Welcome!

New Hampshire AIM Launch
November 12, 2020
NNEPQIN’s history with AIM

- Summer 2016: Tim and Vicki go to Baltimore for AIM kickoff meeting
- November 2017: Vicki, Maggie and Daisy go to D.C. NNEPQIN welcomed as an AIM member (!)
- January 2017 NNEPQIN Winter Meeting: “Taking Action to Promote Physiologic Birth and Safely Reduce Primary Cesarean Sections: The NNEPQIN/AIM Partnership”
- May 2017 NNEPQIN Spring Meeting: Jeanne Mahoney, RN, BSN, Senior Director, ACOG Director AIM Program, “AIM Progress and Vision”
- May 2020: State of NH/NNEPQIN ERASE Maternal Mortality Grant awarded
- October 2020: New Hampshire officially enrolled as AIM State
Acknowledgements and Thank You’s

- Maggie Minnock
- Vicki Flanagan
- Daisy Goodman
- Karen Lee
- Karen Boedtker
- Jennifer Reining

- David LaFlamme
- Ann Collins
- Rhonda Siegel

- Jeanne Mahoney
- Karmah Mcilvain
- Andrea Carillo
- Christie Allen
AIM’s Primary Objective

Reduce preventable maternal deaths and severe maternal morbidity (SMM) in the United States.

By:

- Promoting safe care for every U.S. birth
- Engaging multidisciplinary partners at the national, state and hospital levels
- Developing and providing tools for implementation of evidence-based patient safety bundles
- Utilizing data-driven quality improvement strategies
- Aligning existing efforts and disseminating evidence-based resources
AIM’s Workplan Goals

- Convene a multisector national partnership of organizations
- Identify strategies that will sustain the work of AIM
- Collect outcome data on safety bundle implementation
- Develop patient safety bundles
- Develop data metrics and an online national data collection system
- Provide and facilitate the integration of 50 states and the District of Columbia into AIM
- Provide and facilitate the integration U.S. Territories, IHS, and tribal maternal health into AIM
- Develop and implement and communication strategy
AIM By the Numbers

- 90% of U.S. States Engaged in AIM
- 65% of U.S. States Enrolled in AIM
- 51% of U.S. States Implementing a Bundle with AIM

AIM Bundle Implementation

N=51 (50 states and Washington, DC)

**Multiple states are implementing more than one
AIM National Team

**Project Oversight**
Provide assistance to state teams on the development of bundle implementation workplans. Offer ongoing guidance to help state teams achieve program objectives.

**Engagement Opportunities**
Facilitate opportunities for collaboration, learning, and information sharing amongst state teams. Offerings include bundle interest groups and knowledge library.

**Data Strategy**
Support state teams with the development of a data collection strategy that meets local needs. Provide resources to enable ongoing collection and reporting of hospital-level data.

**Budget Guidance**
Offer guidance on the design of project budgets and strategies for effective utilization of HRSA funds to support program objectives within the state.
Critical Collaborations

Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in care.

Perinatal Quality Collaboratives mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies.

Maternal Mortality Review Committees conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts.

Created from a Centers for Disease Control, Division of Reproductive Health source.
AIM Bundle Components

Readiness
Recognition and Prevention
Response
Reporting and Systems Learning
Respectful Care
AIM Patient Safety Bundles

- Safe Reduction of Primary Cesarean Birth
- Severe Hypertension in Pregnancy
- Obstetric Hemorrhage
- Obstetric Care for Women with Opioid Use Disorder
- Postpartum Basics: From Birth to Postpartum Visit
- Postpartum Basics: From Maternity to Well-Woman Care
- Maternal Venous Thromboembolism
- Reduction of Peripartum Racial and Ethnic Disparities
- Cardiac Conditions in Obstetrical Care
- Maternal Sepsis
AIM Patient Safety Bundles

Patient Safety Bundles can be found on the Council on Patient Safety in Women’s Health Care Website

Accompanied by resources and implementation supporting documents

Will be undergoing updates and template format changes over the next year
Why an AIM Data Center?

