ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Video Transcript: Leveraging System Strengths to Solve Capacity Gaps in Limited-Resource Environments Community of Learning

Session 4: Strategies for Data Utilization in Low-Volume Settings

Allison Finkenbinder [00:00:00] Welcome to the fourth and final session of our Community of Learning about Leveraging System Strengths to Solve Capacity Gaps in Limited Resource Environments. Today's session is going to be focused on strategies for data utilization in low volume and rural birth settings, and we'll hear from three panelists on the strengths and challenges that low volume in rural birthing facilities may face when reviewing their data and using it to make quality improvements in maternal care. Welcome to our session.

Allison Finkenbinder [00:00:34] So a few items, the community learning is hosted by the Alliance for Innovation on Maternal Health Technical Assistance Center, the AIM TA Center. And the AM is a quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes, and save lives. The AIM TA Center is managed by JSI Research and Training Institute, a non-profit public health consulting organization that works both internationally and across all 50 states. We are dedicated to improving lives through better health and education outcomes for individuals and communities. The AIM TA Center is supported by a cooperative agreement with the Health and Resources Services Administration of the U.S. Department of Health and Human Services. And the contents in this webinar today are of the authors, and they may not reflect the policies of HRSA, HHS, or the U.S. Government. And our goal with today's session is to support you all and your organizations and your work around implementing the patient safety, AIM patient safety bundles and maternal health initiatives. Our hope is that by the end of the session, participants will be able to discuss some of the unique challenges and the environment that impacts maternal health and implementing AIM patients safety bundles, particularly in rural and low volume obstetric units. And we'll be able to kind of talk about approaches that will meet rural and low volume facility clinicians and staff where they're at in this work. And then identify some tailored approaches for low volume hospitals to meaningfully track QI or their quality improvement progress, even in places where they have small patient denominators. We have a few housekeeping items. So welcome everyone. We are recording this webinar. And we will be sharing that. It'll be available and posted to the website probably in the next two weeks. We also have time for questions and answers at the end, but you don't have to wait to ask your questions. We really ask you to submit them any time using the chat. We're gonna be keeping track of those and, you know, coming, circling back around to them, to our speakers. Also, we love to see your faces. So if you're able, we welcome you to come off camera. And if you have a question and wanna come off mute. To ask it, it would be helpful if you use the raise hand function. If you need any technical support, you can use the chat feature to message any of the hosts directly. So those of us with our AIM background, I think most of us are purple today, look for us. And then lastly, we really welcome your feedback and it's how we get better. And so we're gonna share the evaluation link out in the chat. And we welcome

you to open it up and fill that out in real time. And then we'll remind you about that once more at the very end.

Allison Finkenbinder [00:03:25] Okay, I'm really pleased and excited to introduce our panelists for today. Whoops, I need to move my slide forward. Thank you, Tanisha, for that link. So our panelists, first, I'd like to welcome Dr. Stephanie Radke, who is a clinical professor of obstetrics and gynecology at the University of Iowa. She is the executive director of the Iowa Perinatal Quality Care Collaborative, which implements AIM in Iowa. And in this role, she's overseen the implementation of four AIM bundles since 2020. Dr. Radke is also the PI for Iowa's HRSA Maternal Health Innovation Initiative, which includes multiple outreach programs, supporting rural and low volume obstetric facilities and non-obstetric healthcare providers. And she is an expert in quality and safety, having trained with an improvement advisor with IHI, the Institute for Healthcare Improvement, and is also a trained simulation instructor. Welcome, Dr. Radke. Next, I'd like to welcome Kristal Graves, registered nurse with 24 years of experience in a rural hospital setting. And she currently serves as the clinical nurse improvement coach for rural hospitals across Iowa. And she supports efforts to enhance quality and safety in maternal and newborn care. And then next, I welcome LeAnn Fenton. Who is the acute care director with Regional Medical Center, which is a 25-bed critical access hospital in Manchester, Iowa. I'm serving Manchester, but then also that rural Northeast Iowa region. LeAnn brings 28 years of critical access-hospital experience, as well as her experience as the nursing director for the obstetrics department, medical-surgical department, surgical services, specialty clinic, wound clinic, and outpatient procedure center. LeAnn did not put this in her bio, but she wears a lot of hats and she's a busy lady and we're really glad she could join us today. Thank you all for joining us.

Allison Finkenbinder [00:05:31] So I'm gonna start us off. So we started planning this session like back in May. And so Dr. Radke, we were meeting with you and we also had been meeting with another nurse, Dawn Fuller, who was from a hospital in Louisiana and was running their OB unit in her smaller rural hospital. And just two weeks ago, we found out from Dawn, who was supposed to be co-presenting beyond our panel, that her facility is closing her OB unit. Um, and so she, she's not able to be here today. Uh, and we miss her, but you know, she, this, this was sudden. It seemed like a surprise to her. Um, so she's really taken up her time. She needs to be there for her unit, her facility, and really supporting her community in this whole process of losing those services. And so also in our planning, Dr. Radke, you mentioned that Iowa has, you've had 20% of your OB units closed. Um. In the state, and I don't remember the time frame, but it seems fairly recent, the last half, five to 10 years, maybe less than that. Anyways, all of that kind of really struck me how important it is to keep context in mind when we're looking at maternal health data, when all of us are looking at our hospitals or our states. And so I wonder if you could kind of start us off, Dr. Radke and speak to doing the AIM work in this context and environment.

