NeoQIC Family Engagement Quality Improvement Collaborative

April 6, 2022

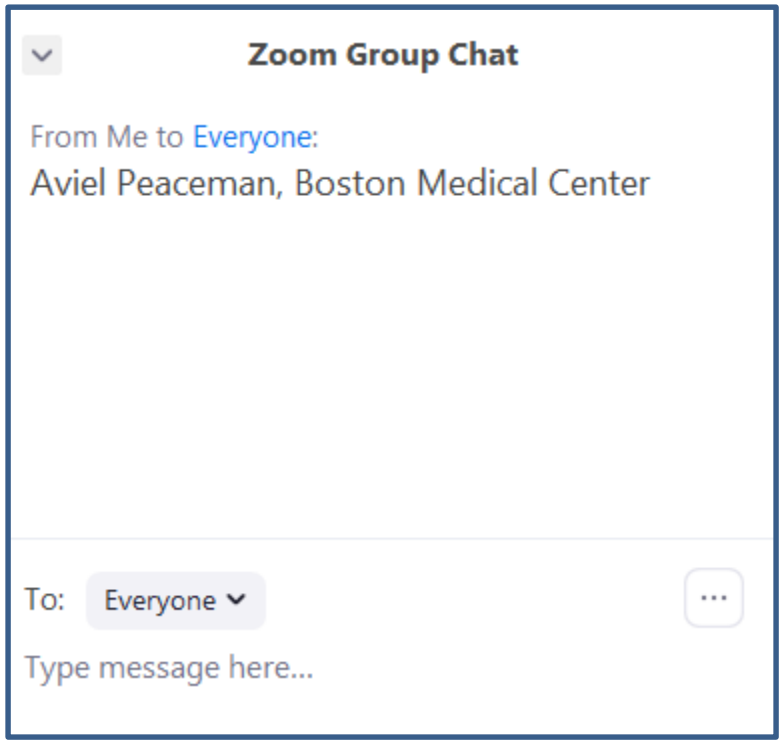
2-3 pm

Welcome, Introductions, and Roll Call

Meg Parker, MD, MPH
Neonatologist at Boston Medical Center
Co-Chair of the Neonatal Quality Improvement Collaborative of Massachusetts
Improvement Advisor from the Institute for Healthcare Improvement

Welcome!

Please chat your name and hospital into the chat box



Agenda

Time	Topic
2:00	Welcome, Introductions, and Updates
2:10	Data presentation
2:25	Skin to Skin Care (and small babies): PAIRED Initiative
3:55	Wrap Up and Next Steps

NeoQIC Family Engagement Collaborative Programmatic Updates

Aviel Peaceman, MPH

Program Manager

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

New Team Member

Welcome, Katy Doughty!!!

Katy will be working as a Research Assistant with us through the spring. She is currently studying at Boston University for her MPH with a concentration in Epidemiology and Biostatistics.

Data Collection: Update to the Parent Consent Form

- At BMC, we found that consenting families in person was quite challenging, so we looked into adjusting the form to do a verbal consent over the phone
- We reached out to our privacy office and were approved to alter our form for the verbal consent
- An IRB amendment was not required
- We shared the revised English and Spanish forms with all teams for you to use.
  - Let us know if you need us to resend it.
- We started this in December at BMC and it's going well
- If your team wants to pursue this option, you may need to review with your IRB and privacy office. Please reach out to our leadership team and we can assist

MOC Part IV Update

- NeoQIC was approved to provide MOC Part IV credit to participating physicians
- We will share a form for you to fill out attesting your participation in this project

Data Updates

- 16 actively participating hospitals
  - IRB review in some capacity: 13
  - Master Data Use Agreement signed: **10** (Tufts, SSH, BMC, BIDMC, BI Plymouth, St. Elizabeth, Emerson, Beverly, Winchester, Newton Wellesley)
  - Scope of Work for Family Engagement signed: **9**
- Data track commitment
  - Track 1- 3
  - Track 2- 10
  - Not committed/ unsure of status- 3

REDCAP Data Collection Update

- **10** hospitals have participated on a virtual site visits to review all forms and use of the REDCAP data base
  - These will continue as hospitals sign their DUAs and SOWs
  - Identify who will be your data collectors!

- **Update on RedCap Data Collection:**
  - 277 entries into REDCap from 7 hospitals: BMC, Beverly, BWH, NWH, SSH, Tufts, Winchester!
  - 20 parent reported measures (track 2) entries from BMC, NWH and Winchester
  - If you have been trained in entering data into REDCap but have yet to start entering data, please let us know if you have any questions or if we can help you in any way.

PDSAs To Date

- 39 PDSAs from 14 hospital teams!
- Primary drivers:
  1. Communication- **16** PDSAs
  2. Social services and supports for families- **8** PDSAs
  3. Hands-on care- **10** PDSAs
  4. Discharge planning- **5** PDSAs

Please keep sending us information about your interventions via monthly homeworks or even brief email updates!

Homework and PDSA Forms

Next PDSAs will be due on Friday, April 22nd.

PDSA FORM

Hospital		Date	
Team Members		PDSA #	
PDSA TITLE:			
PDSA STATUS:	☐ Planned, not initiated ☐ Planned and in progress ☐ Complete		

Part 1

"Aim" and "Plan" should be completed prior to initiating test, and can be updated during test as needed.

AIM

1. Which primary driver does this PDSA address?
Primary drivers for project are: (1) Communication; (2) Social support/services; (3) Hands-on care; and (4) Discharge planning

2. What is your AIM statement for your work on this key driver, including this PDSA cycle?
Use a "SMART" aim: specific, measurable, achievable, relevant, time-bound. Improve [what], from [baseline] to [goal], by [when].

PLAN

3. What is the change you are planning to test?
For new interventions, focus initially on small tests of change, rather than immediate broad implementation of new processes.

Update - AAP Educational Discharge Videos

Filming took place in March! Our family interviewees were wonderful.

Videographers are currently editing the films. Stay tuned to see the final products.

Collaborative Data Update

Meg Parker, MD, MPH

BOSTON MEDICAL CENTER
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REDCap Data as of 3/15

Hospital	# of entries
Beverly	4 (2%)
BMC	112 (45%)
Newton-Wellesley	46 (18%)
South Shore	53 (21%)
Tufts	15 (6%)
Winchester	20 (8%)
Total	252

REDCap Data as of 3/15

Demographics	n (%)
Maternal race/ethnicity	
Non-Hispanic White	117 (47%)
Non-Hispanic Black	56 (22%)
Hispanic	37 (15%)
Preferred Language	
English	198 (79%)
Spanish	24 (10%)
Other	28 (11%)
Maternal age, mean (SD)	33 (xx)

REDCap Data as of 3/15

Pregnancy and Birth Characteristics	n (%)
Singletons	206 (82%)
Vaginal delivery	92 (37%)
Prenatal care	246 (98%)
No maternal substance use	238 (96%)
Eligible to provide mother's milk	241 (96%)
Inborn	219 (87%)
Infant gestational age, weeks, mean (SD)	33 (3.6)
Infant birthweight, grams, mean (SD)	2020 (316)
Discharged home	200 (80%)

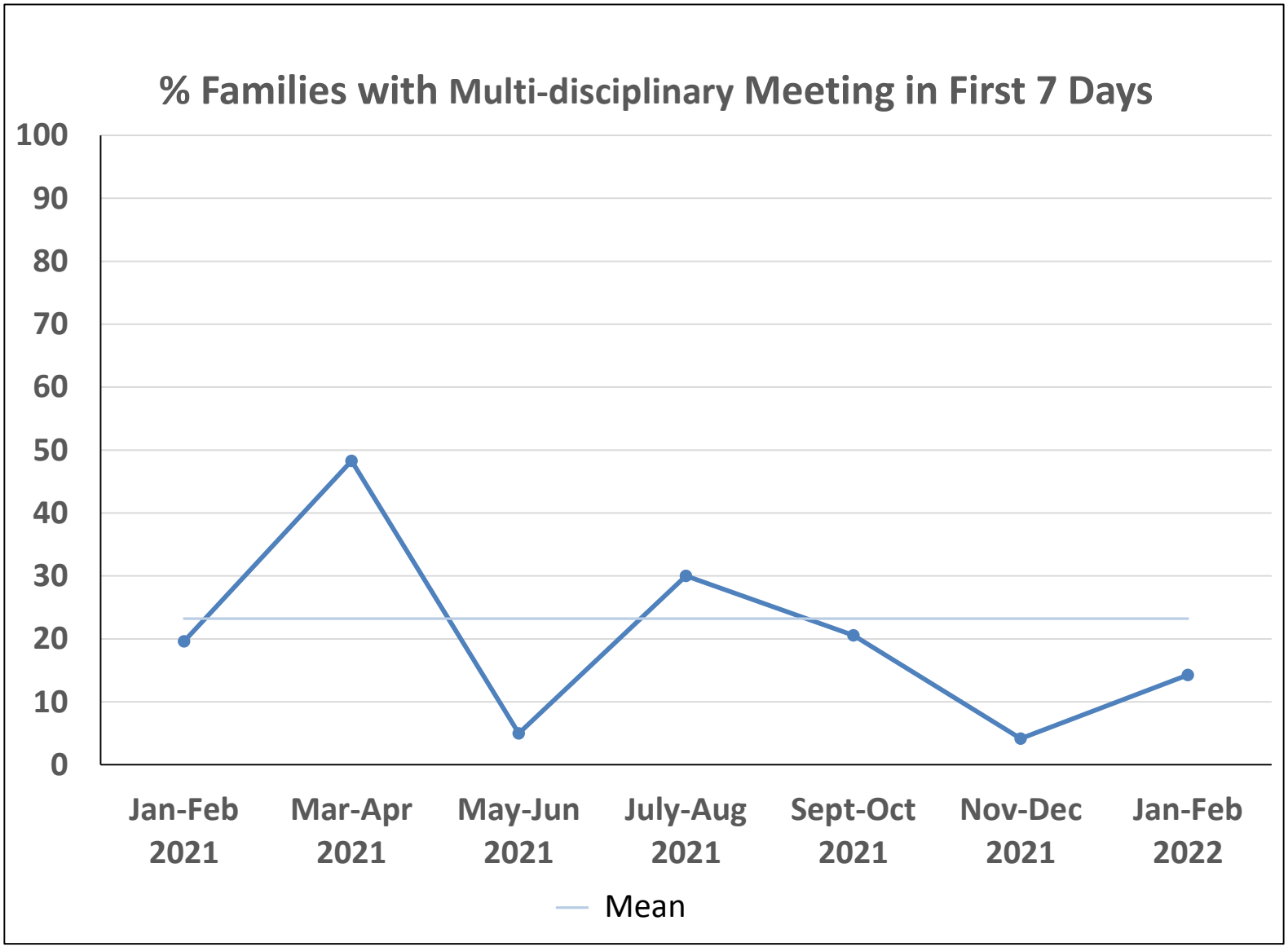
REDCap Data as of 3/15

Main outcome and process measures: communication	n (%)	
Any multi-disciplinary meeting in first 7 days		
Yes	56 (22%)	
No	192 (76%)	
Unknown	3 (1%)	
Family physically present in NICU/SCN	**First week**	**Last week**
Present 0-4 days/week	38 (16%)	66 (27%)
Present 5-6 days/week	72 (30%)	63 (26%)
Present 7 days/week	132 (54%)	113 (47%)
Family present (physically or virtually) for rounds	**First week**	**Last week**
Present 0-4 days/week	184 (76%)	174 (72%)
Present 5-6 days/week	55 (23%)	20 (8%)
Present 7 days/week	7 (3%)	39 (16%)

