



ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Video Transcript: Sharing “The Why”: Turning AIM Data Into Action at Hospital, State, and National Levels

Jennifer Kawatu: Hello everyone. My name is Jennifer Kawatu and I'm the Director of Programs and Quality for the AIM TA Center. And I'm delighted to welcome you all today to today's webinar about sharing the why, turning AIM data into action at the hospital, state and national levels.

I do have just a few announcements before we begin. So everyone on the webinar today is muted given the number of participants, but we plan to have time for questions. And so you can ask your questions at any time during the chat, at any time during the webinar. A recording of today's webinar and the slides will be emailed to participants and available on saferbirth.org within the next few days. And closed captioning has been enabled so you can click on the CC icon at the bottom of your screen for that. Now I have a task for you all. We are going to share the evaluation link in the chat. And what I'd like you to do is to click on it and open it up right now. We'd like you to open it up now, if you could, rather than waiting until the end of the session. Just like you all have to collect data for quality improvement, so do we. And so we really value your input and we use it to improve future sessions. So please consider filling it out in real time as we go along. We're actively trying to increase the number of evaluations that we're getting back. So you can think of this as your. Participating in a QI project. And I know that's near and dear to everyone's heart. So we really appreciate you doing that. Right.

The Alliance for Innovation on Maternal Health, or AIM, is a quality improvement initiative to support best practices that make births 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 working both internationally and across all 50 states. We're 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 Resources and Services Administration of the U.S. Department of Health and Human Services. The contents are those of the authors. They may not reflect the policies of HRSA, HHS, or the US government.

After a very brief introduction, I'm going to turn it over to Dr. David LaFlamme. We're also going to hear from Maggie Coleman from the New Hampshire PQC, and we should have time for our Q&A at the end. By the end of the session, we hope that you'll be able to describe the intended purpose of AIM data at the birthing facility, state jurisdiction, and national levels to differentiate what the AIM Data Center is designed to support versus what facility level QI tools are better suited to do, and identify a few sample AIM visualizations to support action.

David LaFlamme is an applied maternal child health epidemiologist with over 25 years of public health practice experience, including 18 years as the New Hampshire state MCH

epidemiologist. He currently supports the AIM TA Center and other clients as the principal and founder of MCH-EPI-LLC. David also holds an adjunct appointment in the Dartmouth School of Medicine, Department of Obstetrics and Gynecology. Maggie Coleman is a senior population health coordinator at Dartmouth-Hitchcock Medical Center as an AIM data specialist with the New Hampshire PPC. She supports New Hampshire's birthing hospitals in implementing AIM patient safety bundles. And with that, I'd like to now turn things over to David to get started.

David LaFlamme: Great, thank you, Jennifer. Hello, everyone. Good to see so many familiar names and faces. So this slide really is sort of one of the main things that is driving us for this presentation today. So we're gonna use this throughout. We'll kind of come back to it a little bit. It helps us jump into meeting our first objective, describe the intended purpose and primary users' AIM data at the birthing facility, state and jurisdiction, and national levels. So we can see on the left, at the birthing facility level, you're trying to drive local quality improvement. It's mostly clinicians and QI staff who are using it, and you share those lessons learned with peers, right? So those are the pieces that we're trying to compare across these three levels here. At the state and jurisdiction level, we're trying to support and accelerate facility work. So the state team, maybe PQC staff, is trying to understand progress and direct support where it's needed most. Maybe connect two hospitals, one that sort of figured out how to do something and another that's still trying to figure out how to make it work in their system. And then finally, at the national level, those data typically are about accountability and support at the National Scale. So it's the primary users, the AIM TA Center staff, and maybe the funders and things like that. And so legislators and leadership in general are the primary uses there. So understand that these represent the primary flow purpose in users, but there are others too, for example, a birthing facility entering data directly into the AIM data center means that the flow also goes from the birthing facilities to national while still being available at the state and jurisdiction. It's simpler to show it this way, but just understand that these are the primary functions. And of course, we could put arrows all over the place in here, but we don't need to do that.