Stephanie Radke [00:06:55] Yeah. Thank you for that, Alison. I think that it was interesting when Dawn, we heard Dawn's news when you guys shared it with me. It was like a surprise, but not a surprise because this is part of doing, working in a maternal health space, really in any state. I don't know that there are any states that are not being impacted by hospital closures. Maybe a few aren't, but certainly the hospitals are still feeling the pressures that are driving some units to close And I think that that makes leading AIM and quality improvement work a really interesting but increasingly important task, right? But what I would say to other AIM entities in other states is really understanding the context in your state is so important. As you're thinking about planning

initiatives and recruiting facilities, and helping them to be successful in the work is recognizing that their involvement in your initiative is one small piece of what is happening. And there might be some really big factors at play, right? They might know that there are conversations about their facility closing, or they might only have three providers that deliver babies and they know that one of them is retiring next year. And so I think just having an appreciation that the context is really challenging in that this may not be the most important thing, but also in some ways it makes it even more important in this environment. I think the other thing that I think about a lot is how do we measure the impact of this work when we are doing maternal quality improvement in an environment that's very dynamic, right? We've had in Iowa, we've had two and we have one more still coming this year, birthing hospital unit closures. And we've had a couple in recent years and within the past 10 years we've had quite a few. And so access is declining largely in rural spaces, but also in some micropolitan communities or kind of smaller cities. And population health is not improving. And so I think maybe this is more of a call to the AIM TA centers and other smart data people, but How do we measure improvements when we know that the trajectory is worsening, right? If we're trying to reduce severe maternal morbidity, but we know so many other things that influence severe maternal morbidity outside of the quality of health care are working against us, right, like diminished access to Medicaid, increasing portion of the people who are uninsured or driving further for health care, and other just factors that influence health. So. I don't have a lot of answers other than to just say that I think that the environment plays a huge factor, both in how you design your initiatives and then how you evaluate their impact, particularly in rural communities.

Allison Finkenbinder [00:10:04] Thank you. Thanks for that. Kristal, I want to turn to you and I'm just wondering if you can share, you know, what are some of the challenges you've seen with implementing AIM work in rural facilities?

Kristal Graves [00:10:17] Yeah, so as a background, I've worked for almost 24 years in a critical access rural hospital. So when I came onto the team, those are obviously the teams I was going to coach was my like size facilities. And so the first conversation we had when we started AIM was why did some of these level one smaller hospitals not originally sign on to work with our PQC? And I think we first of all decided that there was a fear factor of really, what is this? What are they gonna ask of me? Because as you mentioned, LeAnn wears a lot of hats and to add one more hat to do QI can be a little bit to put you over at the top. And then if that's not your background, which I would say a good majority of my leaders across the state are working leaders. So they work the floor, maybe multiple departments. And quality improvement is not something that they've ever done and potentially not something they ever had a inkling to want to do. So to ask them to add one more hat was a pretty big step. So I would say here in Iowa, I was blessed that Dr. Radke told me to just hit the road. So I hit the road and I visited these small hospitals and basically just showed them we weren't scary. That we weren't gonna ask them to do so much work that it was unreasonable, that we were gonna meet them where they were at. And we felt as if any participation was better than no participation. And so that was kind of our step in the door was just meeting them there. And then we have found a lot of our leaders such as LeAnn, once they really heard what this was and heard what we were asking for them, embraced it and ran with it and have honestly done amazing. And do just as much, if not more, quality improvement data entry and PDSA work than some of our larger counterparts that have actual QI staff assigned to them. So I think the big challenge for them is just finding the time, the resources, and understanding the ask of them. But honestly, once they get into it, we have found that we've had some small hospitals be very successful and our quality improvement work.

Allison Finkenbinder [00:12:34] Thank you. And LeAnn, I'm wondering if you could maybe describe to us a little bit, tell us a little about your facility. But then we're wondering if he could speak to what AIM looks like in your facility?