REDCap Data as of 3/15

Main outcome and process measures: hands-on care	n (%)
Any social work consult in first 7 days	164 (65%)
Screened for postpartum depression with a standardized tool	18 (7%)
Assessed for unmet basic needs	124 (48%)
2 days before discharged, shows skills in:	
Administration of medications or vitamins	205 (82%)
Feeding infant by breast or bottle	228 (91%)
CPR	162 (64%)
Understanding safe sleep recommendation	212 (84%)
Mixing fortified breast milk for formula	209 (83%)
All applicable skills	150 (62%)

REDCap Data as of 3/15



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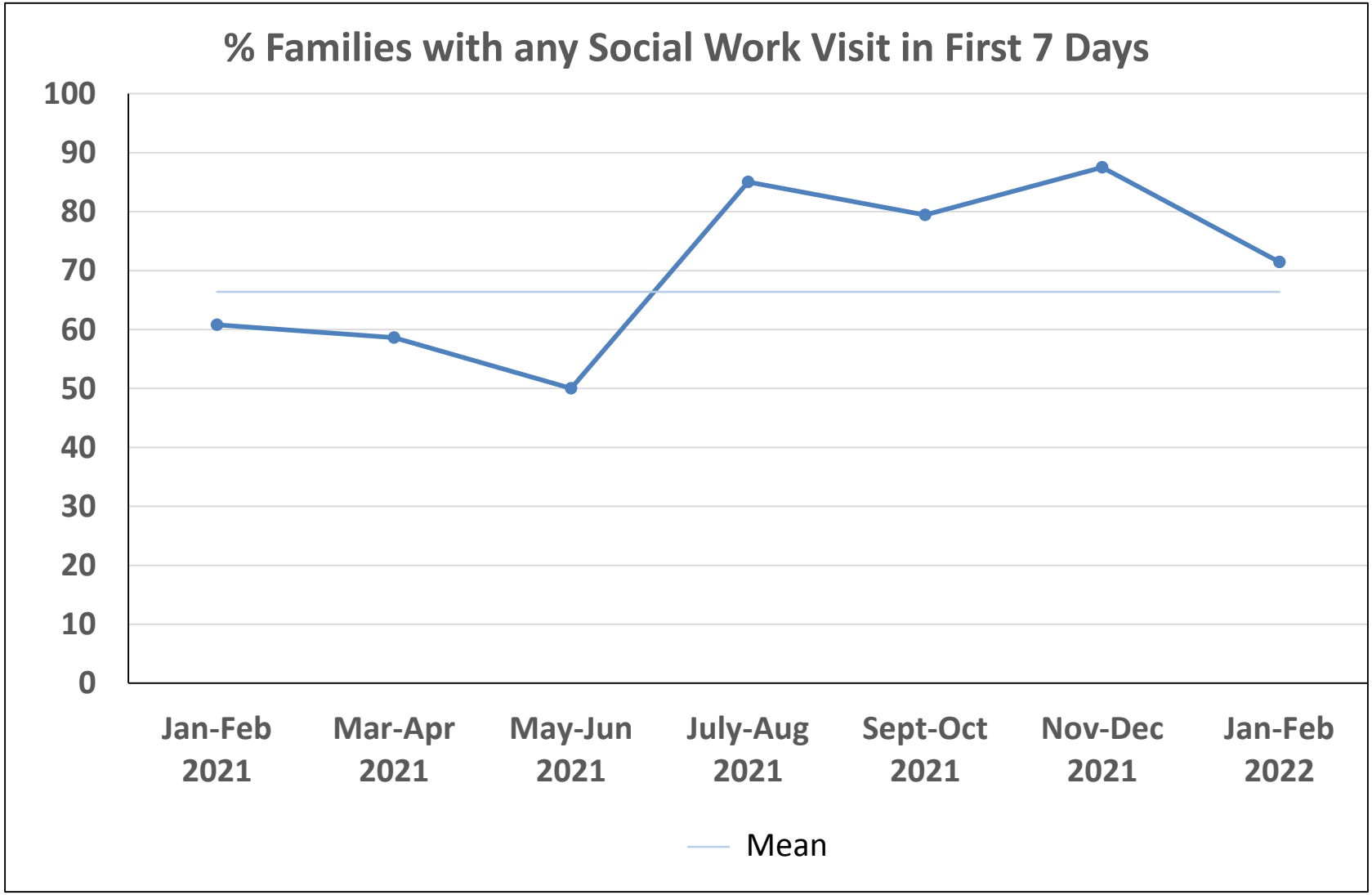

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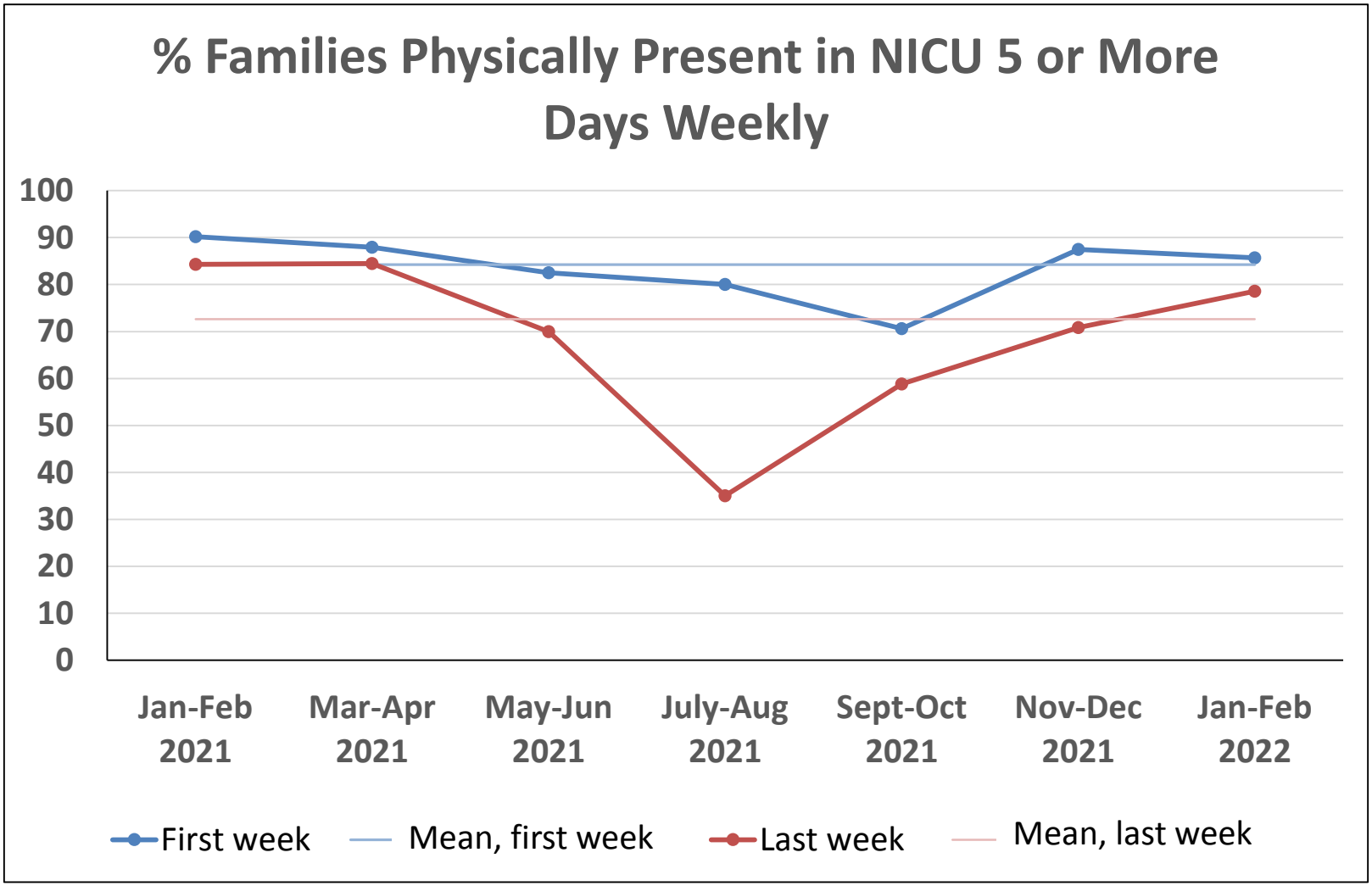