- Supports data-driven quality improvement
- Benchmark metrics against “like” hospitals and stratifies outcomes by patient demographics
- Allows for comparison across state collaboratives
- Tracks bundle implementation and SMM rates overtime
Built to Accommodate Three Audiences

**Participating Hospitals**
- Track processes and structures over time
- Monitor facility-specific outcomes
- Benchmark against “like” hospitals within collaborative

**Statewide Collaboratives**
- Track bundle implementation and data submission across facilities in collaborative
- Use data to assess facility and collaborative impacts
- Benchmark against other collaboratives

**AIM National**
- Track nation-wide bundle implementation
- Determine areas for program support and improvement
- Evaluate program and analyze impacts
What is in the AIM Data Portal?

**Outcome Measures**
- Calculated and submitted on behalf of hospitals by collaborative administrators
- Data primarily sourced from hospital discharge and birth certificate data

**Structure and Process Measures**
- Data collected by participating facilities and submitted by hospital administrators
- Based on AIM Data Collection Plan

**Data from other AIM state teams**
- Provides collaborative-wide data for all metrics provided by all states
- Allowing for improved benchmarking
Welcome, Christie!

Christie Allen MSN, RNC-NIC, CPHQ, C-ONQS is the Senior Director, AIM Projects and Programs. She provides clinical support to end supervision of the AIM Program and other affiliated grants. Prior to this role, Christie served as the Associate Director of Clinical Quality for ACOG, as a quality coordinator for a Planned Parenthood affiliate, and as the coordinator of a statewide Medicaid program for people with opiate use disorder in pregnancy. Christie has practiced as a clinical bedside nurse for over 20 years in adult, pediatric, and neonatal intensive care and inpatient obstetrics, as well as a lactation consultant and is certified in neonatal intensive care as well as healthcare quality. She holds a Bachelor of Science in nursing and a Master of Science in nursing with a concentration in health policy.
Thank you!

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Maternal and Infant Outcomes in New Hampshire
Birth weight

Deliveries occurring in New Hampshire: 2019

- LBW <2500g: 6.2%
  - VLBW <1500g: 0.8% (94)
  - MLBW 1500-2499g: 5.4% (642)
- NBW 2500-3999g: 83.4% (9,864)
- HBW >3999g: 10.3% (1,222)

David.Lefkamm@unh.edu
Diversity Among Birthing Families in New Hampshire
Percent Low Birth Weight by Maternal Race/Hispanic Origin

Deliveries occurring in New Hampshire: 2013 to 2019

Plurality: Single

- Unknown: 6.4% (476)
- American Indian or Alaska Native (non-Hisp): 6.8% (74)
- Asian (non-Hisp): 6.7% (2,836)
- Black or African American (non-Hisp): 8.2% (1,183)
- Hispanic: 5.8% (3,936)
- Native Hawaiian or Other Pacific Islander (non-Hisp): 2.0% (50)
- Other Race (non-Hisp): 6.7% (653)
- Two or More Races (non-Hisp): 5.9% (1,016)
- White (non-Hisp): 5.1% (72,600)