LeAnn Fenton [00:12:50] Okay, so we are a small critical access facility in northeast Iowa. The town of Manchester is where we're at, it's about 5,000 people as far as population. We do have satellite clinics in surrounding small towns that may only have like 1,500 people in them. So we are 45 minutes from our tertiary centers. Pretty much in all directions. It's 45 minutes to the south, east, west to get to a level two, level three facility. So we're a level one nursery that we provide care for here. So we only deliver about 250 babies a year. So our volumes are quite small. That's about 20 to 25 a month. So we are fortunate though, we have great providers, great administration. The support has been amazing. We actually have seven providers that deliver here. We have one OB-GYN, one nurse midwife, and then family practice providers. And four of those family practice providers also do C-sections. In addition to our general to general surgeons that take call for us. So again, we have been very fortunate with the C-section coverage and the providers that we we do have here. So, so we got that going for us, that's for sure. As far as AIM work here at our facility. I'd have to say being here and being a leader in a critical access facility and OB for 20 plus years. I've relied on our state perinatal team. Originally, when I first got into this leadership role, they would travel to each birthing facility approximately every two to three years. Back then, we had a lot more birthing facilities, so it took a little longer for them to get around to each facility, but they always brought us so much great information and as much as I maybe dreaded kind of the chart prep and things that we had to do, we always came out of those meetings and learned a lot from that. Um, over the years, they've been able to get to our facilities a little bit more often because we have fewer facilities that they're having to travel to. But, um, some of those same people that were on that statewide perinatal team that was traveling, um. Have also been part of our, our, um IPQCC in the state. And, um so, so having that working relationship and that relationship with them has really been helpful. As far as being in a small facility and trying to launch these initiatives and get them implemented, you know, it's the resources. I don't have a dedicated education department. I don't a dedicated simulation leader. I am the NRP instructor here and a director like this and doing the QI and I'm also making staff schedules. And jumping in and helping move staff around for multiple departments. So wearing many hats is definitely, but I guess I like the challenge too. That's why I keep doing it. We are able to in a small facility, I think, or at least here. Again, I have great administrative support. If I'm bringing things to them and have the data to back it up, I can usually make some, or we can make changes pretty quickly. We just had a learning session yesterday on safe sleep. It's our next initiative for neonates. And sitting through that learning session provided by IPQCC, I'm already making a list of, OK, who do I need to get at the table so we can start working on this next project? Is it like for HIE, it was I need to get a representative from lab. I need a representative provider. With our mental health initiatives, you know, getting social work, getting our clinic representation, getting obviously, nursing leadership providers. One of our midwife is on our team here. So each initiative, I have to get different membership, but I'm able to get them, get them meeting. We get around the table. We look at our policies. Able to tap into all the resources. The resources have been amazing. Back in the day, you know, I get resources from the statewide perinatal team, but I would be out trying to find things, you know California. Their initiatives and trying to do all that on my own and to have the time to dedicate to that was always a challenge. But now I've got, I can go into this nice online system and I can look at resources that the Iowa group is just putting out there for us. I can throw things on a listserv or ask Crystal to throw this question out and we can get policies and things from

other facilities. And It's not just small facilities, I can take those policies or those recommendations from the larger facilities and try to figure out how can we make that fit us or no, I don't have, you know, an education manager or this person or that, but what can we do here that we can use to help with that quality? So, I dunno if I'm getting off track or not, but yeah, just the resources that this collaborative has opened us up to has been amazing and is so extremely helpful. And I will say, Kristal traveling, she was just at our facility last week, actually, and did a few simulations with us. We learned so much from them, them just coming here. Yes, I'm helping facilitate SIMS, but I learned every single time she comes here, I'm like, oh, I can do SIMS better by doing this or that. And they're just, yeah, great people to work with. And we're so lucky that we have this in our state.

Allison Finkenbinder [00:18:47] Thanks for that. I'm hearing like you don't have to go it alone. Sounds like you've got the support and back and forth. That's great. I'd like to talk about data a little bit. And so back to you, Dr. Radke, what strategies can facilities use to look at their data to identify like true clinical trends and really measure that quality improvement when their denominators are small?

Stephanie Radke [00:19:14] Yeah, I just wanna like, I'm glad this is recorded. I'm gonna use LeAnn as like a pitch for why we need continued funding in our state. And I did actually just wanna clarify. So LeAnn mentioned another program we have in Iowa called the Statewide Perinatal Care Program. And I do, this is a unique program to Iowa that's been around for 50 years and is now kind of merged in with our PQC that does AIM and our neonatal initiatives. I do think that it relates to this topic, so I want to say a few words. I think we were able to really quickly recruit a lot of hospitals to participate in our PQC work through the statewide perinatal program. This is a neonatologist and an obstetrician, used to be somebody else, it's now me, and a neonatal nurse and an obstetric nurse that go to the hospitals and we just do chart reviews and evaluate where we think their care could be better. And so for people with a hospital background, this is like the safety side of a quality and safety department, right? Where you're really doing event reviews to understand, did your care deviate from the standards and where did you have maybe an opportunity to do something differently? But I actually really think that that program gave us the foundation to a really successful PQC launch because we had contacts in all the hospitals and we were generally a trusted entity. And then the previous obstetrician in the program is retired and now that I'm in it, I can use those visits to reinforce things that we've worked on or are currently working on. And it's a really useful way to maybe reach a resistant provider or nurse because you bring in a different spokesperson of the same message as they've been hearing from LeAnn or whoever their leader is. And we just have a lot of instances where a hospital was maybe struggling to get an initiative to move and then I was able to speak a bit and it's not me it's more just like somebody else came in and and talked about it and so I do encourage states to think about like are you visiting your hospitals and are you visiting them to do sim or to do education but I think showing up in person in kind of that like. Not really one-on-one, but it's like you coming just to their facility makes a really big difference. So just a little tangent, but data in small volumes. So I think that this is a space where AIM is at face value can seem like it's not for a small hospital. And so I think it's important for AIM leaders to recognize that if you throw a set of measures at a small hospital, they're just going to be like... A lot of this maybe doesn't apply to me. And so, and it feels like then maybe the program may not be for them. But I think you just have to recognize that with small numbers, you're gonna have a lot more movement in your data, particularly for like NTSV C-section, because we know that it's like, the goal isn't 100% or 0%, the way it is with a process measure. And so it can be really hard to interpret trends over short periods of time. And so you then just need to focus on what you can do. And I think that focus on what you do and what you can always do are your process measures