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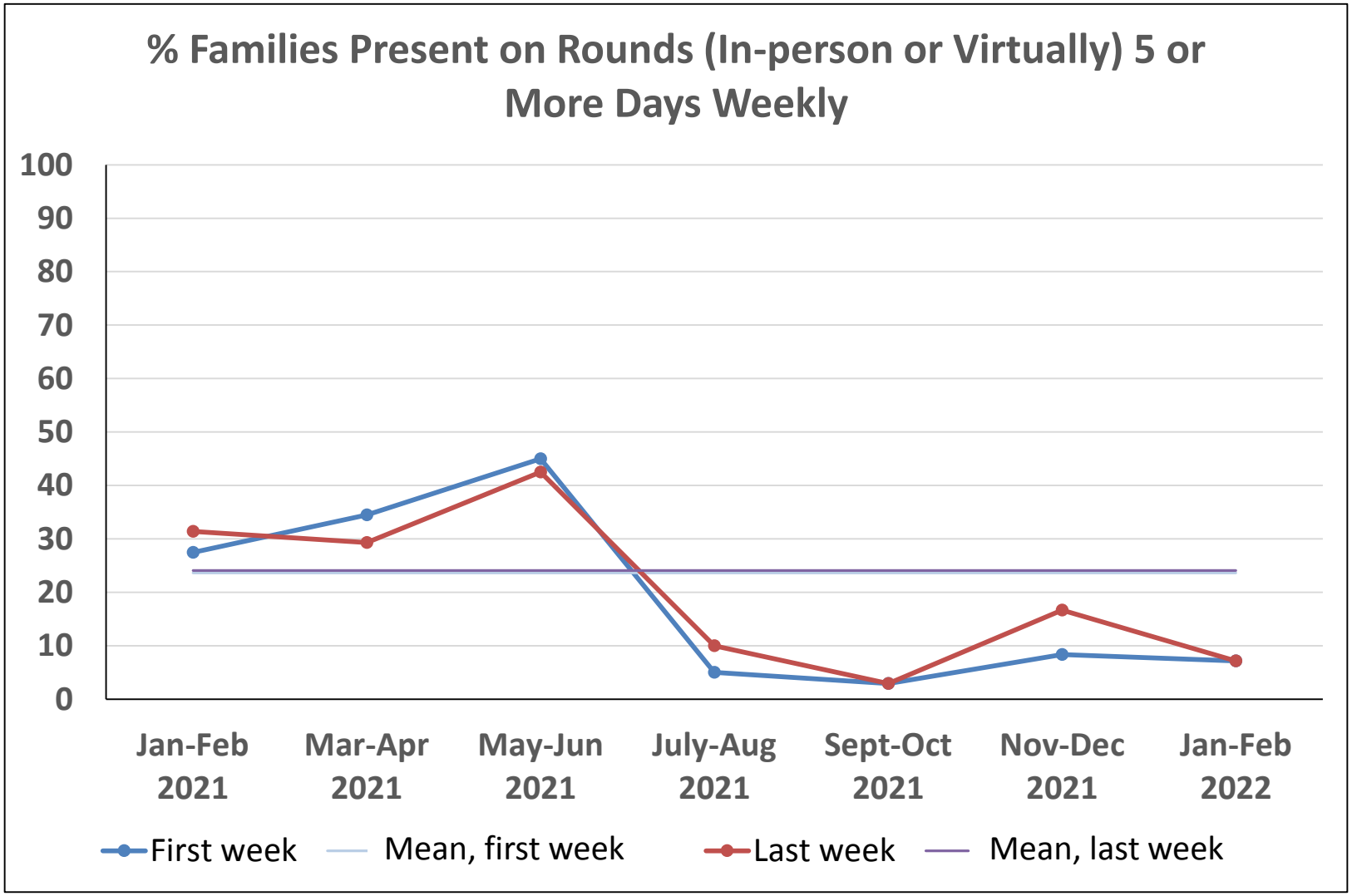

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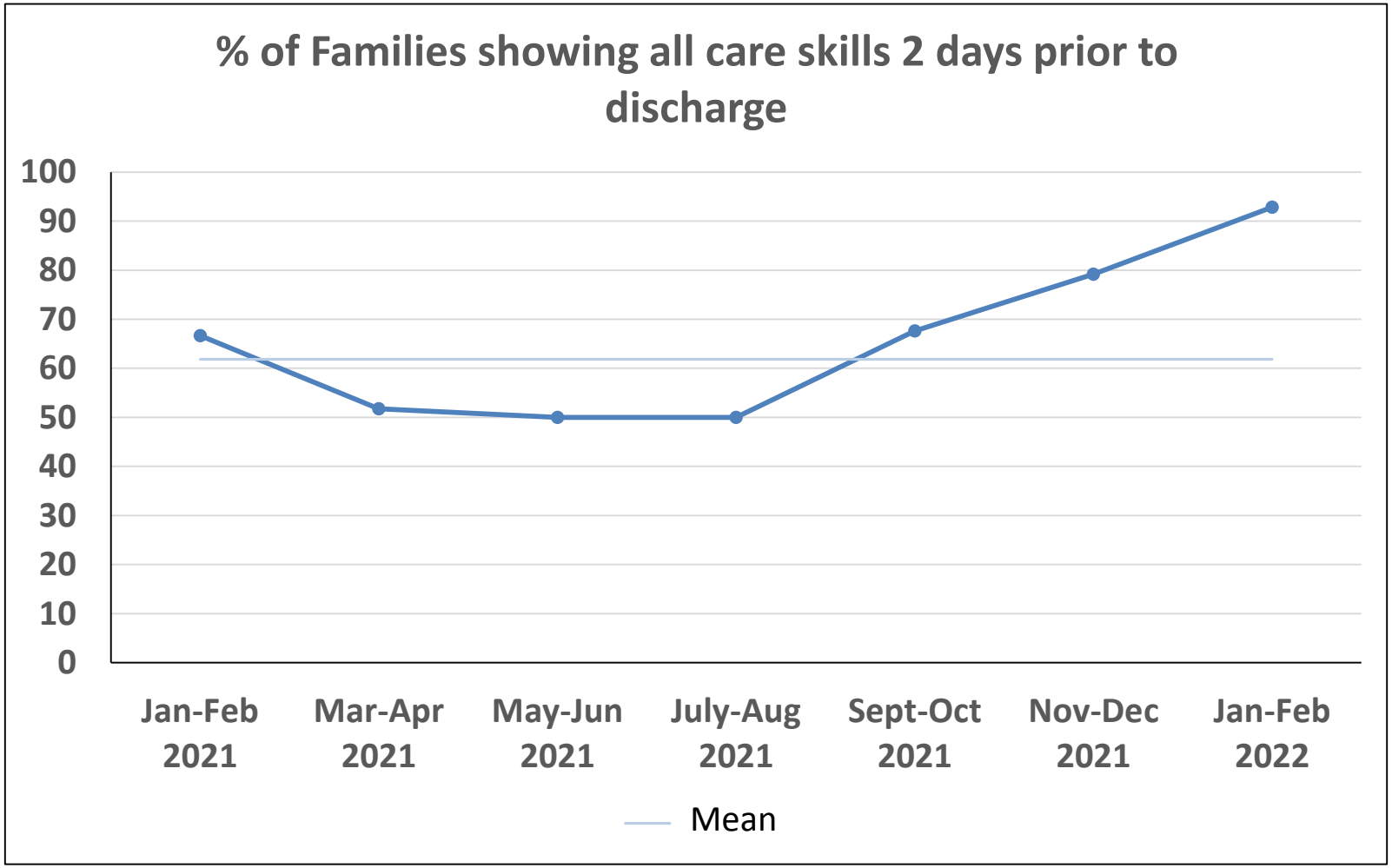

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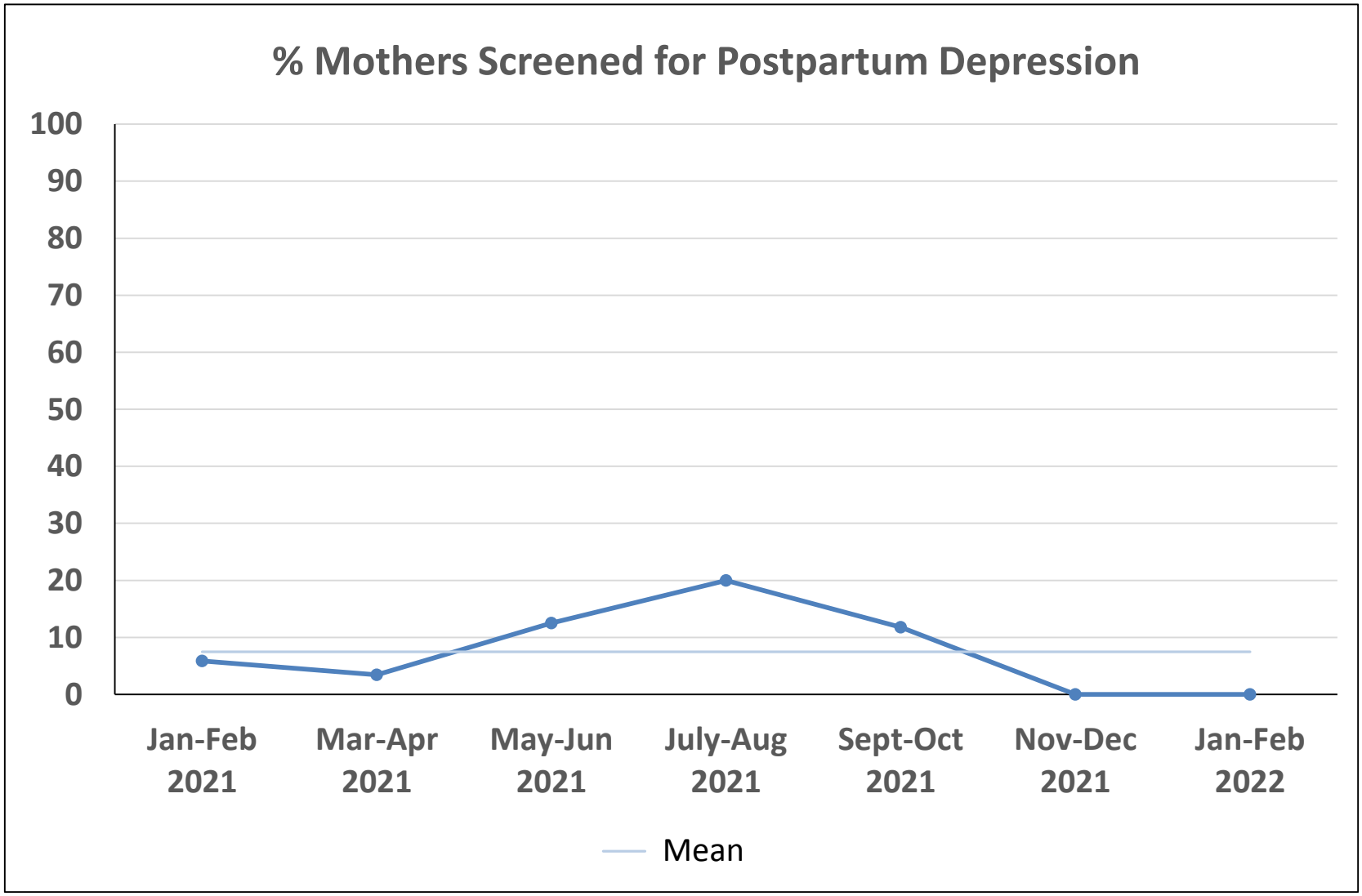