David.Lafliame@unh.edu
<table>
<thead>
<tr>
<th>Asian (non-Hisp)</th>
<th>Black or African American (non-Hisp)</th>
<th>Hispanic</th>
<th>White (non-Hisp)</th>
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<tbody>
<tr>
<td><strong>US Born Birthing People Only</strong></td>
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<tr>
<td><strong>Percent Low Birth Weight by Maternal Race/Hispanic Origin and Education</strong></td>
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<tr>
<td>Deliveries occurring in New Hampshire: 2013 to 2019</td>
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<tr>
<td><strong>Nativity</strong></td>
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<tr>
<td>Mother born in US State/DC</td>
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<tr>
<td><strong>LESS THAN HIGH-SCHOOL</strong></td>
<td><strong>HIGH-SCHOOL GRADUATE/GED</strong></td>
<td><strong>SOME COLLEGE OR ASSOCIATE DEGREE</strong></td>
<td><strong>4 YEAR COLLEGE DEGREE OR HIGHER</strong></td>
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<td>Black or African American (non-Hisp)</td>
<td>Hispanic</td>
<td>White (non-Hisp)</td>
</tr>
<tr>
<td><strong>33.3% (9)</strong></td>
<td><strong>13.6% (22)</strong></td>
<td><strong>11.1% (144)</strong></td>
<td><strong>11.7% (3,862)</strong></td>
</tr>
<tr>
<td><strong>25.9% (54)</strong></td>
<td><strong>7.1% (112)</strong></td>
<td><strong>14.2% (148)</strong></td>
<td><strong>11.7% (3,862)</strong></td>
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<tr>
<td><strong>17.0% (53)</strong></td>
<td><strong>17.0% (53)</strong></td>
<td><strong>15.0% (127)</strong></td>
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<tr>
<td>Ethnicity</td>
<td>Medicaid</td>
<td>Private</td>
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</tr>
<tr>
<td>Asian (non-Hisp)</td>
<td>17.1% (281)</td>
<td>23.9% (1,852)</td>
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<tr>
<td>Black or African American (non-Hisp)</td>
<td>18.6% (484)</td>
<td>22.9% (397)</td>
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<tr>
<td>Hispanic</td>
<td>16.8% (1,406)</td>
<td>23.4% (1,475)</td>
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<tr>
<td>Two or More Races (non-Hisp)</td>
<td>18.5% (248)</td>
<td>20.0% (325)</td>
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<tr>
<td>White (non-Hisp)</td>
<td>17.3% (15,770)</td>
<td>20.5% (40,038)</td>
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Perinatal Substance Exposure

82A: Was the infant monitored for effects of in utero substance exposure?

Infant born 9/1/2020 to 10/31/2020
Data refreshed: 11/12/2020 8:00:33 AM
Data source: VR_BIRTH (EBL_DATAMART VR_BIRTH) + (EBL_DATAMART)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>407 (6.5%)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>5,834 (93.5%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>6,241 (100.0%)</td>
</tr>
</tbody>
</table>

82A Substance Type Summary

82A: If YES, Type of substance(s)
Total Births w/ 1 or more substances reported: 407

Note: The numbers in the table may add up to more than 407 (# monitored) because multiple substances could be reported.

Infants born 9/1/2020 to 10/31/2020
Data refreshed: 11/12/2020 8:00:33 AM
Data source: VR_BIRTH (EBL_DATAMART VR_BIRTH) + (EBL_DATAMART)

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Count</th>
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<tbody>
<tr>
<td>Cannabis</td>
<td>237</td>
</tr>
<tr>
<td>Opioids</td>
<td>144</td>
</tr>
<tr>
<td>Nicotine</td>
<td>124</td>
</tr>
<tr>
<td>Other substance</td>
<td>64</td>
</tr>
<tr>
<td>Stimulants</td>
<td>42</td>
</tr>
<tr>
<td>Cocaine</td>
<td>25</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>11</td>
</tr>
<tr>
<td>Alcohol</td>
<td>17</td>
</tr>
<tr>
<td>Kratom</td>
<td>0</td>
</tr>
<tr>
<td>Bath salts</td>
<td>1</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>7</td>
</tr>
</tbody>
</table>

82A Type Other Specify

Infants born 9/1/2020 to 10/31/2020
Data refreshed: 11/12/2020 8:00:33 AM
Data source: VR_BIRTH (EBL_DATAMART VR_BIRTH) + (EBL_DATAMART)
Perinatal Substance Exposure

82B. Was the infant identified as being affected by substance misuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder?