because what's in your control is the care you provide. And so I think a focus on process measures. Helping people to not perseverate over things that may fluctuate really wildly on a monthly or even quarterly basis. And then also something that small facilities can do, I think often really well, that larger facilities sometimes struggle with is they can do exactly what LeAnn had been telling us earlier they were about to do over a case they had last night, which is they get people together and they can debrief and they review cases. And I think that there is just as much to learn from an in-depth review of a case as there is from looking at a beautiful run chart of an outcome measure. And so sometimes with a smaller team, it is a lot easier to get people together and to look at, I mean, you could look at every unplanned primary C-section in LeAnn's hospital. I can't do that in the hospital that I work at. And so, So there's some strengths there. And I think you just have to align the data strategy might be a little bit more case review heavy and a little less big dashboard of lots of numbers. But in some ways, it may almost be better. I don't know. I mean, it's certainly not not worse by any means, but that's what you have to coach on.

Allison Finkenbinder [00:24:09] Yeah, thank you. And Kristal, you've mentioned and talked about this is part of your work. And so I was wondering if you could maybe walk us through what concrete strategies are you using when you're meeting with these small volume units, whether it's collecting the data or interpreting their data, like what do you do, I guess, to help them use their data to demonstrate changes or maybe advocate for their resources that they want?

Kristal Graves [00:24:37] Yeah, so we always do, I think, a real good job here in Iowa of just saying, like, you have to start with your data. Do we have data to support that we even need to make a change? So that's always our ask of what can you do by next Tuesday is, can you just look to see what your data is showing? And to be honest, with some of our hospitals, they maybe don't have a really robust IT department to help them run reports. So I would say a lot of our ground zero of where to start was. Can we audit some charts? And I even have some of my really small hospitals, because mind you some of my hospitals deliver you know 50-60 babies a year. They will have nurses help with chart audits, which I think is a phenomenal way to help when you have someone like LeAnn who's wearing all of these hats. These nurses do have some downtime sometimes where you don't have patients, and so they're given a list of things to go look at on a chart audit. And see, was QBL documented? Did we have a severe range, high blood pressure in any of our 10 patients we delivered this month? They can look through the entire chart. So although they may not have a robust IT department or an electronic medical record that can run a good report for them, we have found ways around that. And some of that is by asking some of our primary nurses to do some chart audits for us. The other thing is just. Once we meet and we have our first learning session is then exactly what LeAnn said is she has this list of things to then reach out and ask. So it's just an ask to your IT: this is what I'm looking for. Is there a way that I can run this? And if they can't, then sometimes we have them do some sampling. But again, with these smaller hospitals, often they can look at all of their charts. And just finding someone who can help them do that I think is really helpful. And then we come together, usually monthly with my new leaders, especially right at the beginning. I meet with them monthly on a Zoom call and we talk through their data. And then, we enter their data together to really help them understand what is their data showing. And we write PDSAs together. We use the platform called SimpleQI. And so, I, as their coach, will walk through with them and say. What is our plan? What are we gonna do here? And then we meet the next month and we maybe study what their data showed. And I help them do that because if they don't have a quality improvement background I might say, you don't a problem here. You are doing great already. You are already collecting and getting QBL on all of yours. So maybe let's look at your hemorrhage

cart next. And we really just prioritize what they can really impact first and then we take a next step. Because again, with them being so busy, we really identify what is my first priority and let's work on that and see if we really have a problem and work through a PDSA and then if that's not a problem, then let's look at the next thing. Instead of cracking into this and seeing the 20 different measures you could look at and all of these process measures that can be overwhelming, I think for our small hospitals, we really just identify what that thing I can really look at now and see that data. Simple QI has been very helpful for our teams. I don't know how LeAnn feels about it, but it's a pretty simple system for them to, it builds a chart for them. So if it's a nurse manager who doesn't like to get into Excel and build a chart, it will do it for them, that's very helpful. If they need something more than that, Dr. Radke I can help them build a graph or chart if they need more to show to their administrators or direct board of directors and those sorts of things. But We really just do try to find a way to break it down and make it a little bit more simple for them and give them the tools that make it a little easier for them to collect that data and enter it.

Allison Finkenbinder [00:28:28] Thank you. And LeAnn, I'm wondering if you can kind of talk to us from the other side of that. I mean, what is this looking like for you when you're looking at your data and really doing this QI work, you know, at your center?