Skin to Skin Care (and small babies): PAIRED Initiative

Colby Day Richardson, MD

Assistant Professor of Pediatrics, Division of Neonatology

University of Rochester Medical Center, New York

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Learning Objectives

1. Review the FPQC PAIRED Initiative and the importance of skin to skin care

2. Learn about local efforts in one hospital

3. Tolerate Colby talking about the importance of incorporating skin to skin care and families into small baby programs (and NICU in general)

The Impact of Skin to Skin Care

"My first time providing skin-to-skin care was 38 days after the birth of my son, Thomas. I remember sobbing because I was so excited to have true, 'normal' contact with my baby! Tommy enjoyed it so much that we were able to wean his O_2 significantly, and the whole experience is one I'll cherish forever."

-Morgan Kowalski, NICU Parent

Photo shared with permission

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Why is SSC important

Improved bonding

Thermoregulation

Increased oxytocin

Improved milk production

Improved pain management

Improved satisfaction with care

Improved sleep quality

Improved vital sign stability

Reduced infant stress

Decreased maternal depression, anxiety, guilt

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Benefits for Infant

Improved

- Autonomic function & neuroregulation
- Neurodevelopment
- Cerebral volumes
- Cognitive skills
- Oxytocin levels
- Weight, length, head circumference growth
- Pain management
- Breastfeeding at discharge

Benefits for Infant

Decreased

- Physiologic stress responses
- Motor functional deficits
- Hospital length of stay
- Mortality
- Infection/sepsis
- Hypothermia

What is PAIRED

PAIRED aims to improve family-centered care across the four domains of:

PArticipation in care and decisionmaking

Individual recognition of each infant and family

Respectful collaboration with families

EDucation for families about care after discharge

Family Centered Care

- Change from traditional paternalistic approach

- Likely a function of multiple changes in society
  - Increased emphasis on patient and family rights
  - Increased 'norm' of patient and family involvement in medical decision-making
  - More accessible information for patients and families outside of physician's office
  - Social media

Family Centered Care

- Family centered care is defined as a **shared approach** to the planning, delivery, and evaluation of healthcare that is based upon a partnership between healthcare professionals and family caregiver(s).

- There are four essential domains of FCC:

1) Dignity and respect

2) Information sharing

3) Participation

4) Collaboration

Institute for Patient- and Family-Centered Care

Johnson BH & Abraham MR (2012). Partnering with Patients, Residents, and Families: A Resource for Leaders of Hospitals, Ambulatory Care Settings, and Long-Term Care Communities.

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Family Integrated Care

- Families are the primary caregivers

"Patient- and family-centered care is working 'with' patients and families, rather than just doing 'to' or 'for' them."

- Institute for Patient- and Family-Centered Care. Ipfcc.org

Family Partners

- Families determine outcomes…
- Family input should guide our improvement efforts

Morgan, Jeff, and Tommy; photo shared with permission

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Family Centered Care and QI

- Family Centered Care is being increasingly identified as an area in need of quality improvement efforts
  - Needs to be robust
  - Needs to be focused
  - Needs to include family perspectives (often the hardest part)

What is PAIRED

- Started in Florida, piloted by 17 hospitals with a goal of increasing family involvement in infant care
- Focus on family centered care, recognizes that families are essential partners in providing quality care and improving patient outcomes
- Main focus of initiative = improving skin-to-skin care

PAIRED aims to improve family-centered care across the four domains of:

PArticipation in care and decisionmaking

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EDucation for families about care after discharge

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Aim Statement

Primary Aim:

For each participating NICU to achieve a 20% increase from baseline in the percentage of infants who receive skin-to-skin care from at least one family caregiver within 3 days of clinical eligibility as defined by individual unit protocols by June 2023.

Supplemental Aim:

By 6/2023, family caregiver surveys will demonstrate a 20% improvement from baseline in the perception of the culture of family centered care in each NICU as averaged across all four domains.

KDD

Date: 10/9/2020

Family-Centered Care

AIM

PRIMARY

By 6/2023, each NICU will achieve a 20% increase from baseline in the percentage of infants who receive skin-to-skin care from at least one caregiver within 3 days of clinical eligibility as defined by individual unit protocols.

SUPPLEMENTAL

By 6/2023, parental surveys will demonstrate a 20% improvement from baseline in the perception of the culture of family centered care[1] in each NICU as averaged across all 4 domains.

PRIMARY DRIVERS / SECONDARY DRIVERS / PBPs

Participation

Participation of family in care

- Educate caregiver(s)/family to become active participants in the care of their infant from admission to discharge
- Provide caregiver(s)/family with appropriate and increasing direct care opportunities.

PBPs:

- Encourage caregiver participation in early skin-to-skin care
- Include of families in daily rounds/creation of daily care plans/handoffs
- Provide early and continuing lactation support to promote breastfeeding
- Revisit and revise policies that limit caregiver interaction with infant

Dignity and Respect

Identification of each infant and family member as an individual

- Acknowledge that each infant and family member is an individual. Incorporate family knowledge, values, beliefs and cultural backgrounds into the planning and delivery of care.

PBPs:

- Create a culturally sensitive environment supportive of skin-to-skin care (reclining chairs, access to food and water, privacy)
- Identify infant and caregivers by appropriate names in all interactions
- Celebrate milestones and transitions

Collaboration

Respectful and effective communication and partnership with families

- Establish a culturally sensitive environment in which family members feel respected and that fosters anticipatory and effective communication with and trust from caregiver(s)/family.
- Encourage collaboration with families, caregivers and unit leaders in the development, implementation, and evaluation of policies and procedures; in educational programs; and in protocols for family participation in care.

PBPs:

- Consult families, revisit and revise policies that limit caregiver interaction with infant (protocols regarding skin-to-skin care, holding, visitation, signage, etc)
- Improve antenatal counseling
- Adopt technologies to improve communication with caregiver who cannot be at bedside
- Recruit, create and sustain a family advisory council/partnership team
- Engage families in the development of effective patient safety and quality initiatives
- Develop uniform approach to scheduling and staffing complex care conferences with families

Information Sharing

Education about medical care and clinical processes

- Provide families with complete, accurate and unbiased information and graduated education throughout the NICU stay to allow effective participation in care, to optimize decision-making, and to enable caregivers to become competent primary caregivers for their infant(s).

PBPs:

- Initiate caregiver and staff competency training on skin-to-skin care
- Initiate medical education early and throughout NICU stay
- Utilize verbal, written, and graphic methods of teaching to support family understanding and health literacy

Family-centered care is defined as a shared approach to the planning, delivery, and evaluation of healthcare that is based upon a partnership between healthcare professionals and families of patients. There are four essential domains of FCC: 1) family participation in care, 2) dignity and respect, 3) family collaboration, and 4) information sharing.

ANO SPITAL

The Team

Advisory Board

- Physicians
- Nurse practitioners
- Nurses
- Occupational therapists
- Lactation therapists
- Lawyers
- Epidemiologists
- QI Experts
- Heads of volunteer organizations
- Family liaison
- Department of Health representatives
- Members of academic institutions and private institutions
- Members of level 2, level 3, and level 4 NICUs

Family Advisory Council

- Mothers
- Fathers
- Adoptive parents
- Non-traditional family units
- Diverse ethnicities and races
- Recent versus distant NICU experiences

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Metrics

Outcome Measures
% infants receiving prompt SSC
Average DOL for first SSC
% eligible inpatient days where family caregiver provided at least 1hr of SSC
% infants receiving MOM at time of discharge
Scores on family caregiver surveys

Balancing Measures
% of unplanned extubations associated with SSC
% of other unplanned events associated with SSC

Structural Measures
Use of standardized documentation of SSC in EMR
Development/implementation of NICU policy promoting SSC

Process Measures
% of providers, nursing, and respiratory therapy staff who received education and competency training in SSC
% of family caregivers who received education and competency training in SSC

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The process

Primary Driver: Participation of Family in Care
Subtopic: Inclusion of Families in Long Term Care

Tasks:

- Perform a literature review of this topic
- Summarize evidence-based findings related to this topic
  - Importance of the potentially better practice (PBP) in furthering family-centered care
  - What evidence exists for this PBP
  - What process, outcome, balancing measures could be tracked for this PBP
- Present findings at Advisory Board Meeting on Friday 5/15/2020 and discuss with group

Group Lead:
Group Members:
Potential Collaborators:

Some possible Potentially Better Practices (starting the brainstorming):

- Development of roadmaps for families to follow
- Standardization of family meetings/complex care conferences
- Documentation of partnership between families and medical team
- Improvement in antenatal counseling

Some references which may relate:

Literature Search:

Article #	*Author/ Date*	*Evidence type*	*Sample size*	*Study findings that help answer the question*	*Limitations*	*Evidence rating level/quality*	*Resources from article?*	*Measures?*
1	***, et al 2020	Expert opinion	N/A	Antenatal Counseling - Perinatologists and Neos should discuss mode of delivery/ risks/morbidities/mortality - Short and long term outcomes should be presented based on GA and BW - Discuss expected length of stay	Opinion	Low	N	None provided

Non-Published Resources:

Topic	Source Center	Resource
Complex Care Conferences	L3 NICU, referral center for high risk pregnancies. Majority inborn.	Care conference Protocol: Criteria and Timing: All infants born at <1000 grams or ≤28 weeks gestation should have at least 2 care conferences during NICU stay.