CAPTA/CARA

Infants born: 5/1/2020 to 10/31/2020
Data refreshed: 11/12/2020 8:00:33 AM
Data source: VR_BIRTH (EBI_DATAMART.VR_BIRTH)

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<table>
<thead>
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<tbody>
<tr>
<td>Yes</td>
<td>164 (2.6%)</td>
</tr>
<tr>
<td>No</td>
<td>6,077 (97.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>6,241 (100.0%)</td>
</tr>
</tbody>
</table>

83: Was a Plan of Safe/Supportive Care (POSC) created?

Infants born 5/1/2020 to 10/31/2020
Data refreshed: 11/12/2020 8:00:33 AM
Data source: VR_BIRTH (EBI_DATAMART.VR_BIRTH)

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<table>
<thead>
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<tbody>
<tr>
<td>Yes</td>
<td>6.0% (374)</td>
</tr>
<tr>
<td>No</td>
<td>94.0% (5,867)</td>
</tr>
<tr>
<td>Total</td>
<td>100.0% (6,241)</td>
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</tbody>
</table>
## Perinatal Substance Exposure

82B. Was the infant identified as being affected by substance misuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder?

<table>
<thead>
<tr>
<th>83: Was a Plan of Safe/Supportive Care (POSC) created?</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>82B.</strong> Yes</td>
<td>5,851 (96.3%)</td>
<td>148 (90.2%)</td>
</tr>
<tr>
<td><strong>82B.</strong> No</td>
<td>16 (9.8%)</td>
<td>226 (3.7%)</td>
</tr>
</tbody>
</table>

90.2% of infants identified per CAPTA/CARA criteria had a POSC created.
Critical Collaborations

**Alliance for Innovation on Maternal Health** moves established guidelines into practice with a standard approach to improve safety in care.

**Perinatal Quality Collaboratives** mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies.

**Maternal Mortality Review Committees** conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts.

Created from a Centers for Disease Control, Division of Reproductive Health source.
Findings From New Hampshire’s Maternal Mortality Review

• Eleven of the twelve pregnancy-associated deaths in 2016-2017 occurred during the postpartum period, and one occurred during pregnancy.

• The leading causes of pregnancy-associated deaths in NH are accidental drug overdose and suicide.

• Almost all deaths reviewed were substance-involved.
New Hampshire MMRC Recommendations to Maternity Care Providers

Support engagement in prenatal care and substance use treatment

- Educate healthcare teams to reduce stigma against people who use substances
- Provide warm handoff from PCP to facilitate engagement in prenatal care
- Improve collaboration between substance use providers and mental health providers

Address social determinants of health

- Assess social determinants and link to services directly from Emergency Department for patients with substance-related complaints
- Increase outreach to unhoused people, prioritizing access to women's services

Overdose prevention

- Standardize perinatal education about risk for overdose after pregnancy or any period of abstinence
- Provide naloxone kits and standard education at discharge for postpartum patients with OUD
How Does AIM Work To Reduce Maternal Mortality?

Selection and implementation of maternal safety bundles

1. Maternal hemorrhage
2. Hypertension in pregnancy
3. Reduction of venous thromboembolism
4. Supporting vaginal birth/Reduction of low-risk primary Cesarean births
5. Reduction of peripartum racial and ethnic disparities
6. Postpartum care basics for maternal safety
7. Obstetric care for women with opioid use disorder
A SMART Aim

Achieve 100% reduction in opioid- and other substance- related maternal mortality in New Hampshire by 1/1/2023

• Specific
• Measurable
• Achievable
• Relevant
• Timed
Initial Implementation Targets

- **Provide naloxone** to all pregnant and postpartum people with opioid use disorder at hospital discharge and during prenatal/postpartum care.

- **Improve collection of Race, Ethnicity, and Language (REaL) data** at New Hampshire birthing hospitals and ambulatory maternity care settings.
Initial Steps to AIM Program Implementation

1. Establish **multi-disciplinary leadership/advisory group** for this project; include leaders from clinicians, public health, hospitals, improvement science, persons with lived-experience, and others as appropriate.

2. Provide opportunities for **collaborative learning** among clinical teams with face to face or interactive group on-line meetings, specifically not web lectures or other one to many events.