LeAnn Fenton [00:28:43] I'd have to agree. Simply QI, like Kristal said, has really helped make it easier for us. Having the phone calls with Kristal, she's our coach, her helping me understand what the measures are truly asking for and what we should be reporting and do we have a problem or do we need to work on something else. And even just to start like. You know, do we have a smart goal that is appropriate for our facility? We might not have the same goals that other larger facilities have because it's just not an issue here or the feasibility of it, you know? Trying to make it right size for us is important. Yeah, now, when I first went into leadership in QI, that was just another task, just another to do. I got to get the numbers so I can get them reported to whoever needed them and, you know, check it off the list of things to do. Now over the years, seeing that data in a small facility when you only deliver 20 or 25 babies a month, one or two cases can really skew your numbers. You can really, so yeah, those trends are kind of all over the place. But we can really kind of dive into. We had a emergency c-section last night for a prolapsed cord. That happens maybe once a year, if that, at our facility. I got in here this morning and I was able to talk to every nurse that was involved in that case. So being in a small facility, just having that connection with the staff, surgery staff, OB staff. So being able to do that, get their feedback real time and now we're gonna do a kind of a little case study on this and that way the rest of the team can learn from that experience, because it doesn't happen here very often. I'm glad you mentioned PDSA, Kristal, because I have that kind of on my list of things too. Years ago when PDSA was first rolled out at our facility, I think there was probably a lot of size and eye rolling, and it wasn't just in obstetrics, it was across the facility. Obviously, we've come a long way. I've actually used tools from um, IPQCC and shared them with other managers here, um, to help make things simpler, um or a little easier to understand for PDSAs. Um, and now, now we're doing PDSA and I don't even realize we're doing PDSAs, it's just part of the, you're like, oh, that was a little PDSA, I should write that up because our, you know, we can report that off that we did another PDSA. You know, that type of thing. So, um again, all the tools, Simply QI, I, I will log right into Simply QI during a meeting with our team or maybe at our we have a multi-disciplinary team every month we have with providers and every OB provider is there at that meeting. It's at seven in the morning on the third Tuesday. Every provider's there. We talk about high-risk cases, but then also talk about maybe occurrences and things that happened and quality things and IPQCC items that have up maybe through our task force. I can log right in the Simply QI, I can pull up our charts, show them, I don't have to have the time to

create those charts like Crystal said. So it's been very, very useful to see the trends by being able to look at that and log into that. So just knowing that there's not a one size fits all for the facilities that are delivering in our state and trying to, again, Crystal is great about helping help them figure out maybe where we need to tweak some things. I can email her at any time. She will jump on a phone call with us and we can reach out. So it's been great. And emailing that team, they've just been very, very helpful with what's continued to improve. You know, obviously the goal is to have the best outcomes we can. That's a small facility or a large facility wherever you're at. That's our goal and how we can do that. We just we are so lucky to have the support I also, with quality, our CEO, our governing board, they're looking at our quality indicators too. And our CEO recently went to a hospital leadership meeting that we had in Des Moines and Kristal and Dr. Radke were there and coming home, we're about a three hour, two and a half, three hour drive, so I'm riding home with her and we're talking about the programs, the initiatives. And she was just like, I wish that our surgery department, I wish that our med-surg department had this type of resources, this type of group so that those managers could get the information and get the support and the help and the resources that we do for OB. She just was amazed at how much support and how much these programs help with our quality initiatives that we're doing here in a small facility. So I don't know if I answered the question, but hopefully I did. Thank you so much.

Allison Finkenbinder [00:33:44] Yeah, thank you. I think just to follow up on that, so is your staff like, it sounds like you have a culture of QI there. I'm just curious, what does it look like? Do you share this data kind of back? So whether it's a case review and you're like, hey, or maybe you are looking at numbers, maybe there's a chart in simple QI, what does that look like sharing it back with your staff? Maybe I'm thinking this is more, I guess I'm wondering if it's more formal or it's just kind of this is part of our conversation and there's a small enough crew that that works or how does it look like?

LeAnn Fenton [00:34:25] Like today was more of kind of a just check-in kind of debriefing like how you doing? Oh, give me feedback, but we do take our initiative our measures and then we have we have a OB department staff meeting actually every six weeks at our facility So at least quarterly at those meetings, we will review our numbers our trends, you know so, you we will formally add a meeting review that with staff, kind of see where we're at, see where we, you know, we're not quite at goal yet. These are some things that I found, you know, we we missed some of our screens or we had a chart here that didn't have a QBL documented or, you know, so bringing that back to staff. Obviously, we tried to do it even in more real time. So if I noticed it when we're doing chart reviews, or, like Kristal said, sometimes we'll have staff, if it's a slower night, and they only have one, you know, one couple in the department, like, hey, can you review the the last, the charts for the last two weeks and make sure that all the postpartum risk assessments were done. You know, and and a nurse will do that for me. So I've got an OB lead. She's our interim manager right now. She is doing a lot of that data collection too, and helping get that stuff to chart reviews and things too. So we do have formal routes that we're presenting information, quality indicators, that type of thing. But then also the informal like, hey, I just need touch base with you and talk through things and it helps with that. As your managing staff helps with that connection to them too, that they know if they have a concern or they're concerned about a quality measure or anything, they can come to me, just making that connection or come to one of our leaders. And we're going to take it then to our next OB committee meeting or one of AIM-focused meetings in-house and talk through it.

Allison Finkenbinder [00:36:11] Great, thank you. I do want to just invite our audience to share questions you may have for our panelists in the chat. And I'm going to keep asking

questions as they come in, but just want to remind everyone, we'd love to hear from you. So I have another question for our panelists. I'll probably start with you again, Dr. Radke, but cause I think each of you is going to have a unique perspective on this, given your different roles and where you're working, but what distinct advantages do small volume facilities possess that really enable them to cultivate a strong culture of quality and belonging and that they belong in programs like AIM? What are some of those advantages?