- What potentially better practices can be implemented?
  - Why are these important? What evidence supports them?
  - What resources currently exist?
  - What measures can be utilized to measure improvement?

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What is PAIRED Plus?

- PAIRED Initiative → primary QI aim = skin to skin care

- BUT Family Centered Care encompasses so much more!

Please see our toolkit for detailed information on change ideas, resources, and potential metrics!

PAIRED Plus?

	Potentially Better Practice for FCC	Family Advisors		Advisory Council	
		Raw Score	Score %	Raw Score	Score %
1	Daily rounds including families	199	90.0%	94	72.3%
2	Develop complex care conferences with families	141	63.8%	67	51.5%
3	Early and continuing medical education of families	136	61.5%	91	70.0%
4	Use appropriate infant and family caregiver names	134	60.6%	78	60.0%
5	Create family advisory council	133	60.2%	64	49.2%
6	Policies on family caregiver-infant interactions	132	59.7%	82	63.1%
7	Early and continuing lactation support	129	58.4%	88	67.7%
8	Improve antenatal counseling	115	52.0%	73	56.2%
9	Technologies to improve communications	114	51.6%	63	48.5%
10	Engage families in QI and safety initiatives	106	48.0%	58	44.6%
11	Celebrate milestones and transitions	101	45.7%	62	47.7%
12	Multiple methods to support health literacy	90	40.7%	56	43.1%
13	Other (please explain)	17	7.7%	34	26.2%

Data Collection Form

PAIRED Initiative
Family-Centered Care

Inclusion criteria for patient level data (qualifying infants)—An infant of any gestational age who: (1) requires NICU hospitalization for more than 5 days; (2) is eligible under the current NICU protocol for skin-to-skin care (SSC); (3) survives at least 3 days beyond their eligibility for SSC as defined by the current NICU protocol; and (4) has a family caregiver who visits and is involved in the infant's overall care

INFANT/FAMILY CHARACTERISTICS
(Verified by the date of discharge)

Study ID # _____

Birth weight (g): _____ **Gestational age (completed weeks):** _____

Race of primary family caregiver (check all that apply): ☐ White ☐ Black ☐ Asian ☐ NA/AN ☐ HN/PI ☐ Other: _____ ☐ Unknown

Ethnicity of primary family caregiver: ☐ Hispanic or Latino ☐ non-Hispanic or non-Latino ☐ Unknown

Preferred language of primary family caregiver: ☐ English ☐ Spanish ☐ Other _____ ☐ Unknown

Inborn: ☐ Yes ☐ No

Date of birth: ____/ ____/ 202___

Date of NICU admission: ____/ ____/ 202___

Date of NICU discharge: ____/ ____/ 202___

Date on which the infant was first eligible to start receving SSC: ____/ ____/ 202___

Beginning with the day that the infant first became eligible for SSC, on how many different days did a family caregiver visit the infant in the NICU? _____

Did at least 1 family caregiver receive a complete SSC education bundle? ☐ Yes ☐ No ☐ Not Eligible

Was the infant receiving any of the mother's breastmilk at NICU discharge? ☐ Yes ☐ No ☐ Not Eligible

Is information about episodes of SSC available? (EHR or SSC log) ☐ Yes ☐ Not recorded ☐ No SSC was provided at any time by family caregiver

Skin to Skin Log

Patient Name:_____ **Patient MRN**_____

SKIN-TO-SKIN CARE (SSC) LOG

Collected for Each SSC Episode Once Eligible for SSC

Date	Resp Support	Lines	SSC Start time	SSC End time	Family Member	Type of Adverse Event				
						None	Unintended Extubation	Significant A/B/D*	Hypothermia	Line dislodgement
MM/DD/YY	HFOV, HFJV, CMV, NIPPV, nCPAP, NC, None	UC(UAC and/or UVC), PAL, PICC, PIV, None (circle all that apply)			Mother, Father, Grandparent, Sibling, Other	Check Mark When Meeting Definition*				
		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐
		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐
		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐
		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐
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		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐
		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐
		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐
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		UC / PAL / PICC/ PIV /None			M / F / GP / S / O	☐	☐	☐	☐	☐

*** Adverse Health Events:** **Significant A/B/D (apnea/bradycardia/desaturation)** requiring early termination of SSC per unit guideline; **Hypothermia** - temp < 36.5 at any time during or immediately after SSC; **Line dislodgement** - loss of line or subsequent malfunction or malposition of line

Respiratory Support: HFOV - high frequency oscillatory ventilation; HFJV - high-frequency jet ventilation; CMV - continuous mandatory ventilation; NIPPV - nasal intermittent positive pressure ventilation; nCPAP - nasal continuous positive airway pressure; NC - nasal cannula.

Lines: UC - umbilical catheter; UAC - umbilical artery catheter; UVC - umbilical venous catheter; PAL - peripheral arterial line; PICC - peripherally inserted central catheter; PIV - peripheral intravenous line.

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SSC Policy at URMC

Ineligible infants:

- IVH bundle
- Unstable PPHN
- Infants receiving vasopressors or paralytics
- Infants with NEC or suspicious abdominal distention
- Unrepaired surgical conditions including gastroschisis, omphalocele, myelomeningocele
- Chest tubes
- Unstable vital signs or acute clinical change in status from baseline
- Parents/guardian with rashes or open skin lesions or cold symptoms

Roll Out Phases

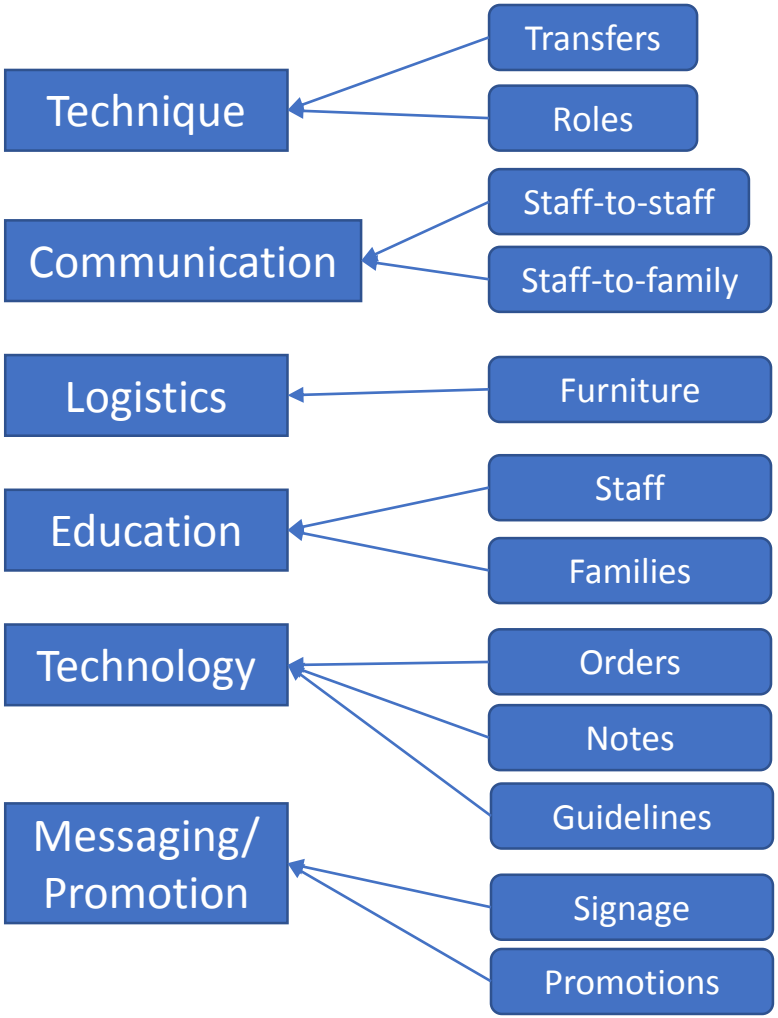
Phase 1: Baseline data (Feb – Mar 2022)

- Erecord flowsheet build
- Nursing education

Phase 1.5 & 2: Staff and parent education (ongoing)

- Education of healthcare team
- Unit simulations on transfers
- Small baby simulations
- Google classroom
- Daily rounds

