asked providers to complete the post-survey after reading the material that day.

**Decision:** Team decides to ADAPT: Dr. Post will visit with a provider in his office to get initial feedback via discussion.
UPCOMING EVENTS
You’re Invited!

2019 OB & Neonatal Face-to-Face Meetings

Nurses, Providers, & Staff join us for an interactive day of collaborative learning for current ILPQC initiatives!

OB Teams: May 29, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
 Mothers and Newborns affected by Opioids - OB (MNO-OB)
 Immediate Postpartum LARC (IPLARC)
 Improving Postpartum Access to Care (IPAC)

Neonatal Teams: May 30, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
 Mothers and Newborns affected by Opioids - Neonatal (MNO-Neonatal)

Register now!  https://ilpqc.eventbrite.com

This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. (OBN-001-91)

Abraham Lincoln DoubleTree Hotel, Springfield, IL

Illinois Perinatal Quality Collaborative
633 N. St. Clair, 20th Floor
Chicago, IL 60611
FACE-TO-FACE REGISTRATION OPEN!

Visit www.ilpqc.eventbrite.com to register today!
Breakout Session for IPAC Teams

IPAC Panel Discussion
Dr. Michele Bucciero – St. Anthony Hospital

IPAC
IPAC- Getting started with improving access to postpartum care

Make sure to bring team members to Face-to-Face Meeting to attend break out sessions!
Storyboard Template for 2019 Illinois Teams

Every hospital team brings a storyboard describing ongoing ILPQC QI work to Face to Face
Storyboard Instructions

- **Storyboards must fit into a space approximately 28 x 40 inches.** It may be created from a collection of letter-sized sheets (print outs of your power point slides or word documents) that are convenient for carrying while traveling. About six 8x10 inch sheets can fit in the available space. Large post-it sheets and tape will be provided at the meeting.

- **Share your story:** about your hospital, about your team, describe your goals for this initiative, include process flow diagram draft, can include any barriers you have identified and opportunities for improvement, describe next steps or action items for your team

- **Keep it simple:** the Storyboard is not meant to be an extremely time-consuming project.

**Display Tips**

- Be creative- there is no wrong way!
- Use fewer words and more pictures and graphics
- Include photos, collages, and illustrations (including a photo of your team)
- Use the largest font size as possible for readability
- Use color to highlight key messages (If you don’t have a color printer, use bright highlighters)
- Clear titles and labels if you use graphs (X and Y axes, dates, brief explanation of what it shows)
Storyboard Instructions: Participating in Multiple Initiatives?

- Your hospitals may be participating in multiple OB & Neonatal initiatives at in 2019. We encourage teams to bring **one OB and one NEO** storyboard addressing the active initiatives they are participating in:

- **OB Teams:**
  - MNO- OB
  - IPLARC Wave 1 or 2
  - IPAC

- **Neonatal Teams:**
  - MNO- Neonatal
OB Teams Story Board

Key Components

- Describe your hospital and demographics
- List team members and their roles (add a team photo if available)
- List potential barriers and strategies for addressing
- Describe any PDSA cycles and their results
- Describe 30/60/90 day plan for ongoing / or getting started QI work in 2019
Initiative Specific Content

- **MNO-OB teams:**
  - Process flow for OUD protocol
  - Progress on structure measures and key process measures including MAT at delivery and OUD clinical care checklist in chart

- **IPLARC and IPAC teams:**
  - Wave 1: Include information about comprehensive contraceptive counselling & documentation (prenatally and on L&D), process flow, and GO LIVE date.
  - WAVE 2 and IPAC teams: Include team goals, next steps, draft process flow, 30-60-90 day plan- where are you starting, what do you want to accomplish next?
Example: Team participating in 2 initiatives

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>MNO-OB</th>
<th>IPAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Demographics</td>
<td>Identified MNO-OB Team goals and successes</td>
<td>IPAC Team</td>
</tr>
<tr>
<td>OB HTN QI Team Composition</td>
<td>30-60-90 Day plan</td>
<td>30-60-90 Day plan</td>
</tr>
<tr>
<td>OB MNO QI Team Composition</td>
<td>Hospital OUD process flow</td>
<td>Identified barriers &amp; strategies to address</td>
</tr>
<tr>
<td></td>
<td>Identified barriers &amp; strategies to address</td>
<td>Early PP Visit Scheduling process flow</td>
</tr>
</tbody>
</table>
Sample Layouts

With 4 portrait oriented sheets in the middle panel

With 3 landscape oriented sheets in the middle panel
<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 20, 12-1pm</td>
<td>IPAC Launch Call</td>
</tr>
<tr>
<td><strong>May 29</strong></td>
<td><strong>OB Face-to-Face Meeting, Springfield, IL</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Breakout session for IPAC Teams</strong></td>
</tr>
<tr>
<td>Monday June 17, 11a-12pm</td>
<td>Getting started with the IPAC Toolkit and debrief from Face-to-Face</td>
</tr>
<tr>
<td>Monday July 15, 11a-12pm</td>
<td>Obtaining OB Provider / Outpatient site IPAC buy-in and engagement</td>
</tr>
<tr>
<td>Monday Aug 19, 11a-12pm</td>
<td>Creating IPAC process flow and system changes to facilitate universal</td>
</tr>
<tr>
<td></td>
<td>scheduling prior to hospital discharge</td>
</tr>
<tr>
<td>Monday Sept 16, 11a-12pm</td>
<td>Strategies to launch IPAC provider and nurse education</td>
</tr>
<tr>
<td>Monday Oct, 11a-12pm</td>
<td>Implement IPAC process flow and system changes to provide patient</td>
</tr>
<tr>
<td></td>
<td>education prior to hospital discharge</td>
</tr>
</tbody>
</table>
Next Steps

• Finalize your IPAC Team and establish a time for at least monthly IPAC meetings
• Team baseline evaluation: review where your team is in the process will help establish your team goals
  – ILPQC will provide survey to guide your teams discussion
• Each team will create a 30, 60 and 90 day work plan for success to be shared at May 29 Face-to-Face
• Review data form, strategize plan for data collection
• Plan to have team members join monthly IPAC webinars 3rd Monday of the month 11am-12, starting in June
Contact

• Email info@ilpqc.org
• Visit us at www.ilpqc.org
THANKS TO OUR SPONSORS

IL PQC
Illinois Perinatal Quality Collaborative

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

march of dimes

IHA Illinois Hospital Association

CDC

IDPH
Process Flow for Scheduling Early Postpartum Visit

Patient meets all discharge criteria

Counsel patient on the benefit of early postpartum visit

Provide patient education materials on the benefit of early postpartum visit, warning signs/symptoms to seek care (ie. AWHONN hand out), and information on benefits of pregnancy spacing/family planning options.

Patient ready to make early postpartum appointment

Yes

Appointment scheduled and appointment date and time added to patient’s discharge paperwork

Provider documents counseling, education and postpartum care plan

No

Explore barriers and reinforce importance of early postpartum visit

Patient ready to make early postpartum appointment

Yes

No