Stephanie Radke [00:37:00] Yeah, I actually think that our small hospitals are often having the fastest and most impactful trajectories of change during our initiatives. And some of it is some of the things that Leigh Ann has already sort of illustrated through her comments that inherently their team is really small. And so one of the thing you have to do with every AIM bundle is educate everybody on the topic. Cool. That's a lot easier to do if you have maybe like 12 nurses that work your perinatal unit versus a tertiary care center that might have a hundred nurses It's a lot easier to change a policy if there's only like kind of like one signature needed for approval and not to mean that you don't like get other people's input, but there's just not the same barriers to what is often in a lot of the structure measures for AIM bundles, policies and staff education are generally a little easier to move. I've also been really impressed with the generosity and the dedication to a perinatal population in many of our small hospitals. I think a lot of these small communities really pride themselves on their hospital being a place where you can be born. You have a lot of people living in smaller communities that may be multi-generational residents of that community. And they often have really generous foundations or boards behind them. So... And this isn't a product promotion, but some people may be familiar with the really fancy postpartum hemorrhage carts that are on the market that have a little refrigerated unit for your refrigerated medications. The only hospitals that I have seen in Iowa that have those carts are critical access hospitals where they then just went to their foundation and said, we would like to have this to provide safer care for the mothers giving birth in our community, and there they are. If I tried to pitch at my academic hospital that I needed to replace all six hemorrhage carts that we had with these ones that cost five figures, like I would get laughed out of the room. So I think that there's a lot that they can do and they can test things quickly. Yeah, I think anybody who's like struggled to get your small facilities in or wondered how they're going to be in an initiative, I would challenge you that they might actually become your model organizations in your PQC implementing the AIM bundles. And I'll pass to Kristal because she's got lots more thoughts on this, I'm sure too.

Kristal Graves [00:39:47] Yeah, I sure can. And that it is very true, honestly. And a lot of our small hospitals, when we go and do our simulation training for the PQC, it's not abnormal. LeAnn's CNO joined us for an entire hour and a half of our simulation, just so she could learn what her staff were learning. And she's also a CNO who jumps in and she says, I don't like OB, but if they're having an emergency or they're really short, I can write and I can help and I can move patients and just the- community, I think, in these hospitals. We go to LeAnn's emergency room and we pack a room. Their entire providers and nurses and techs all come in and they learn from us and have us talk about postpartum preeclampsia and it's just amazing. Really that sense of community, I think makes them want to do what's best for their patients. And when we come in and we say, here is a bundle that's been created that is best practice and we wanna help you implement this. It's been embraced and I can't say that we have a single small facility that hasn't embraced it. We're very lucky here in Iowa where we have all of our hospitals participating with us. Um, and like I said, some of our smallest hospitals are our most engaged and it's just been great to see how they jump in and they want to do the best they can. And, um, some our hospitals we've even had like the foundation director come and meet us and have lunch

with us while we're there because they're just so thankful for what we're doing for their facilities and the information we're sharing. So it is actually really great just to see how these small hospitals can really get engaged.

Allison Finkenbinder [00:41:23] Thank you. LeAnn, do you have anything you'd like to add?

LeAnn Fenton [00:41:27] Um, I would probably, you know, just the less red tape, I guess I could say, um, you know just, you now, if I take information I get from the initiative and get a policy updated, um and take it to our OB committee, that's, we get it approved and I can roll it out typically, you know, in the next couple of days. Um, it, you know, it just, it's able to happen faster. If we can get everybody to agree, obviously sometimes we have to have sub-meetings and task force and different things, but just having a really engaged group of providers, having a real engaged administration. We are not affiliated, we're not like in a network, we're an independent critical access facility, so with that we have great, I said like I said, that first, that woman's first delivery is usually or first pregnancy is usually her first like adult experience in healthcare and her experience, we want to be positive. We want good outcomes because then it's business too. We want patients to come back to us so we can keep our doors open. So we can recruit staff. So we take care of our community. Our big goal is we wanna take care of our communities and our surrounding communities. If we can get them in the door and they want to deliver a baby here, then they're going to bring their children back. You know, and as they age, they're gonna come back, bring their families back. Um, women are a lot of times the kind of healthcare decision maker for, um, the family. So, um you know, just, it's, it just, it's such a big, it grows in it so much. Um. And that's why we really value having OB services at our facility. Obviously, there's a lot that goes into that. It's a very expensive department to keep open. And that's why a lot of facilities are not able to keep their departments open. But again, having programs like this to help so we can continue to have good outcomes just and keep progressing, you know, we want to keep improving, keep improving and having good outcomes. So yeah, that's what I got.

Allison Finkenbinder [00:43:39] Thank you. All right, I just want to prompt our audience again, if you have any questions, please put them in the chat. You're also welcome to come off mute or raise your hands. I'm going to try and keep an eye on that as well. But I have another question, and this is for you,stal. I mean, you had talked about, you know, the road trip that you went on. Like, you were like, all right, go out, right? And go meet these hospitals and kind of help walking them through, talking with them, making QI. You know, it's not scary. I'm curious if some of your interactions involve meeting with hospital leadership, what that looked like, if you have any lessons learned about how to engage with hospital leaders. Could you speak to that?