Goals



Mariah; photo shared with permission

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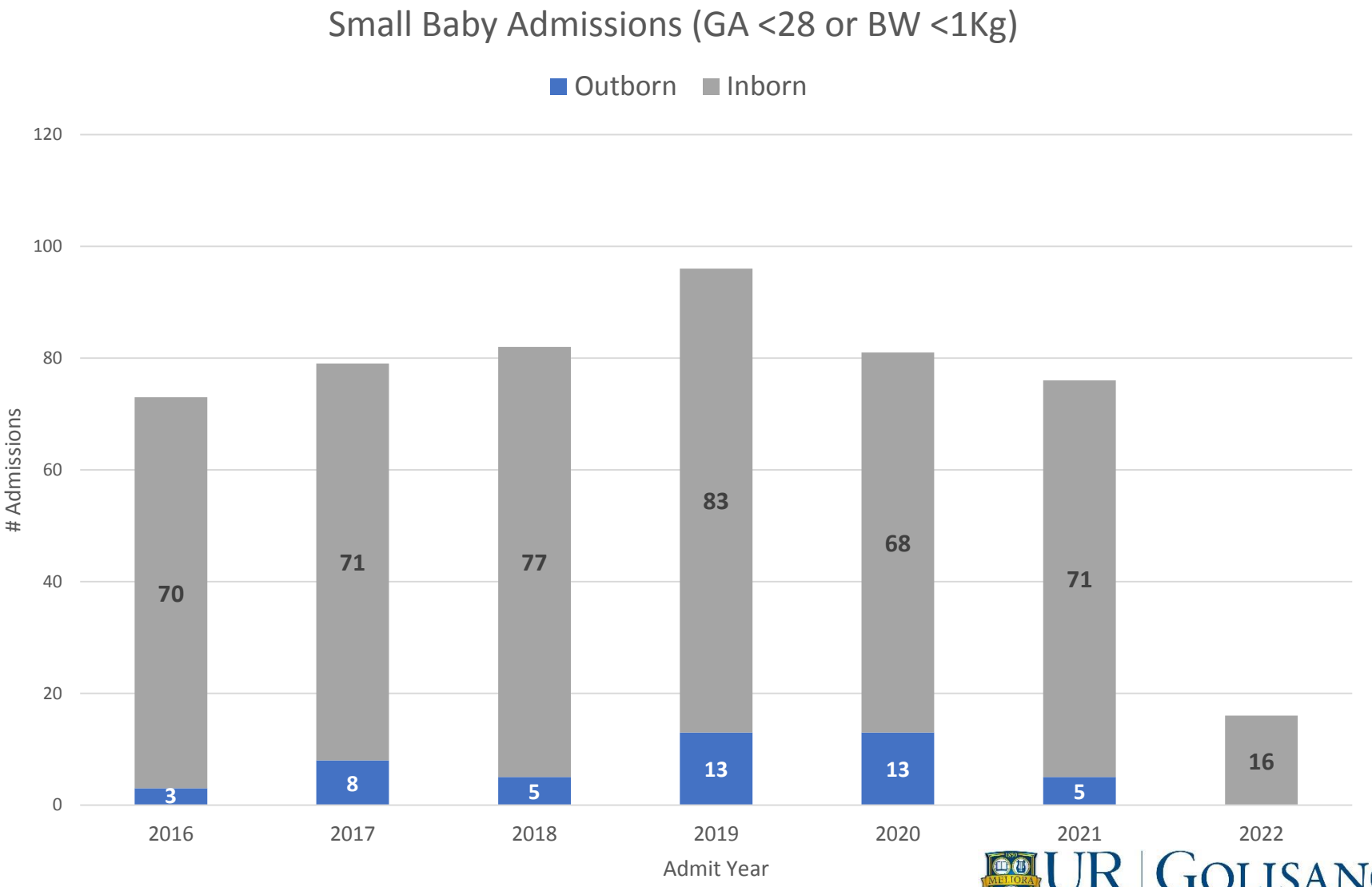
Small Baby Births URMC



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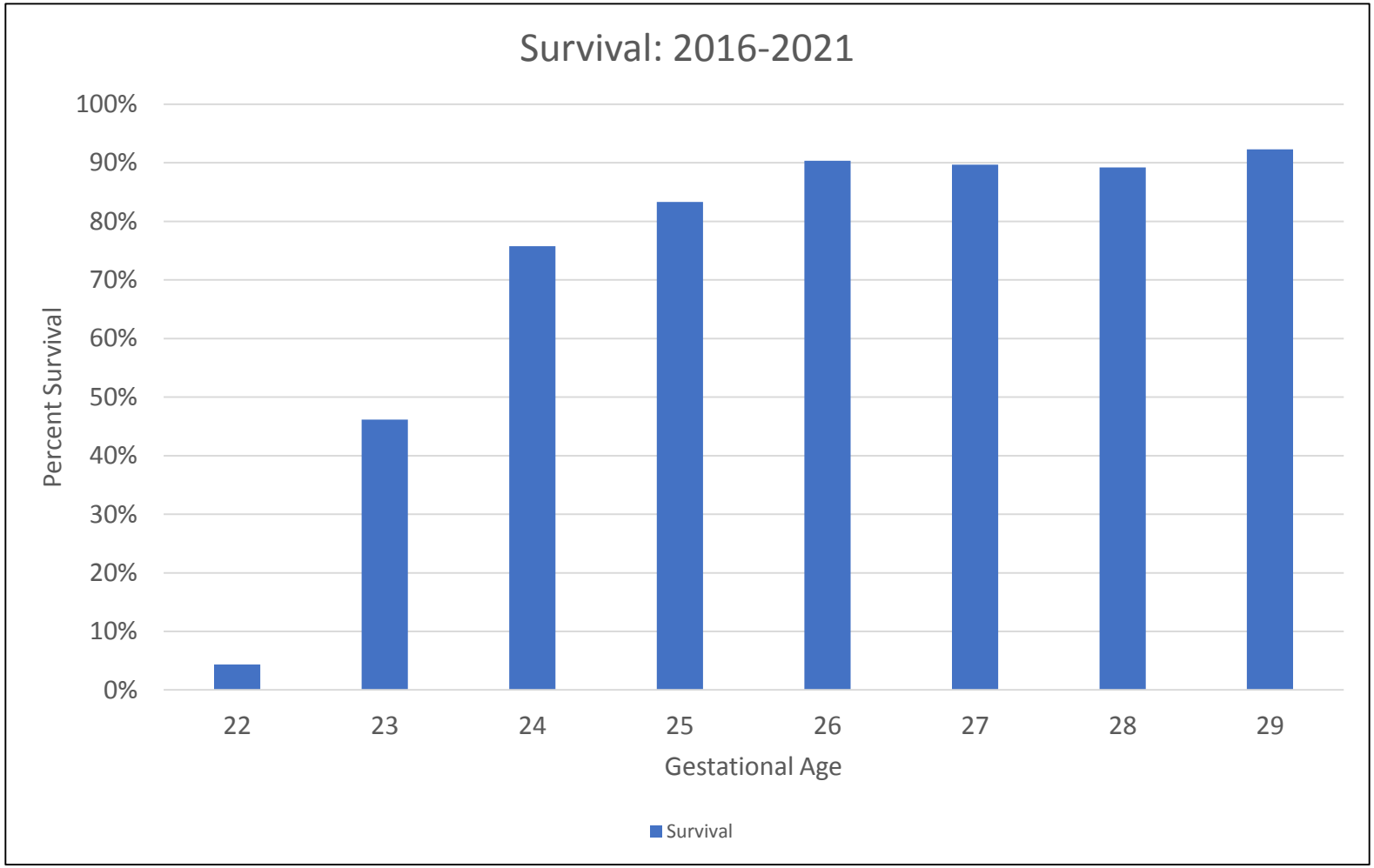
Small Baby Outcomes URMC



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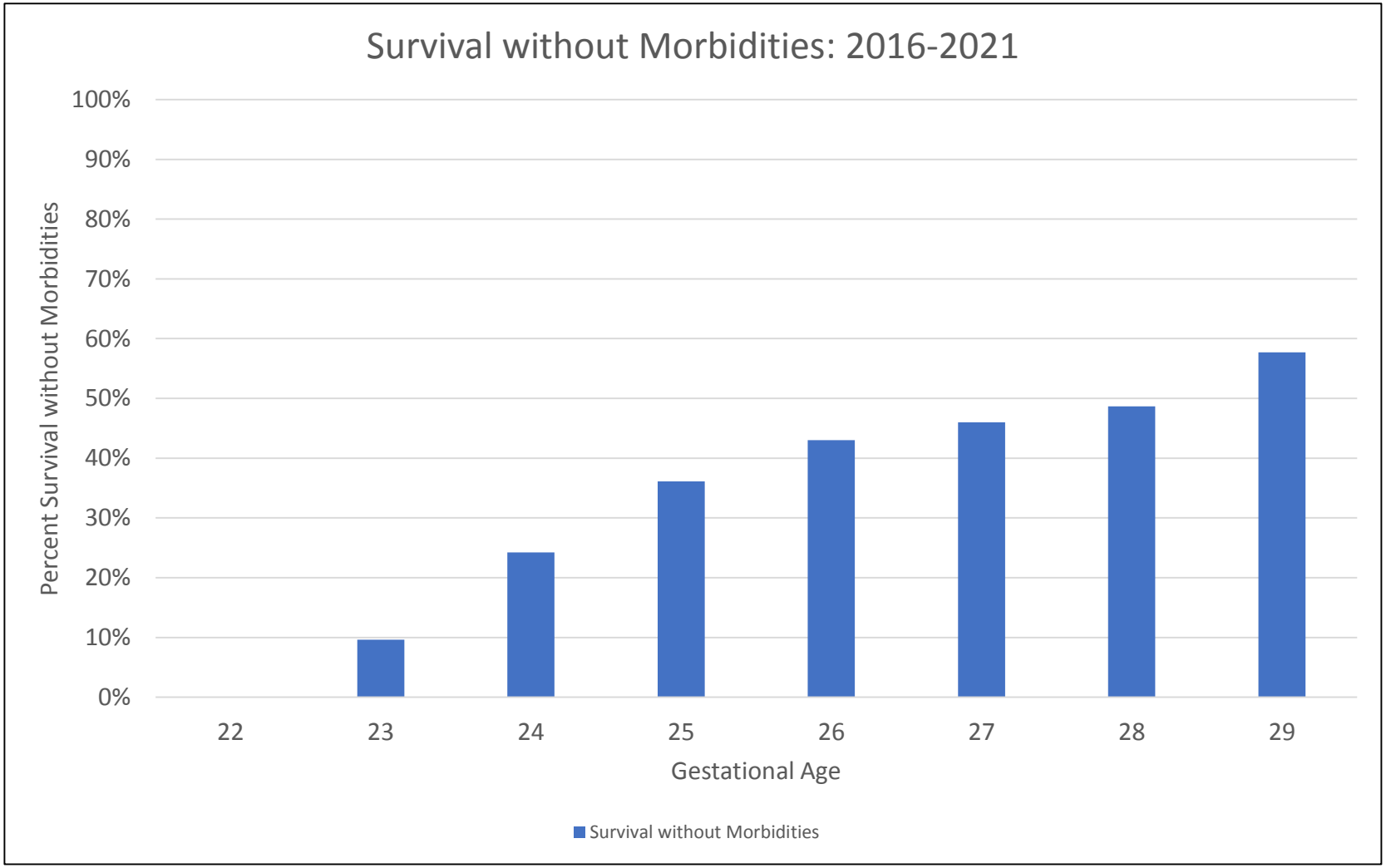
Small Baby Outcomes URMC



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Small Baby Program URMC

Global Aim/Mission

To optimize clinical outcomes, including long-term neurodevelopmental outcomes, for small babies (born < 28 weeks' GA OR < 1000 g birthweight) and families through a comprehensive, interprofessional program.