One subtlety or another thing to see and understand here is that most AIM data originates at the birthing facility level. So although most data is collected at this level, we often want to use it across all levels. And a key thing to understand is that data collected at the facility level for the purpose of driving local quality improvement can become less comparable as the data move from left to right in this model. However, the most important thing to sort of get right about the data collection is to get the data needed to drive quality improvement at the facilities level. It must take precedence because it's the main way to achieve overall improvements across all levels. Also remember that each birthing facility can and should be seen as a micro-system and the data we collect and use to drive improvement could sometimes be very different across micro-systems. So within a state, for example, or PQC or across states. Finally, I want to explicitly acknowledge here that our AIM measures, because they were reported on a monthly or quarterly cadence, are often not what is needed at the facility level to truly drive quality improvement. So as anyone trained in quality improvement knows, we most often need data for our plan, do, study, act cycles or PDSA cycles at a much finer grain. For example, we might do a PDSA cycle with just a day or a week of data within a specific facility. Of course, facility volume plays into that a little as well. While some of the core AIM patient safety bundles and it should be collected and used at that cadence, there are also times when it's appropriate to design and collect custom measures within a facility that are tailored to that particular microsystem. While these custom measures don't typically get reported directly into the AIM Data Center, they might be used when you're describing success stories or lessons learned that can be

shared across your collaborative and across AIM in general. And just one quick note on a lot of the slides that I prepared today. In the notes field of the PowerPoint presentation, you'll get some version of this down the road shortly after the presentation. There are additional citations and links on a lotta my slides. So if you're seeing something on the slide and you want more often, those things, you want a little more information, that info will likely be in the notes fields. And you're always welcome to reach out as well.

So we're gonna go to the. Next slide, oops, moving to presentation so I can keep up with my notes. So in this one, this gets us at the second objective, right? Differentiate what the AIM data center is designed to support versus what facility level QI tools. So local dashboards, REDCap, Tableau, what those facility level QI Tools might be better suited to do. So the AIM Data Center, it's used by the facility or the state to collect data for the AIM core measures, either direct data entry or file upload, depending on your setup. It's used to conduct some analysis, some basic analysis at all levels, but perhaps is the most useful at the state and national levels for that. And it supports reporting primarily at the State and national level. Other tools might be needed to supplement the AEM data center functionality, especially at the facility level. Examples include Excel, REDCap, Tableau, Power BI, and other QI specific solutions. There are things like Life QI, Simple QI. And this is not any endorsement of any of those. It's just these are some of the things that we've seen out there, that's all. Not a recommendation. Custom measures and a more frequent cadence of data collection and use it often requires additional tools beyond the ADC because in the ADC you're limited to reporting either on the monthly cadence or the quarterly cadence. You can always talk to your TA specialist if you need to change that cadence from one to the other. So, I'm going to go ahead and show you a couple of examples of how we can do that.

One example I came across recently, so I want to spend just a little bit more time on this idea of custom measures. So one of our state's collaboratives had wrote up a nice description recently of some of the SUD measures and an example. And so let's look at, without showing you on the screen, this was a recent example. Let's take the SUD outcome measure two, O2, it's an outcome measure 2, for example. So this measure is the percent of pregnant and postpartum people with opioid use disorder, or OUD, who received or were referred to medication for opioid use disorders, MOUD. When core measures are designed, AIM staff and subject matters from across the country must take into consideration what's feasible for facilities of varying size and resources to collect and report. While the received or were referred language in that measure can make it easier for all facilities to collect in report, the trade-off is that it may not be as useful within a tight little PDSA cycle within a facility. As it would be if you broke it down into sub-measures that can differentiate between those who were referred and those who actually received MOUD. If your resources allow, using custom measures in addition to the AIM core measures is encouraged and appropriate. As I mentioned earlier, these custom measures are not typically reported into the AIM data center. However, you might use them when describing success stories or lessons learned that you can share across your collaborative or even AIM in general.

This slide helps us, especially those of us who are trained in public health or epidemiology, it helps us think about the data a little bit differently than we might typically think about it. So the citations on the slide comes from a book called the Healthcare Data Guide, Learning from Data for Improvement. The full citation is in the notes field. It describes how data can differ based on the intended use. So whether that be improvement. Judgment or accountability, or clinical research. So most people trained in the collection and use of public health data tend to think mostly about data for judgment or accountability such as in

evaluation of public-health programs or clinical-research. Less common in formal public-health training is data for improvement. So note the differences across these intended use categories. For example, you can see that in improvement, we might accept consistent bias in the data, while we might want to adjust for or eliminate bias in data for other uses. The key reason for these differences is that data for improvement is hyper-focused on being useful for improvement cycles. For many of us trained in public health data this might require a shift in our thinking that might feel uncomfortable at first. But the idea is that you're using it for a very specific purpose. So when we look at AIM measures and think, oh, are these good for a quality improvement cycle? Are they good for judgment or accountability? Maybe up the ladder, either at the state or national level? Measures aren't going to always be perfect for all of those. And so we have to think about trade-offs when those measures are being designed, but understand. That while we need you to collect the core data collection measures for each bundle, thinking about it in this way and considering what you need for your PDSA cycles within your facility and making sure you have the right tools to deal with that, that is something we like to I'm going to move to the next.