Kristal Graves [00:44:32] Yeah, I think like Dr. Radke said, so many of our hospitals knew about the statewide perinatal that had been doing chart audits and visiting them for years. So I think it was helpful for me to say that I was coming in working with a physician that had part of that. So I wasn't a scary person to start with. But I think the other part was I also walked in and I said, I'm also a critical access OB nurse and I... For the first initiative, I didn't work for the IPQCC. I was the hospital lead that was doing the work. And I walked in and I, you bring cookies or candy because we can buy nurses with food, right? And so I just said, I would love to stop by and drop off some information, shake your hand, just give me five, 10 minutes. I would really like to see your facility, show it off. That's always great for another small hospital to show us what their facility looks like. And I said, I just wanna meet you and let you know that I'm not a scary person. And then if they gave me a little bit

more time, then I did pull up what our data collection tool looked like, showed them that I would meet with them on a monthly basis and they wouldn't be in this alone. And I think just walking into their facility and showing them that I was taking the time to come to them and that we were gonna continue that relationship, I think that was a big selling point just to walk in there. I had the opportunity to a lot of these places where I originally planned to just meet. The OB, maybe manager or supervisor, and then I was quickly walked down to administration and said, well, let me have you meet our CNO, who would be our leader who would sign the agreement if we were going to join you. And sometimes my planned 10 minute meeting turned into a couple of hours. I always made sure I had enough time to stick around if possible, but it was amazing. And after that road trip, we were able to get all of our hospitals to sign on, which was great to hear. Um, I think a lot of them said it, they just found that we weren't scary then. We weren't going to be asking them to put in days and days of work and that we were going to do there to support them. I think that was the biggest thing. And I think it helped that I was also from a like-size facility. So I wasn't someone coming in, you know, saying that I'd only worked at a big facility and I have a QI person and I have all of the stuff. And so for me to say, I've done the work and I can help you make it work for your size facility was helpful.

Allison Finkenbinder [00:46:58] Sorry, I was muted. We do have a question that came in, so thank you for submitting that. But someone asks, is there a role that PQCs can play in preventing or advocating against hospital closures? Dr. Radke?

Stephanie Radke [00:47:14] I don't know. I wish. I mean, if there is we haven't exactly figured it out in Iowa to my knowledge, right? It's always very challenging to measure harms averted. And so I don t know. Maybe there are some hospitals in Iowa that were on a trajectory to closing and we had a role in changing that. I think, you know, hospital closures are driven usually by one of three things or a combination. Staffing. Um, is a challenge. So maintaining providers, anesthesia, um, providers with the ability to perform a cesarean, um because in smaller communities it's generally family medicine physicians and they don't all have cesarean training. Um, but sometimes it's nurses, sometimes it is anesthesia. Um so, you know, it's a workforce issue, it is a finances issue. You know, as LeAnn said, you know, your perinatal unit is generally a loss leader in your hospital and that has to be offset by a more profitable service line, something fancy like an ortho. But sometimes it is concerns about quality and safety. And so I think that's the space where a PQC has a role. You know lawsuits are very expensive depending on tort laws in your state. And making a case that your PQC is a resource to help ensure that the standards of care are followed in a facility can minimize concerns about malpractice. And that's not like the most fun way to have to make a case for it. But I do think it's realistic, right? Is that you can help make sure that that facility isn't isolated from standards of care. And potentially practicing medicine that is no longer, you know, kind of up to standards. I think the other role of a PQC is you're often a spokesperson for perinatal health care in your state. You kind of become a go-to person in PQC leadership. And so I think being a voice of the facilities and providers and nurses and the challenges that they're facing to people in positions of power. I'm not advocating for lobbying per se, but I think for educating different stakeholders, including legislature, state Medicaid and other state payers about the realities that people are facing is another role that you have for sure.

Allison Finkenbinder [00:49:58] Thank you. LeAnn or Crystal, do you have anything you want to add?

Kristal Graves [00:50:05] I would say that our most recent closures, we were contacted prior to the closure when things were starting to be discussed that maybe they would

close. And of course we said, you know, if there's anything you need from us. And then we did as our simulation team, Amanda Stabb is the other instructor with me, we then went to those hospitals and worked with their emergency room when they closed because we know pregnant women are still going to show up at their hospital maybe not knowing that the OB unit closed and so we work with the emergency room and get them prepared. We spend a few days actually at a few of them and then we worked with EMS service because they'd have to transfer more out. So although we couldn't stop the closure, we tried to support that community hospital as best we could when the closure occurred. And Dr. Radke was like, yes, go work with that ER because we know how nervous ERs are, anyone that works in OB knows most ERs are like, don't come here, go straight to OB. So that's the only way that I can say that we've really supported them, haven't really been able to stop them. But I would say a lot of our leaders do say that they wouldn't be able to do all of these policy revisions and so forth without our robust listserv is honestly amazing for a lot of our leader so they don't have to make a checklist and write a new policy I have even had some hospitals sharing privately when they need some locums. I know two of my hospitals. I connected them that have locums because they needed more in one facility. I've helped share some names that way too. Sometimes we're just a bridge to help some of these hospitals with their communications and trying to make sure they're getting the needs that they have to stay open.

Allison Finkenbinder [00:51:52] I love that you're just pointing out even when an OB closure happens, you know, it doesn't mean that relationship is done or gone, right? I mean, you're still there and supporting that community is supporting that hospital because yeah. Just because the OB closes, the pregnant people, you know, those who are gonna have a baby are not gonna go away. They're still there, gonna have emergencies. LeAnn, I'd like to circle back. You had talked about PDSAs and how kind of it sounds like this is just, like it's been part of your work, it's part of the culture there. I'm just curious. How you kind of made that happen? Like what has helped create that positive culture around QI? Cause it sounds like people are on board with this. So I'm curious like kind of how that buy-in happened and then how does it look now? Are they giving you input on the next QI projects? As they look at data or how does that work? If that makes sense.

