PAIRED Mid-Initiative Meeting: *Getting Ready to Deliver*
FPQC’s Vision & Values

“All of Florida’s mothers, infants & families will have the best health outcomes possible through receiving respectful, equitable, high quality, evidence-based perinatal care.”

- Voluntary
- Data-Driven
- Population-Based

- Evidence-Based
- Equity-Centered
- Value-Added
All Florida maternity hospitals are required to participate in two FPQC quality improvement initiatives at all times.

All hospitals participating in Medicare are required to report whether they are participating in a national and state perinatal quality collaborative and implementing their safety bundles.

TJC accredited hospitals must select one hospital QI health equity issue and present a series of QI steps performed to address this issue.
PAIRED Mid-Initiative Meeting: *Getting Ready to Deliver*

- Less than 9 month to deliver
- Family Center Care has never been needed more than now
- COVID-19
- Staff Turnover
- Family Stress
- Today is the day to get ready
PAIRED Leadership Team

Nurse Consultant
Sue Bowles

Clinical Co-Leads
Mark Hudak

Parent Consultant
Lelis Vernon

Samarth Shukla
Pilot & New PAIRED Hospitals

33 FL NICUs & 1 NY NICU
What would you like to get out of today?

- Continue to see improvements; more engagement and continue to grow
- Feedback from hospitals regarding parent education and CGS
- Revamping PAIRED Initiative w/in their hospital system
- Documentation of SSC
- Increase SSC engagement, engage travelers, best way to implement CGS
- Increase staff comfort level with infants who are more critical
- Staff engagement and getting new hires up to speed on initiative
- Knowing what similar challenges other hospitals are having
- Employee turn over and staff engagement in SSC
- Working on sustainability and getting numbers back up after the kangaroo-a-thon
- Getting new graduates comfortable with standing transfers; increasing survey numbers
- Engaging new grads and central line infections/infection control
- Staff engagement and educating parents
- Learning to maintain the initiative after the initiative ends
- Motivating staff to encourage parents to do SSC; implementing CGS w/in hospital
- How to teach FCC to staff?
- Maintaining the importance of SCC among staff over time
- How to move the needle forward and sustain
YOU ARE THE BEST!

Facebook.com/TheFPQC/
@TheFPQC
Join our mailing list at FPQC.org
E-mail: FPQC@usf.edu
By 6/2023, each NICU will achieve:

A 20% increase from baseline in the % 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.

SUPPLEMENTAL
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 4 domains.
**PAIRED—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 family caregiver within 3 days of clinical eligibility as defined by individual unit protocols.

**SUPPLEMENTAL**

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 4 domains.

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**PRIMARY DRIVERS**

**Participation**

Participation of family in care

- Educate family caregiver(s) to become active participants in the care of their infant from admission to discharge

- Provide family caregiver(s) with appropriate and increasing direct care opportunities.

**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.

- Establish a culturally sensitive environment in which families feel respected and that fosters anticipatory and effective communication with and trust from family caregiver(s).

**Collaboration**

Respectful and effective communication and partnership with families

- 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.

- Provide family caregiver(s) 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).

**Information Sharing**

Education about medical care and clinical processes

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**SECONDARY DRIVERS**

- Encourage family caregiver(s) participation in early skin-to-skin care

- Provide early and continuing lactation support to promote breastfeeding

- Create a culturally sensitive environment supportive of skin-to-skin care (reclining chairs, access to food and water, privacy)

- Consult families, revisit and revise policies that limit family caregiver interaction with infant (protocols regarding skin-to-skin care, holding, visitation, signage, etc.)