In terms of the AIM data center, or ADC for short, if you go to the website, saferbirth.org, the AIM website, and you go up to the menu and you click on AIM Data and Resources, this slide shows us how to search for and find additional resources specific to the AIM data center. So you can see at the top of the graphic here, this is a screenshot from the search feature once you're on that data resources page. If you take that filter at the right that's circled, it says AIM Data Center. If you select just that, what you see on the screen here is what comes up. And so this can be a great source of information. There are so many resources on here that were really carefully developed to support you when working with the AIM Data Center. And if as you're using those, you find there's something else you need, reach out to your TA specialist. Or if you think something needs to be updated, edited, changed, or clarified in a document that you're using, let us know, let those TA specialists know.

So did you know that you can compare your data to others in the AIM data center? Your user type determines what you can do. So this table excerpt describes what a state level administrator can do in the data center. Keep in mind that data is often most comparable within a facility. Cross-facility comparisons are also likely quite comparable within a state of jurisdiction, though it depends on how well the collaborative has been able to ensure that comparability across facilities. And so this comes from the AIM Hospital Data Administration Guide. It was shown on the previous slide in that search. And again, you can talk to your TA specialist for assistance if you have any difficulty in finding this functionality. This table excerpt, same table, same document, describes what a hospital level administrator can do in the AIM Data Center. And again, ask for assistance if you need some help with that. So you can compare your data, say to a national average or to similar groups in the data center and let's move on to some examples.

First, the facility level visualization examples. And these are often done using software outside of the AIM Data Center. There are some that you can do within the data center, but mostly we do these outside of AIM center. So let's look at a couple of examples. This slide comes from a previous AIM webinar on the practical use of statistical process control charts, SPC charts, that was presented by Brent Oliver and Daisy Goodman. Thank you. I missed that forwarding. This article that is the source of the graphic is cited at the bottom of the screen and the presentation slide deck is linked in the notes field on the slide as well. You can see that this visualization is a typical SPC chart used in many quality improvement projects. It tracks the proportion of patients that were asked about naloxone,

so something to do with the SUD bundle. The chart includes relevant annotations such as the start of the COVID-19 pandemic and the start of the naloxone distribution program at this facility. And when it comes to visualizations to support quality improvement cycles, it's hard to beat a good SPC chart. I'm gonna move to the next one, there we go. I remembered that, sorry. So here's another visualization from the same presentation and article. Again, it uses a familiar SPC chart format that provides a lot of details that can be helpful in interpreting and making use of information. So again, just remember, you know, we're at that facility, birthing facility level now, and these are a couple of examples for that.

Moving on to the the next level, state of jurisdiction, right? So the state and jurisdiction category data visualizations are often done using the AIM Data Center, though they may also be custom visualizations that you create outside of the ADC. So let's look at a couple of examples in this category now. This example comes from the AIM-provided Tableau dashboard template that utilizes the AIM Data Center data extracts. So all that data you put into the Data Center, you can get it out. And AIM has built a Tableau prep flow and a Tableaux workbook that can help you take that data and create this data visualization with very little work on your part. And there's a guide on how to do that. The template and the instructions can be found on the Safer Birth website. And it's also linked. On the additional curated AMRS resources slide later in this presentation. So let's orient you to this visualization a little bit now. The Greek names represent facilities, so they're masked in this case. So each row in this highlight table belongs to a single facility. This example shows data for the OUD Pain Management Guidelines Structure Measure used in the SUD bundle. And it can be used to quickly check the current status and progress over time across the state and jurisdiction. So if we're thinking about that middle level, that state level, that's what we want to know. What's the current status and what's the progress over time for each hospital across the entire state and jurisdiction. So when you're designing data visualizations, consider the end user and the purpose. In this case, the time to insight is quite fast. A state user can very quickly identify facilities that might need targeted technical assistance by looking at the lighter colors in the most recent column. So on the far right of the table, that's 2025 quarter two. And the lighter ones, there's a blank cell, which means there were probably no data submitted by that hospital for that quarter in that year. But then you see some that are at five, great. You see a few at three, not so great. And four in between. And thankfully, no ones or twos anymore. So there's been progress all the way across. And you can see that progress when you look from left to right. So additional details can be provided on an interactive mouseover. So that's not active on this slide, but it is built into that template that AIM provides. Also, notice the convenient structure scale description at the bottom right, along with the color legend just above it. It's important to provide data on the screen with the data visualization to just answer all those basic questions that a user might have when they're initially looking at this. Now I'm going to pass you over to my New Hampshire colleague, Maggie Coleman, to hear about how she supports birthing facilities across the state.