LeAnn Fenton [00:52:56] I guess at our facility, we had a quality staff member that was her job. She kind of introduced PDSAs years ago, probably 10 plus years ago. And every department, you know, was supposed to be doing them and working on things. And as we look at our data that we're collecting, if we're seeing that we are not meeting goals, then we would go the PDSA route. As far as like how it happened. They said it just as part of, I think obviously the departments that are reporting to me or that I'm working with just. It's kind of the expectation, you know, when we're identifying gaps, we're, okay, so what's our plan? What are we going to do? What do we gonna try? Let's try for a little while. Let's revamp. You know, it's just it just starting to come natural. It's just part of our culture. I can't say that I can speak for the rest of the facility, but I think it's just having the support and like I said, it just kind of become an expectation, you know or part of our culture And yeah, you pull people in and hopefully they'll come willingly as you need to do it. So, and I would say as far as the hospitals that are closing, anytime I hear about an OB department that's closing, it just breaks my heart because, you know, out in rural, you know, Iowa is not the only state that has rural areas where they just don't have very much for OB services. So. The initiatives and the IPQCC here for Iowa is really just, it's really for maternal health across the state, whether you have OB or not. I know Crystal's talked about going to EMS and different, you know, communities and doing simulations and education and how important that is. Cause it's maternal health, whether you a delivering facility near you or

not, there are pregnant women out there that need, that are gonna need our help and need cared for, so.

Allison Finkenbinder [00:55:00] Yeah, it's tough. Thank you. Well, in our last few minutes, I have one more question, and I wanted to circle back to you, Dr. Radke, and your comment on small hospitals that really, they can be model programs. I'm curious if there are opportunities for small hospitals to kind of share with the larger ones on what they've accomplished. I don't know if that happens with your PQC in Iowa or if there other avenues. Um, like kind of disseminating, you know, those promising practices. Could you speak to that?

Stephanie Radke [00:55:34] Yeah, so we, like I think many PQCs, we use the IHI breakthrough series collaborative framework for our initiatives. And one of the cornerstones of that approach is really leaning into team shares. And so we make sure that like on our monthly calls with our facilities, we always have some sort of a didactic topic, but we try to have one or two, ideally two, like 10 to 15 minute presentations from facilities because that's what makes it a collaborative, right? Otherwise it's not really a collaborative. It's just a collection of webinars and people reporting data. And I really think it's like the secret sauce of getting change to happen because you know, you can sit up there as a talking head and like tell people this is what you should be doing, but you don't have as much credibility if you didn't actually just make that change in your own organization. So across facilities of all sizes, I think team shares are really important, but we really make sure that we balance the teams presenting. And so we have a lot more small volume hospitals in Iowa than large volume hospitals. And so we make sure that there are small volume hospitals presenting just as frequently, if not more frequently than larger facilities. I think that really helps solidify that this work is for everyone and can be done by everyone. But I also think, again, with our small facilities sometimes being so nimble and creative and empowered to try different things, They can... Do a lot of really cool stuff that would be potentially a lot harder to do in a large facility, but maybe they can be a source of inspiration. One thing that we're seeing a lot that is really relevant to work we're doing right now in Iowa around maternal mental health is people who are in some sort of an OB navigator type position. And this is almost entirely in our small hospitals. And they're these magical combinations of patient educators, care coordinator, people. And it's so easy to introduce some of the key practices, particularly for the perinatal mental health initiative into their work. And I'm just like, I don't know how this would happen in a big hospital, like the number of FTE you'd have to hire. But I think it's another example of where your small facilities can be really innovative. And so. Yeah, if people aren't doing team shares on your AEM events, I'd encourage you to. It's just really powerful to create space for people to talk about the work in their organization.

Allison Finkenbinder [00:58:25] Great. Kristal or LeAnne, do you have anything to add? Have you done that? I'm curious LeAnn, if you all have done it, share back to larger hospitals or that team share.

LeAnn Fenton [00:58:37] Um, yes, even at our learning sessions, they will have us make a, I have us make, um, we get the opportunity to make a storyboard. So, um again, and then we go into breakout groups and things and just kind of like, I usually just am throwing ideas on a, on the board or the screen. But then when you get to see what other, it's just like, Oh, I didn't think of that or, Oh that's a really great idea. We can do that here too. Or, you know, just some of the stuff that comes through, again, The larger facilities to get great ideas and everything from them and then just trying to figure out how we do that here at our facility. So yeah, that team share. I think it is an important part of the collaborative and

it's it's always really kind of fun to see what other places are doing because they can come up with some really great stuff.

Kristal Graves [00:59:30] And I will say my team leaders are sometimes cautious to tell me the neat things they're doing because they know I'll be like, that just bought you a team share. So then they know they're gonna be sharing on an all team call or on a learning session. But LeAnn has done quite a few team shares for us. So it's great to have them share the great work they're are doing.

Allison Finkenbinder [00:59:50] That's great. Thank you. Well you are getting some kudos in the chat. We are at the top of our hour. Just ask everyone to help me just thank our panelists for being here. Thank you so much. And a reminder to please fill out the evaluation survey. Thank you, Tanisha. That link is in the chat. And that concludes our session for today and this learning series. Thanks, everyone. Take care.