Aim Statements

By December, 2024 we aim to support this mission and improve long-term neurodevelopmental outcomes by:

1. Creating a shared model of care through the use of formal education and simulation
2. Developing standard of care practices focused on neuroprotection
3. Involving families in the care of their infants throughout the NICU stay and empowering them to be confident, competent caregivers by the time of discharge home
4. Improving follow-through neurodevelopmental care after discharge from the NICU

Primary Drivers	Secondary Drivers
Structured Approach to Education	Use robust education to develop shared mental model, including method to onboard new team members
Interprofessional Teamwork	Establish interprofessional team, including families & promote psychological safety to encourage active participation
Families as Partners (Parent Involvement)	Integrate families into the care of their infant and foster collaboration
Standardization of Practices (QI Methods)	Develop written guidelines, policies and procedures for care of small babies that are easily accessible by staff
Data Accessibility & Benchmarking	Ensure access to in-hospital and follow-up data, including benchmarking, and make visible to staff

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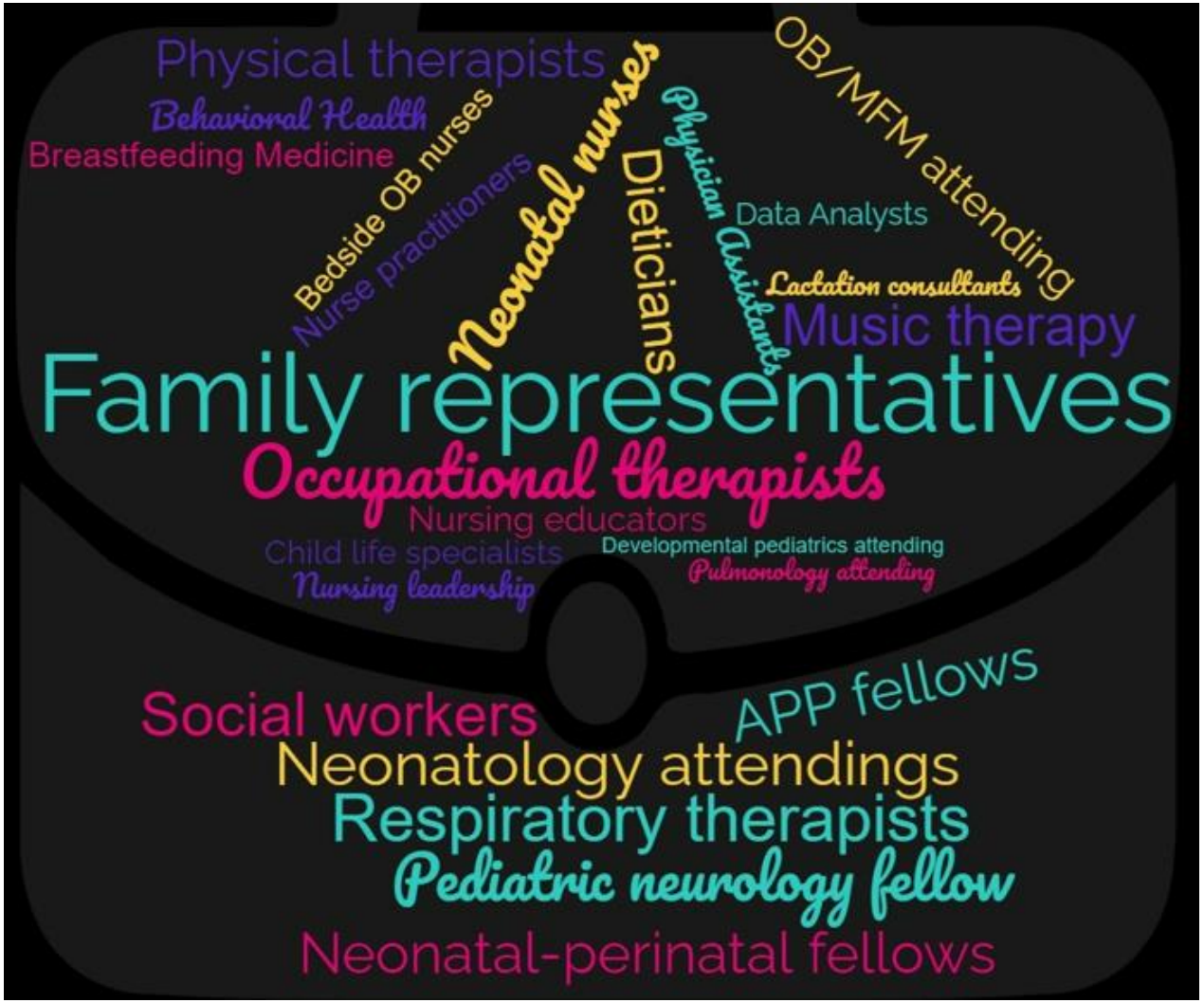
Shared Model of Care URMC



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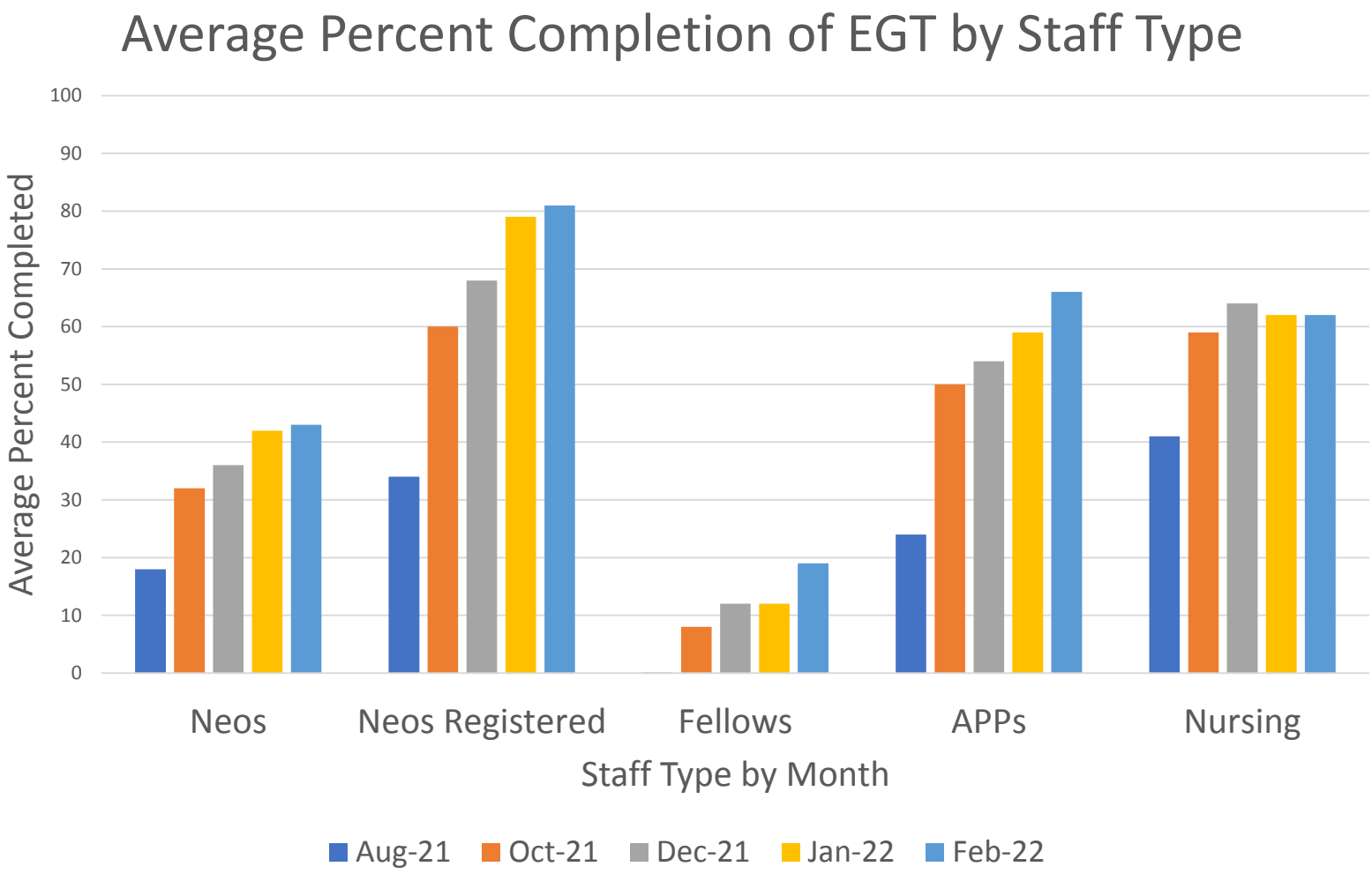
Shared Model of Care URMC



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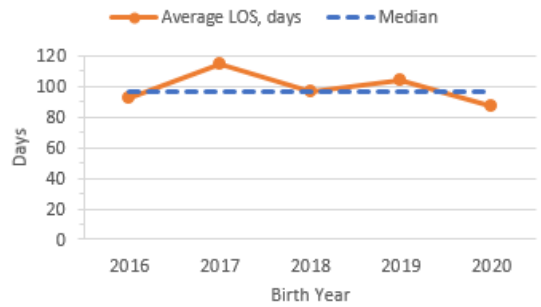
Specific Aims	Outcome Measures	Process Measures
Shared Model of Care	1. Increase % of nurses with national Extremely Low Birthweight (ELBW) certification	1. Increase SBP team completion of Engage Grow Thrive curriculum from 36% to 90% 2. Increase SBP team completion of Simulation workshops from 30% to 75% 3. Increase unit staff completion of skin-to-skin standing transfers simulation 4. Increase faculty and fellow completion of shared decision-making education 5. Increase % admissions utilizing an admission huddle 6. Increase % families completing skin-to-skin care education
Standard of Care/Neuroprotection	1. Increase % of infants surviving to discharge without major clinical morbidities* from 50% to 60% 2. Decrease % infants scoring ≥3 on composite neurodevelopmental risk score** 3. Decrease % infants discharged <10th percentile for weight from 39% to 30%	1. Decrease time to first fluid administration after admission 2. Decrease admission hypothermia 3. Decrease average venipunctures for labs 4. Increase % infants receiving 2-person cares 5. Increase compliance with neuroprotective bundle 6. Improve TIMP Scores
Family Integration	1. Decrease average length of stay in the NICU from 96 to 91 days 2. Increase % completion of parental discharge readiness survey from 41% to 70% 3. Decrease time to first skin-to-skin holding 4. Increase % of infants receiving any breastmilk discharge from 35% to 50% 5. Improve scores on family caregiver surveys related to family centered care culture	1. Improve family experience with prenatal consults (survey) 2. Increase % families receiving visual cue cards during prenatal consults 3. Increase % of families experiencing shared decision-making during prenatal consults 4. Increase % prenatal lactation consults 5. Increase % families participating in 2 week and discharge care conferences 6. Decrease time to first breastmilk expression
Follow Through	1. Increase % infants attending first scheduled visit at ITDP Clinic	1. Increase % infants receiving longitudinal neurodevelopmental consultation
Overall Aim: Improved NDO	**1. Improved Bayley-III scores at 2 years**	