Maggie Coleman: Great, thank you, David. So yes, we'll do a little run through of some of the ways that our New Hampshire jurisdiction team takes visualizations like the one that David just showed and creates some active opportunities for improvement for our birthing hospital. So before I get into that, I want to give a little bit of exposition, some context about our portfolio and what we're currently working on in New Hampshire. We have four birthing hospitals who are actively implementing the AIM patient safety bundles. And because we have that luxury of a relatively small 15 site portfolio, our NHPQC New Hampshire perinatal quality. Collaborative, has the opportunity to play a really hands-on role in designing and testing statewide bundle education and TA. So just want to offer that big asterisk, we're talking about 15 sites here. We currently have two bundles that are

active as of March 2026. The SUD patient safety bundle was launched in New Hampshire in 2023. Sites are still collecting data for that, but it's currently in sustainability mode. So to accommodate a more feasible data collection lift, we're now only collecting the structure and process measures for that bundle. And then we are more focused on a complete bundle implementation for the perinatal mental health conditions patient safety bundle, or we say the PMHC safety bundle. We're actively implementing that in all 15 hospitals right now.

So we use AIM data, like some of those visualizations that David was demonstrating, to support and accelerate facility work in one way by just fueling sites' internal curiosity, right? So a couple of ways that we do this. A big piece that's a pretty low lift on our part is supporting sites with accessing the summary reports that are in the AIM Data Center. This can inspire a bit of healthy competition by showing sites how they stack up against others in the state. So. We have regular check-ins with our sites each quarter, and we often log into the ADC share screen and demonstrate exactly how sites can generate these reports. And then at the end of each year of bundle implementation, we also just quickly pull a summary report for each site and send it to them. These are really useful, again, for that healthy competition piece, but it's also useful for our site champions who can use these reports as a conversation starter to share their performance data internally and then inform some of those more site-specific QI PDSA cycles around particular measures or related processes for the bundle. So those reports are really useful to our team. And we've also used data from these kind of summary statewide comparison visualizations. To help our state jurisdiction team to sign some quality assurance plan to study act cycles of our own. So the example screenshot here shows a measure from the PMHC patient safety bundle that's looking to identify the prevalence of pregnant and postpartum people who are delivering with an active perinatal mental health condition. And of that denominator, the numerator is those who are either receiving treatment or were referred to treatment. There's our sample from across the state of New Hampshire, and our state team was concerned a bit about the data quality for this measure. We happened to collect that denominator and numerator two-part measure response on the New Hampshire birth certificate facility worksheet, but we know that finding the info needed to determine if a patient had an active PMHC or if they were receiving a referred to treatment can be a little bit tricky, right? There are a lot of different data sources for this information for patients. It might show up in the problem list, in a medication list. It might be buried in provider notes somewhere. And oftentimes a birth registrar is the one who's filling out that worksheet and they might not have a sense of the full clinical picture for a patient.

So to try and get a sense of where we might have opportunities to improve data accuracy, we designed a statewide QA focused specifically on this measure. So. For two weeks, we kept a manual record, each hospital kept a manual record on the unit of the delivering patients that had active PMHCs and whether they were receiving treatment or referred to treatment. And then we compared that, you know, on unit manual record with what got reported via each site's current data collection method on the birth certificate worksheet, and then compared the two identified discrepancies and set up some kind of follow up. With each of our sites and then also a statewide webinar to think about how we might improve the data collection sources that feed into responding to that measure. So we'd like to use these kinds of visualizations to help our team design quality improvement and quality assurance PDSA cycles as a state as well.

Another way that our state and jurisdiction level uses AIM data is it helps us understand progress and where we might need to employ some direct support where it's needed most at our hospitals, specifically around educational planning, so our own kind of state-specific

TA. Our team hosts monthly implementation webinars for sites that are implementing the bundles that focus on some of the more challenging or complex measures or elements of the bundle. The topics for these monthly webinars are directly informed not only by feedback from sites, but as you may have guessed, by the measures indication of opportunities to improve. So during these webinars, we frequently share blinded data from the ADC, like the screenshot you're seeing here, to inspire more of that healthy competition that we mentioned previously, and also to help us identify where we might need to focus some statewide education efforts. So the screenshot that you see here is a cross bundle measure that appears in both bundles we have active right now, the SUD safety bundle and the PMHC safety bundle. And it's looking for sites to estimate the proportion of providers and nursing staff that have current education on respectful and equitable care. So when we were looking at this initially in quarter one of 2024, you can see the purple bars here. Our team saw a flag that maybe we should step in with a little bit of support around helping sites bump up their estimated proportion of providers who would have this really necessary education. So our team ended up designing a 1.0 Continuing education credit hour eligible film screening and facilitated discussion on the topic of racial injustice and bias in prenatal care. So we have this little educational opportunity we created that can be, it can be presented in a hybrid setting, virtually or in person with sites. And once we got that education designed, that film screening and discussion designed, you can see that one quarter, quarter four of 2024 rolled around. We have a lot of sites in those yellow bars reporting much higher numbers of provider education in a current education on respectful and equitable care because we were able to come up with a low lift way for them to meet that, the need of that measure in their hospital population. And then lastly, as a PQC, one of our... main goals is to help identify participating hospitals' best practices related to the bundle implementations and serve as a convener and a sharer of what might be, you know, replicable across the state.

