CCMH Quality Improvement Learning Collaborative: Initiative One Implementation Guide

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Introduction: How to Use the Implementation Guide

Thank you for your participation in the CCMH Quality Improvement Learning Collaborative as an Implementation Partner! We at AllianceChicago are excited to support you in any way we can, and this Implementation Guide is one component of that support.

The Chicago Collaborative for Maternal Health (CCMH) is a collaboration of public health, community based, and health care organizations, led by AllianceChicago and EverThrive Illinois, working together to improve maternal health in Chicago and reduce disparities in maternal morbidity/mortality. The CCMH Quality Improvement Learning Collaborative is a community of health care organizations providing ambulatory maternal/reproductive health care working together to develop, inform, and support implementation of at least two maternal health QI initiatives over 2 years.

Each section of the implementation guide is designed to support you throughout the planning, implementation, and evaluation of the CCMH's proposed quality improvement initiative at your health center. Please feel free to refer to this document as much as you need throughout the process, and to reach out to AllianceChicago with any questions and concerns.

Access the QI Implementation Site Hub for all resources!

Initiative One: Overview and Aims

Primary Objective: Improve number of patients with pregnancies complicated by medical conditions who are linked to PCP by 6 months postpartum by December 31, 2021.

The American College of Obstetricians and Gynecologists (ACOG) recommends that postpartum care providers include the transition to well-woman care as part of the postpartum care plan, and that additional referrals should be made as appropriate (ACOG Committee Opinion, 2018). ACOG additionally notes that the transition needs to be documented in the medical record and communicated with the patient and all members of the care team (ACOG Committee Opinion, 2018). Evidence supports primary care provision to high risk prenatal patients, such as patients with gestational diabetes and postpartum depression, to reduce disparities in treatment and improve health promotion (LaManna & Quelly, 2020).

The primary objective of Initiative One was identified by surveying QI Collaborative participants in March 2020. Secondary outcomes can be prioritized per health partner jurisdiction.

Proposed Implementation Timeline

CCMH QI Initiative One																	
Initiative Pre-Launch			**Initiative Implementation**												**Initiative Sustainability**		
Oct. 2020	Nov. 2020	Dec. 2020	Jan. 2021	Feb. 2021	Mar. 2021	Apr. 2021	May 2021	June 2021	July 2021	Aug. 2021	Sept. 2021	Oct. 2021	Nov. 2021	Dec. 2021	Jan. 2022	Feb. 2022	Mar. 2022

**this timeline is subject to change depending on when a CHC is able to participate!*

CCMH QI Collaborative Process for Initiative One:

1. **Identification of project via partner survey:** Improving postpartum care for patients with high risk pregnancies, specifically linking medically complex patients to primary care providers.
2. **Identification of proposed intervention to achieve desired outcome:** Development of "registry" of high-risk patients, and a process to support receipt of prioritized services in postpartum period, with highest priority being linkage to PCP
3. **Identification of proposed evaluation measures (see "Resources" section for key driver diagram)**
4. **Re-engaging partners, confirming implementation sites and initiating kick-off calls**
5. **Resource collection and development for implementation sites**
6. **Finalize quality improvement protocol, data collection tool and process, and prep for implementation**
7. **Implementation, monthly data collection, technical assistance and collaborative shareout meetings**
8. **Finish formal data collection, plan for sustainability and potential test of Initiative Two from findings of Initiative One**
9. **Closeout of Initiative One**

Resources

To achieve our outcome of increasing the number of high-risk patients linked to primary care providers, we have several resources to guide you:

Resource	Description
Key Driver Diagram	Organizes strategies for implementation and measures to evaluate Initiative One
Process Flow Example	Guide for partner sites to consider their current workflows and opportunities for adjustment
Implementation Checklist	Identifies key staff and process changes to implement Initiative One
Risk-Stratification Tool (PCC Wellness)	Example guide for establishing criteria for high-risk patients
Registry List Template	Example for creating patient registry and tracking care outcomes
1-week/2-week/1-month plan	Tool for getting off the ground and planning implementation
Plan-Do-Study-Act	Tool for implementation and assessing progress

Throughout the planning process, please reach out to AllianceChicago for questions and feedback.