3. Plan for at least one population outcome measure with **stratification by race**.

4. Plan for **data collection** strategies for outcome, process, and structure measures.

5. Plan for **project measurement** strategy: list all metrics to be used.

6. SMART goal
Engaging A Multidisciplinary Advisory Group

• **AIM Champions**
  - Professional organizations
  - Clinicians
  - Policymakers
  - Payors

• **AIM Implementation Team**
  - NNEPQIN Leadership
    - Timothy Fisher, MD
    - Victoria Flanagan, RN, MS
    - Maggie Rose Minnock, MBA
  - AIM Lead coordinators
    - Daisy Goodman, DNP, MPH, CNM
    - Ann Collins, RN, BSN
  - AIM Data coordinator
    - David Laflamme, PhD, MPH
  - AIM Improvement Advisor
    - Karen Boedtker, RN

• **Patient and Family Advisory Committee**
Opportunities for Collaborative Learning

- READINESS
- RECOGNITION & PREVENTION
- RESPONSE
- REPORTING & SYSTEMS LEARNING

PATIENT SAFETY BUNDLE
- Obstetric Care for Women with Opioid Use Disorder
- Racial/Ethnic Disparities

NNEPQIN

NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

AIM

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
AIM OUD Bundle Measures

Alliance for Innovation in Maternal Health OUD Safety Bundle Measures (AIM Participants)

Outcomes
O1: Severe Maternal Morbidity
O2: Severe Maternal Morbidity
O3: Pregnancy Associated Opioid Deaths
O4: Average length of stay for newborns with Neonatal Abstinence Syndrome (NAS)

Process
P1: Percent of women with OUD during pregnancy who receive medication assisted treatment MAT or behavioral health tx
P2: Percent of Opioid Exposed Newborns receiving mother’s milk at newborn discharge
P3: Percent of Opioid Exposed Newborns who go home to biological mother
P4: Universal Screening at Prenatal Care Sites

Structure
S1: Universal Screening on L&D
S2: General pain management practices
S3: OUD pain management guidelines

State Surveillance
SS1: Percent of newborns diagnosed as affected by maternal use of opiates
SS2: Percent of newborns diagnosed with NAS

Outcome, Process, and Surveillance data stratified by race, ethnicity, & payor to identify disparities in care and outcomes
Data Collection

• Clinical Outcomes
  • Payor-level data

• Process
  • De-identified, hospital level data
  • Baseline survey about screening practices
  • Compare Race, Ethnicity, and Language (REaL) Data from administrative record to BC

• Structure
  • Hospital level data about policy and procedure

• Implementation
  • Baseline QI needs assessment (required by AIM)
  • Organizational readiness assessment (optional)
Implementation Strategies

• Promote messaging about Maternal Mortality through partner organizations, professional societies, and NH DHHS website
• Engage birth facilities and associated prenatal/postpartum care providers
• Partner with Public Health
• Share tools and technical assistance for self-evaluation and quality improvement planning
• Provide step by step implementation support
• Generate real time data to promote quality improvement initiatives

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
Implementation Goals

• Focus on interventions which are relevant across different types of settings
• Recognize that every participating program will have a unique path to success
• Identify and build on existing work to maintain momentum
• Expect incremental adoption
• Learn from each other
• Involve patients and families
• Keep the public informed about our work
Invitation to Engage

Next steps:

• AIM implementation webinars: **second Thursday of each month from 12-1pm** – **To register, email:** Karen.G.Lee@Hitchcock.Org

• Individual calls with each participating site to identify key opportunities and develop strategies

• Initial implementation targets:
  • **Provide naloxone access** at hospital discharge and in prenatal/postpartum settings
  • **Improve collection of REaL data** at all maternity care providing sites
Fall Meeting

**November 13, 2020**

To Register, Email: Karen.G.Lee@Hitchcock.Org

AIM Questions: Daisy.J.Goodman@hitchcock.org
Victoria.A.Flanagan@hitchcock.org