So we mentioned we have these quarterly one-on-one data reviews with sites where we walk through the measures of the bundle, collect their data, and then also ask them what's going well. It's really nice for our team to see in those meetings what some of the opportunities could exist for sites to share their replicable processes with others in the state. So for example, with the PMHC patient safety bundle, some sites developed a template for a PMHC-focused cover sheet that goes on all patient charts. That was a template we could easily share with permission with other states in the, with other hospitals in New Hampshire. We get as granular as sharing out some of the example dot phrases that might be useful in the EMR, specific workflows for data collection when a nurse takes the chart facility worksheet and hands it off to a provider when that happens during the patient care, things like that. Um, we then want to make sure that once we identify those best practices, we have a way to share them. So we do some of that kind of, um, intermediary identification. We take the resource, we email letter, we meet with another site, direct kind of sharing of resources, but we also serve as a convener. So we mentioned the monthly webinars that our state and jurisdiction team holds, one of the ones that we decided to do after a year of PMHC bundle implementation. Was to have a strategy showcase. So we invited facilities to speak directly to their own concrete examples of processes, resources, other ideas that their peers could use in bundle implementation at their own sites. So on the screen here are a couple examples of some of those projects and presentations. We had one site with an embedded maternal mental health navigator role. As you can imagine, that's a huge win for supporting patients with PMHCs. We had a hospital hosted postpartum emotional support group. A postpartum wellbeing plan document template that stays with the patient's chart as they move through the perinatal period. One site totally revamped their postpartum resource list and the education that was happening at discharge. So once we identify our best practices, it's

kind of on us as a state jurisdiction team to serve as a convener and get them out to the rest of our sites. So just a couple of examples of how we use this data in New Hampshire. I'll pass it back to David now to take us further upstream to the national level visualizations and their use.

David LaFlamme: Thanks, Maggie. Let's go back to our model here, and now we're looking at the national level examples. And these are often done using the AIM Data Center, but not always. Sometimes they come from other things, maybe an annual report or something like that. So let's look at just a couple of examples now. This example comes from the AIM Data Center, and it shows six collaboratives, so states or jurisdictions, compared to the national rate. So the national only includes states working on this bundle. I've omitted the color legend and other details since they're not really important for the purpose of this example. We can do this for just about any measure in the AIM Data Center. If it was a measure that more states used, there would be more states on here, although you can turn states on and off. So if we wanted to, say, look at New England or northern New England, we could click just those states and maybe keep the national average on there, and we have some control over that. So you're able to do that in the AIM Data Center. The colors here indicate the different states and that national rate. So remember, though, that this type of visualization is available only to certain types of users in the AIM data center. Typically, a state-level administrator has access to this kind of comparison.

This example comes as an excerpt from a Maternal Health Progress Report. So that AIM data makes it all the way up from the facility level to the state level to the national level and is used for reporting accountability, right? So this example comes from that progress report. It's from quarter one fiscal year 23. But the data that's in it really comes from the AIM biannual reports that each participating state or jurisdiction contributes, and it's aggregated by AIM national staff. And we're just looking here at the birthing facilities participating in AIM over time, the baseline being that November, 2021 to fiscal year, 22, a couple of different quarters along with a target on the same screen. It's important to remember that the count of birthing facility is alone. You have to be careful when you're interpreting that because... We all know many of us are losing, especially, rural birthing units. So only looking at the number is not the only thing you should be doing. You should also be looking at the proportion of births covered and things like that. And we do that. But one more example of national level, how the data can be used for that.