** we will continue to add to these resources!

Additional Resources: Defining the PCP Role for Patients

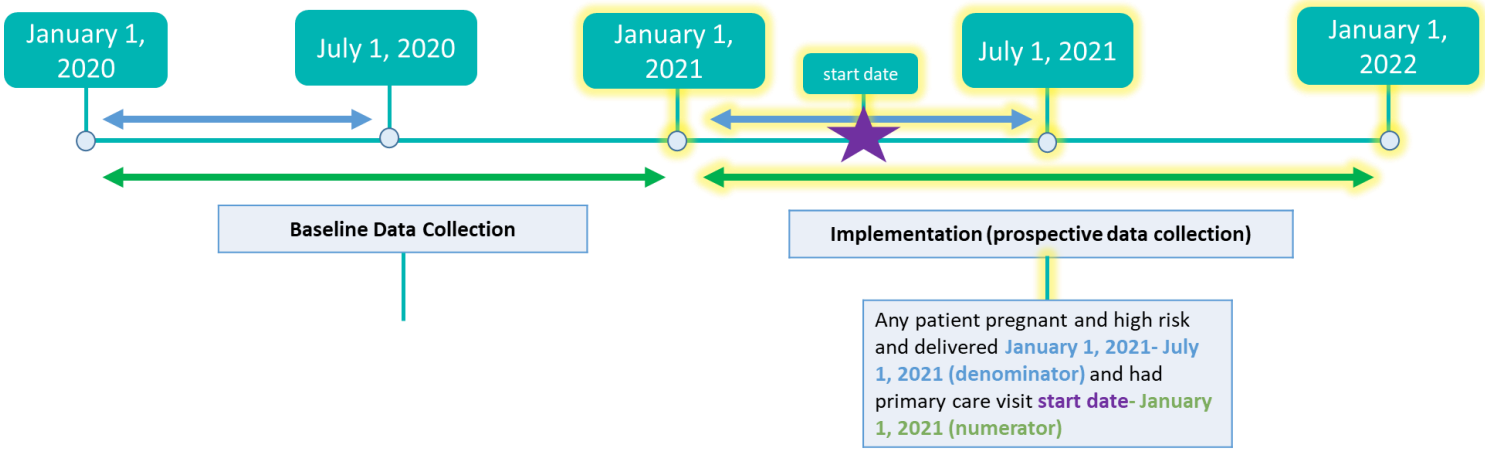
- Patient Advocate Foundation – Preventative Care Definitions and What Services Qualify
- Healthy People 2030
    - Preventative Care
    - Increasing the proportion of patients who receive evidence-based preventative care
- AHRQ – Patient Centered Medical Home Resource Center
    - Defining Patient Centered Medical Home
    - Tools for Implementing PCMH
- U.S. Preventative Services Taskforce - Education Resources for Pregnant Patients
- American Medical Association – Health Promotion and Preventative Care

Data Collection and Reporting Process

Please follow the below pathways for monthly data collection. All data reports are due on 15th of each month with data from the previous month. For example, submit/review January 2021 Data by February 15th, 2021. Be prepared to discuss these results at monthly technical calls!

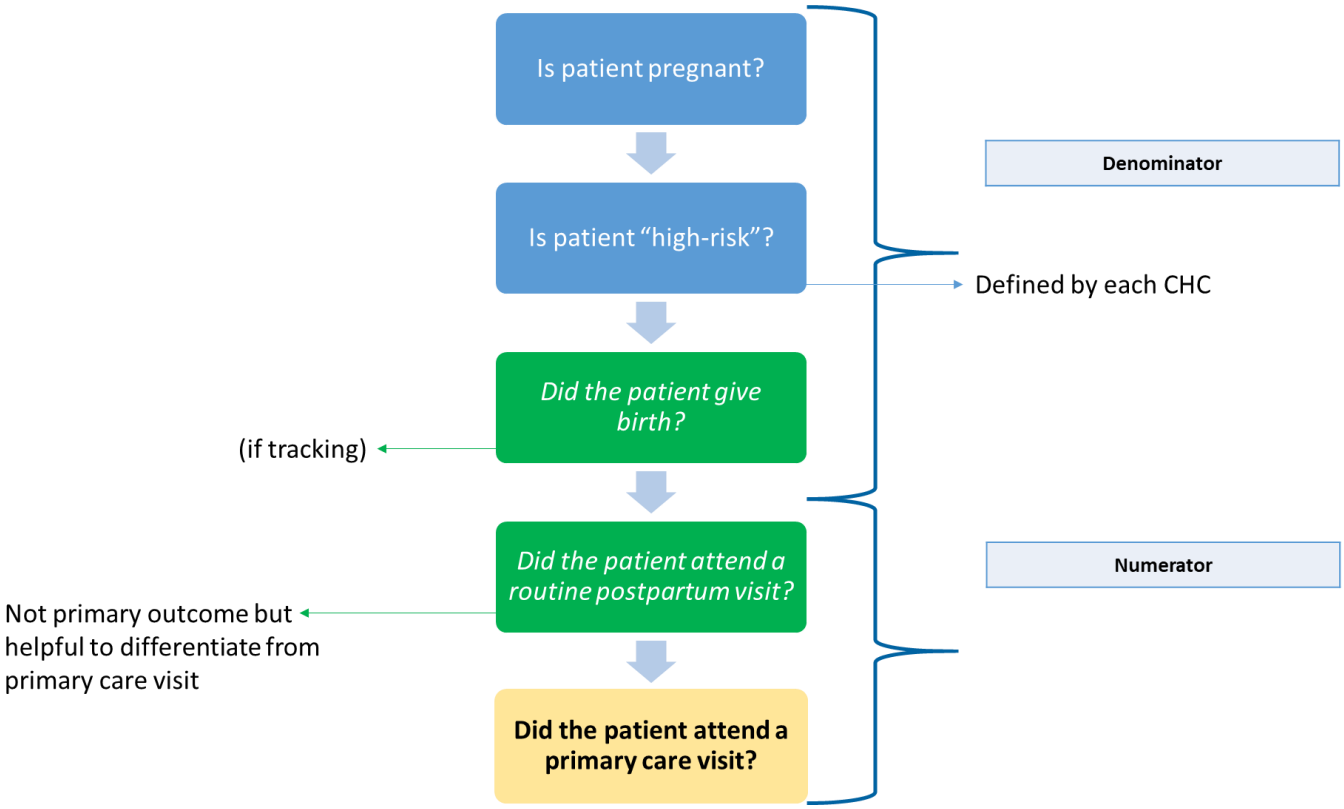
AllianceChicago In-Network Partners	**AllianceChicago External Partners**
STRUCTURE and PROCESS Measures	**STRUCTURE and PROCESS Measures**
By the 15th of each month, fill out the Monthly Structure and Process Measure Reporting Document (Excel Sheet)	**By the 15th of each month,** fill out the Monthly Structure and Process Measure Reporting Document (Excel Sheet)
OUTCOME Measures and Patient Registry Validation	**OUTCOME Measures**
Step 1: AllianceChicago will pull and provide data and patient list for registry for your review **at the beginning of each month.**	Step 1: Email AllianceChicago excel spreadsheet including outcome measures **by the 15th of each month**
Step 2: Review your data and patient list **by the 15th of each month** for any changes or discrepancies and report back to AllianceChicago.	
AllianceChicago will compile and return monthly reports for each QI Implementation Site in advance of the monthly technical call.	