*severe intraventricular hemorrhage (sIVH), periventricular leukomalacia (PVL), necrotizing enterocolitis (NEC), chronic lung disease (CLD), pneumothorax, late infection; **Score created by SBP: sIVH, PVL, severe NEC, severe retinopathy of prematurity, CLD, meningitis

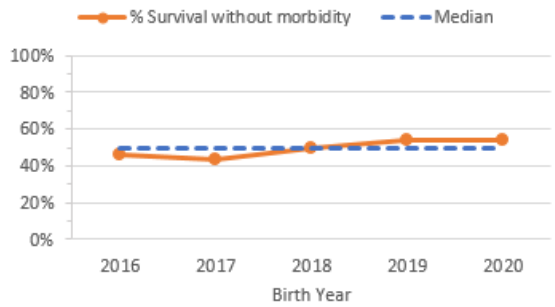
QI Dashboard

Small Baby Program Outcomes Dashboard

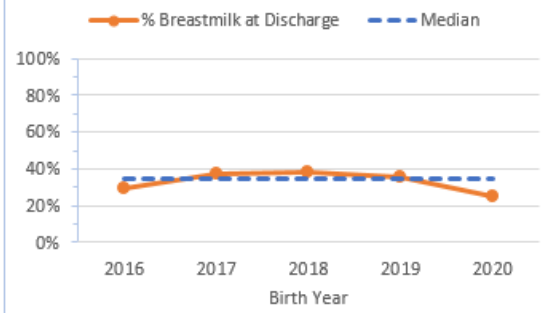
Average Length of Stay



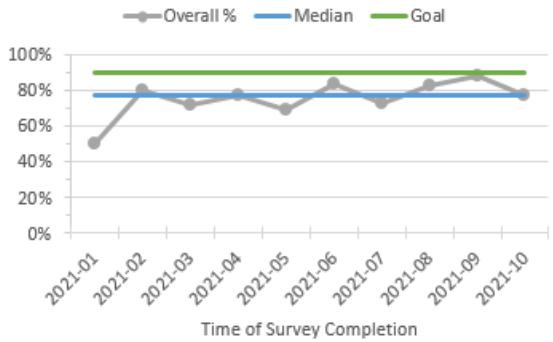
% Survival Without Morbidity



% Receiving Breastmilk at Discharge



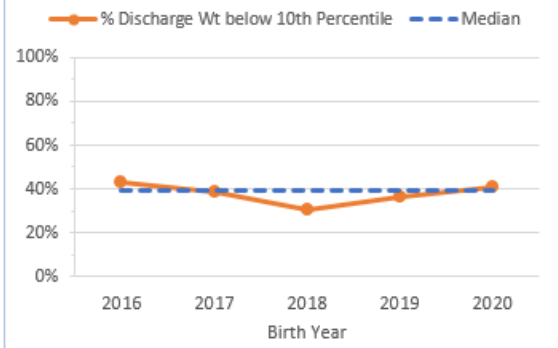
% Parental Discharge Readiness



Two-Year BSID-III Scores

Coming soon…

% Discharge Weight < 10th Percentile



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Longitudinal Neuroprotective Care

To optimize outcomes for small babies (born < 28 weeks' GA OR < 1000 g) and families through a comprehensive, interprofessional program

- Increase survival without morbidities
- Decrease IVH/PVL
- Improve NDI
- Decrease NEC/SIP
- Decrease CLD
- Decrease Infections
- Decrease Severe IVH
- Increase skin to skin care
- Increase parental discharge readiness
- Decrease LOS
- Improve Growth
- Decrease PTX

- Antenatal
- Delivery Room Golden Hour/Resuscitation
- Nutrition Oral Feeding
- Respiratory Care
- Skin to Skin Care Family Integration
- Transition out of SBU Transition Home

Neurodevelopmental Care/Neurosensory Bundle

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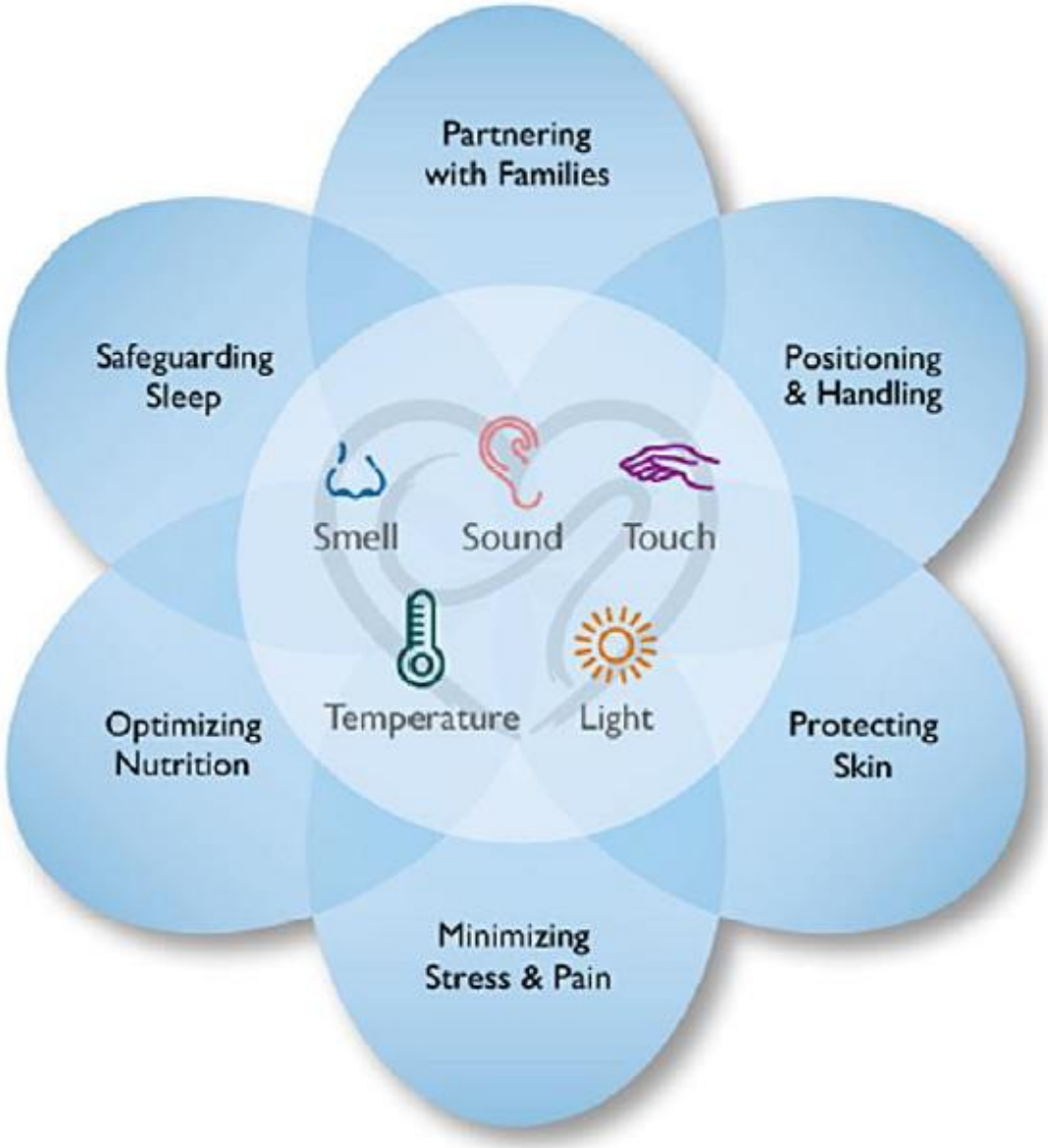
Longitudinal Neuroprotective Care



Neonatal Neuro-Protective Best Practice Guidelines:
NICU Brain Sensitive Care Committee, Swedish Medical Center

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Beyond optimizing NICU care…

- Parental involvement
- Outpatient follow up
  - PCP
  - Developmental pediatrics
  - Therapies
  - Subspecialists

Tommy at 3 weeks old in the NICU
and on the first day of UPK-3
Photo shared with permission

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Thank you!

Feel free to reach out to me!
Colby_Richardson@urmc.rochester.edu

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Wrap Up and Next Steps

Aviel Peaceman, MPH

Program Manager

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Upcoming Webinar Dates

- Spring Summit: May 3rd and 4th from 1-4 pm each day
- June 8 from 2-3 pm

Spring Summit!

- Parental mental health during and after the NICU
- Keynote speakers:
  - Kate Robson, Psychotherapist, Sunnybrook Health Sciences Centre
  - Tiffany Willis, PsyD, Licensed Clinical Psychologist, Division of Neonatology and Fetal Health, Children's Mercy Kansas City
- Topics will include:
  - PPD screening in the NICU
  - Perinatal mental health in the NICU
  - Parental stress levels and discharge readiness
  - PDSA review

Next Steps for Hospital Teams

- Please keep working on your:
  - Data entries in REDCap
  - DUA/SOW for those who have not signed one yet
- Keep working on your PDSAs!

Any Comments, Reflections, or Questions?

Thank you!
We look forward to seeing you again on the next webinar!

We enjoy working with all of you on this journey to improve family engagement with NICU families across MA