And so finally, on this slide, I've pulled together just a few links from the resources that I mentioned during my section of the presentation. Just remember that saferbirth.org contains a ton of resources to support you. So let's just quickly cover what these are on here. There are three main things, right? So it's the AIM Tableau dashboard template. So that highlight table, visualizing your AIM patient safety bundle data. There's a recording and slides from when it was first presented. And then there is the dashboard template itself and the instructions. And when I say dashboard template, there's also a prep flow that feeds into that, a Tableau prep flow, which cleans the data and builds the data model. The second one, using data for QI, interpreting variation and trends in lower volume facilities. So that's a great example of something that not everyone may remember or know is available. But there's a recording and slides for that presentation. And then finally, that last one, practical use of statistical process control charts, again, recording and slide. So those are all available to you. They are linked in this presentation. So you'll get that after this presentation. And there's a ton of other stuff up there. So again, if you're having trouble finding something, talk to your TA specialist, and I'm sure they can help you. And now

we're gonna move on to question and answer. We've left plenty of time for that. Jennifer, I'm gonna hand it over to you.

Jennifer Kawatu: Yeah, thank you so much, David and Maggie. I think that was a really great way to start thinking about some of the different ways that the data can be used to drive improvement. So, we know that it takes so much work to collect the data and we just wanna make sure that it's being used and being used to drive improvement. We do have time for questions, as you said, David. It's really nice that we've left so much time, so we're really hoping that you all will submit questions. You can submit them either with the, you can just put them in the chat if that's easiest. There's also a Q&A function that you're welcome to use. I think we did have a few questions come in. So let me start. Um, one question is, I think for Maggie, for you, um, you talked about several resources and the question was, are some of the resources that you mentioned, for example, the dot phrases available on your, uh, website, I'm assuming the New Hampshire PQC website.

Maggie Coleman: Great question. We do have an active NHPQC website that actually was very recently revamped, and that is not something that we have a tab for yet, but the idea of, you know, some really practical resources like that would be great. In a past iteration of a WordPress site we had a really long... Kind of messy list of links and documents and downloadable PDFs, things like that. So that would be something that would be really helpful, I imagine, for any PQC site to include a tab on the website. Great, great idea. Thank you.

Jennifer Kawatu: OK, thanks, Maggie Another question, maybe for either of you, but I think probably more for David, but is there a guide to developing and using run charts?

David LaFlamme: Sure, so. I'm assuming you're asking about an AIM specific guide and I don't remember seeing an AIM specific guide to it like a document kind of thing. There are the presentations webinars transcripts things like that that I think support that and within those there are tons of resources. Yeah AIM specific thank you. Within those there are many resources referenced really it would sort of be recreating the wheel because there's already a lot of good information online whether it be a textbook or an online course IHI for Institute for Health Improvement and other sources where you can go to find really good guides that are mature guides and really give you everything you need with those.

Jennifer Kawatu: That said, it still gives us something to think about, and the AIM TA Center is always looking for, you know, what kinds of tools and resources and training would help. So just hearing that question is helpful to us, and we can think about whether that's something we could offer, something that was AIM specific. Let's see, some other great questions. Is there a way to find what other hospitals are doing for a specific project nationally?

David LaFlamme: Meaning what bundle are they working on? Or can you say more?

Jennifer Kawatu: That's as much of the question that I can see. I'm not sure if there is more context. I'm assuming that's probably.

Maggie Coleman: I can speak to one example that our team had as we were digging into the quality of that perinatal mental health conditions, outcome measure about prevalence of PMHCs and whether or not patients are being received, receiving or being referred to treatment. We reached out to our AIM TA lead about finding out if any other sites were doing. Quality improvement initiatives around using the problem list specifically for that. So

our workflow was to bring that ask a specific project related to bundle implementation to our AIM TA specialist who then connected us with other teams to discuss some possible strategies. But that was our New Hampshire experience.

Jennifer Kawatu: Thanks, Maggie. And I see that the question is what's possible in that regard. So I think there are, there is some that can be seen. The safer birth website does show, give like a snapshot of what bundles folks were implementing, at least from the last biannual survey. So it's the AIM Data Center, but it does have, that's a good place to get a snapshot. The AIM Data Center is another place that you can, you can see some comparisons as David was talking about. And then as Maggie's talking about the, the TA specialist for New Hampshire was able to connect. And I would encourage anyone to reach out to the TA specialists for your particular state or jurisdiction. I'm in the meetings all the time when TA specialists are talking to each other and are always talking about who would like to learn more from others about what. So that is really something that we're able to help with and that we love helping with and because we have connections with all of the 51 state or jurisdiction AIM participating entities. So let us know if that's something that you can help with. In addition to using data, we're happy to help the next. Okay, let's see the other questions. Another question is, state-to-state comparisons would be helpful at the national level. What's possible in that regard? I see. I don't know if the person who asked the question wants to give any more context or David or Maggie if you have initial thoughts, but state- to-state comparison. They wanna do more of that. And David, you talked about some of that, I don't know if you wanted to expand a little bit.