Data Collection Timeline



**this timeline is subject to change depending on when a CHC is able to participate!*

Defining the Denominator and Numerator



Driver: Identify and follow high-risk pregnancies

Please see the strategies, measures, and resources for this driver:

Strategy	Measure	Resource(s) for Application
Establish criteria for identifying high-risk/medically complex patients.	**STRUCTURE:** Are criteria for identifying high-risk patients defined?	• Nelson, Honiz, & Davis (2018) "Population-level factors associated with maternal mortality in the United States, 1997–2012" • ACOG – "Severe Maternal Morbidity Screening and Review"
Develop registry of high-risk/medically complex patients during pregnancy	**STRUCTURE:** Is a registry to identify high-risk patients in place?	• CDC – "Pregnancy Surveillance System" • CDC – "Pregnancy-Related Deaths Happen Before, During, and Up to a Year After Delivery"
Realign workflow to identify patients and coordinate care through postpartum follow up	**STRUCTURE:** Is a process in place to coordinate care for high risk patients? **PROCESS:** How many cumulative locations of care to date are implementing this process?	• ACOG – "Optimizing Postpartum Care" • O'Connor, Rossom, and Henninger (2016) "Primary Care Screening for and Treatment of Depression in Pregnant and Postpartum Women"

Driver: Training on process

Please see the strategies, measures, and resources for this driver:

Strategy	Measure	Resource(s) for Application
Train providers and staff on the importance of and process of care coordination for patients with high risk pregnancies	**PROCESS**: % of staff trained (by type)	• Council on Patient Safety in Women's Healthcare – "Safety Action Series Presentation: Postpartum Care Basics for Maternal Safety" • ACOG – "Eliminate Preventable Maternal Mortality"

Driver: Ensure delivery of prioritized health services (postpartum care)

Please see the strategies, measures, and resources for this driver:

Strategy	Measure	Resource(s) for Application
Ensure postpartum visit scheduled and attended.	**OUTCOME:** % patients who attended a postpartum appointment	• ACOG – "Optimizing Postpartum Care" • Howel et al (2018) "Delivery and Payment Redesign to Reduce Disparities in High Risk Postpartum Care"
Create a process for establishing primary/well-person care following initial postpartum visit	**OUTCOME:** % patients linked to PCP at delivery discharge and 3 months and completed appt	• ACOG – "Optimizing Postpartum Care" • Council on Patient Safety in Women's Healthcare – "Transition from Maternity to Well-Woman Care" • LaManna & Quelly (2020) "After Gestational Diabetes: An Overlooked Care Transition in Primary Care"
Establish checklist of appropriate postpartum services necessary for patients on high-risk list	**OUTCOME:** % of patients from registry who received care per checklist item	• ACOG – Optimizing Postpartum Care • Council on Patient Safety in Women's Healthcare – "Postpartum Care Basics Resource List"

Important Contacts

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