David LaFlamme: Yeah, yeah, I mean, that one slide I showed from the AIM Data Center, like I said, is available for just about every measure, I think it is available for every measure every bundle and every measure where you can compare your state to other states that have worked on that bundle. And it's all sort of time adjusted so that, you know, if somebody did it last year, somebody who's doing it this year, you're going to see those, you know, adjusted normalized on the same graph. You'll see the national rate and you'll see whatever other state you want to look at. So that was at sort of the first slide I showed in the national level section.

Jennifer Kawatu: Great. Thanks, David. Someone else is also suggesting, which is helpful. Thank you very much. Someone is saying that the states, what states are doing can be seen also on the NNPQC website. They have a map that you can search by topic. So that's nnpqc.org. So in addition to the saferbirth.org website, which has the map that has some information, it sounds like nnpqc.org also has some additional information. So I encourage everyone to check that out as well. Partner organization and a great source of lots of great information. Another question that has come in is, is risk adjustment comparison? Let's see, is risk-adjustment comparison for SMM several of the hospitals have requested? So is there risk- adjustment comparison possible for the SMM? David, are you?

David LaFlamme: Yeah, I'm not sure if that's possible. I think generally we think of SMM as mostly preventable when things reach that severe level. And so yeah, so I'm out of way of any work doing that, I guess is what I'll say. Yeah, you'd have to check the academic literature. And I'm not sure what the value would be. You'd have to really think about a hospital volume enough to see significant differences. Because with small volumes, it's going to go up and down, or just be such a rare event that it's hard to say too much with that. At larger hospitals, of course.

Jennifer Kawatu: Great, thank you. Here's another question from Maggie and keep the questions coming in. These are fantastic. So thank you so much to everyone who has submitted a question. Question for Maggie. I'm curious about the reports that you pull from the AIM Data Center. Can you share more about what specific reports you found you find most helpful and do your hospitals access the ADC and pull reports for themselves? Lastly, and sorry, this is a multi, multi, we can go I can repeat them if helpful, but can you share what data or data visualizations your hospitals appreciate seeing the most?

Maggie Coleman: Okay, so I found your question in chat. So on my other monitor here, if it looks like I'm looking up, I pulled up from my own reference, the end of year summary reports that we used as kind of a carrot to encourage sites to more proactively log into the ADC and generate their own reports. So hoping to answer two of your questions there. We've found those to be most useful when we included comparators for the New Hampshire average. Their own obviously response. And then there's a completion status column that shows kind of how they're, it's color coded or check mark and red X coded based on kind of, how they are performing against what the ideal report would be for each measure. So we had them, we had one report for the perinatal mental health condition safety bundle with all of those fields. And then one with, for the SUD bundle with all those fields, just for. A year of data. And they're sorted by structure measure, then process measures, then outcome measures. So that was our, again, with a 15-hospital portfolio, manageable lift for our team, but that's what we pulled on our end to show them what's available to them in that report generator tool in the AIM Data Center. And in terms of. Visualizations they appreciate seeing the most. I will say we do get really positive feedback from our monthly webinars when we show blinded data, so that kind of healthy competition that I keep measuring. I think sites have mentioned being able to take that, bring it back to their teams and use that as a motivator to really focus some energy around QI initiatives based on their performance and how they stack up against other hospitals. So those have been and we have had a couple of sites be really proactive, kind of customize their own reports in the AIM data center and bring them back. Say if it's kind of a nurse who's championing the work, she might bring it to a provider meeting and use it to sort of maybe bridge some communication gaps or reach an audience that's not as familiar with the ins and outs of safety bundle implementation as our head contact who might be a nurse or a different role.

Jennifer Kawatu: Great, thank you so much. David, anything to add or?

David LaFlamme: Um, there's one more for Maggie and nothing to add to that. There's another one for Maggie there in the chat.

Maggie Coleman: Do hospitals in New Hampshire enter their own data into the AIM data center? With one exception, no. We do have one site that has a lot of devoted capacity for AIM patient safety bundle implementation and other safety data and QI-related data. So they are in there all the time, uploading their own data. I think they may have even designed some custom measures, as David was alluding to earlier in the presentation, to compliment what's in the patient safety bundle. But for the most part, again, with our 14 other hospitals, during our quarterly check-ins with sites, we pull up the AIM Data Center's data collection fields and walk through, we share screen, we go through each measure, and they see us manually enter their responses, which for us, again, with, with it being so feasible with only 14, 15 sites, it's really helpful to help our team understand measure by measure what some of those wins or replicable best practices are, and then also where sites are having trouble with data collection or interpreting the definition of the measure,

things like that. So for the most part, we are holding hands and entering that data kind of side by side in our virtual check-ins.

Jennifer Kawatu: Thanks, Maggie. So there was another question that's related to that, in fact, while you're on a roll, which was the question as you talked about data check-in. So I thought that was just a, I'll ask it now. Can you tell us more about what these data check ins look like?

Maggie Coleman: Yeah, so we have kind of our self-identified champions at each of the 15 hospitals that at minimum we invite those folks to attend. We do stand up typically if we can get an hour of their time. It's a dream. It's usually about 30 minutes and we do these once a quarter because we are on a quarterly data collection cadence with AIM. So every quarter we meet one-on-one with a site, but we do, where possible, invite additional folks from that site to join the conversation. At minimum, we are pulling up the AIM Data Center and screen sharing and walking through measure by measure, making sure we're getting all their data for the quarter. We also then save time to ask about any kind of in the weeds implementation questions they may have. We are also always soliciting those best practices that we can share with other sites. It's a lot to fit into a 30-minute meeting, but oftentimes that is the time we get. And something that we've learned from those is on our team, it's meant a lot to these sites to really have some consistency on our side of who's able to attend. Just that relationship building is a huge piece of keeping sites engaged with this implementation. So that's another priority for those check-ins. But yeah, I'm happy to share if anyone has specific questions about what an agenda looks like, please reach out. I'm I'm to be a contact for support.

Jennifer Kawatu: Thank you.

David LaFlamme: Jennifer, if we have a minute, I wanna revisit one of the earlier questions about state to state comparisons, being helpful at the national level. And as I said, it's possible, like in the example I showed with different states, as well as the national average, all on the same graph, but also recollect what I was talking about at the very beginning, as you go from left to right in that model I was showing you, from the hospital to the state level to the national. For some measures they become less comparable as you go across. So that SUD measure is probably one of them, right? So. Choose your measures carefully. Think about how tight is that measure? How much wiggle room is there for people to sort of interpret it differently so that you know you're comparing apples to apples? So I just would say, pick your measures carefully as you do that. Some measures will lend themselves to that. Others just have a little more fuzziness to them. And it's just part of trying to design measures that can be collected and reported by everyone without overburdening everybody. We're trying to block that line of giving you something useful, giving you time to do your own custom measures too, and then trying to use what we're collecting mostly at the facility level throughout all levels, even though sometimes those comparisons become a little less valuable the further out you get.

Jennifer Kawatu: Great, thank you so much. Couple other questions, we'll see how many we have time for. One of them is what is the advantage to using the AIM developed REDCap for?

David LaFlamme: Sure, I can take that. So, when you're using a tool to collect data outside of the AIM Data Center, it allows you to do those custom measures more easily and keep all your data collection in one tool. So that's one of the main advantages. The other is that the forms within REDCap are designed so that... The questions are worded

very specifically, rather than just sort of a label about what it is, it's a question to help you get to the answer. And resources are included within the REDCap surveys to support each question. And everything's labeled in terms of being able to figure out which measure is it and refers back to the core data collection plan. And they roll things up so that it can be uploaded into the AIM Data Center with either no work or very little work by simply running a report. But the other big advantage of the REDCap forms, even if you're not using REDCap, seeing what those REDCap forms looks like can help you develop in whatever your tool of choice is. We chose REDCap because many states were using it. It's often something that you can get access to through an education partner or university or something like that, might have a server running that you could use so the startup is often relatively inexpensive. But some states prefer other tools and that's fine. Use whatever tool works for you. But the advantage of taking a look at the REDCap, even if you're not using it, is that the time to develop in whatever your tool is should be greatly reduced because you can see what the layout is, the logical flow, the support questions, the wording, all of that is there for you. That helps.

Jennifer Kawatu: Great, thank you so much, David. And we're coming to the end of our time. So I think I will leave it there, but thank you so much Maggie and David. So I will go to the conclusion. Just wanna thank you both. And I hope everyone will thank me and will join me, not thank me, will thank you all. Will join me in thanking you. You know, for such a great presentation and for answering so many questions, we really appreciate it. Again, I would just ask that all of you who opened the evaluation link, that you go to that link and just take a moment. It's brief and pretty painless. So we would just ask that you kindly take a movement to complete the evaluation and submit that for today's presentation. As a reminder, we will have the materials emailed to participants and available on saferbirth.org. Within the next few days. You can sign up for the monthly newsletter at the bottom of the homepage of saferbirth.org. So we encourage you to do that if you have not already signed up. If you have additional questions for us, please don't hesitate to email us at info at saferbirth.org. And thank you again so much for joining us. And that concludes today's webinar.