- Initiate family caregiver and staff competency training on skin-to-skin care

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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) family participation in care, 2) dignity and respect, 3) family collaboration, and 4) information sharing.
HOSPITAL PARTICIPATION AND ENGAGEMENT

% HOSPITALS SUBMITTING MONTHLY QI DATA

% HOSPITALS ATTENDING MONTHLY COACHING CALLS
PAIRED DATA

Patient-level data – 10 infants per month
- Skin-to-skin care and adverse events during SSC
- Mother’s own milk
- Primary caregiver education

Hospital-level data
- Staff education
- SSC policy
- Standardized documentation

Auto-submission – 48 hours prior to discharge
- Family caregiver survey
3011 infants
BW (mean): 2242 g
GA (mean): 34 wks.
NICU LOS (mean): 28 days
PC - Spanish: 9%
SSC PRACTICE

Improvement in documentation

No SSC documentation: 40% in Q2-21 to 30% in Q3-22

Father engagement in SSC

16% in Q2-21 to 21% in Q3-22
## SSC PRACTICE

<table>
<thead>
<tr>
<th></th>
<th>Q2-2021</th>
<th>Q3-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td># SSC episodes/hospital</td>
<td>78</td>
<td>102</td>
</tr>
<tr>
<td># SSC hours/hospital</td>
<td>97</td>
<td>147</td>
</tr>
<tr>
<td>Average SSC duration/episode</td>
<td>75 min</td>
<td>90 min</td>
</tr>
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</table>
% of Eligible Infants receiving Prompt SSC Initiation

![Graph showing the percentage of eligible infants receiving prompt SSC initiation over time.](image)

**Prompt Initiation of SSC**

- NH-White
- NH-Black
- Hispanic

![Graph showing the prompt initiation of SSC for different ethnicities over time.](image)

**Prompt Initiation of SSC**

- < 1000 g
- 1000-1500 g
- 1500-2500 g
- > 2500 g

![Graph showing the prompt initiation of SSC for different birth weights over time.](image)
* Other unplanned events include: Significant apnea/bradycardia/desaturation (ABD), Hypothermia and Line dislodgement

<table>
<thead>
<tr>
<th></th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td># SSC episodes</td>
<td>4097</td>
<td>7207</td>
</tr>
<tr>
<td># unintended extubations</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td># line dislodgements</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td># significant ABD</td>
<td>40</td>
<td>89</td>
</tr>
<tr>
<td># hypothermia</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td># Total unplanned events</td>
<td>76</td>
<td>127</td>
</tr>
</tbody>
</table>
PAIRED DATA

Patient-level data – 10 infants per month

• Skin-to-skin care and adverse events during SSC
• Mother’s own milk
• Primary caregiver education

Hospital-level data

• Staff education
• SSC policy
• Standardized documentation

Auto-submission – 48 hours prior to discharge

• Family caregiver survey
NICU policy promoting SSC for all eligible infants and family caregivers

- Baseline: 6 Fully implemented, 17 In-place, 4 Planning, 2 Not started
- Q3-2022: 17 Fully implemented, 9 In-place, 4 Planning, 3 Not started

Staff educated about SSC to date:
- 66% Doctors, NP, PA
- 69% Nurses
- 52% Respiratory Therapist
PAIRED DATA

Patient-level data – 10 infants per month
- Skin-to-skin care and adverse events during SSC
- Mother’s own milk
- Primary caregiver education

Hospital-level data
- Staff education
- SSC policy
- Standardized documentation

Auto-submission – 48 hours prior to discharge
- Family caregiver survey
The family caregiver felt that the NICU team....

- Encouraged them to be present and participate when they made daily rounds on their baby
- Encouraged them to spend as much time with their baby as they wanted
- Encouraged them to be with their baby as often as they wanted
- Helped them feel like they were truly their baby's caregiver

# respondents
**PARTICIPATION - First NICU encounter**

- % that held their baby the first time they saw their baby in the NICU:
  - No: 41%
  - Yes: 59%

- Of those that did not hold their baby in their first NICU encounter, reason for not holding:
  - I was told that my baby was too sick or unstable for me to hold
  - I did not feel physically ready to hold my baby
  - I would have liked to hold my baby but did not ask
  - I did not feel mentally or emotionally prepared to hold my baby
  - I was scared to hold my baby
  - I did not know that I could hold my baby

- Activities done by the caregiver when unable to hold baby:
  - % Sit at bedside: 97%
  - % Gently touch: 82%
  - % Hold hand: 73%
  - % Talk/Read: 70%
  - % Breastpump: 42%
  - % Change diaper: 39%
  - % Play music: 24%
PARTICIPATION - SKIN-TO-SKIN CARE

% of caregivers that provided skin-to-skin care in the hospital

- Qtr 1: 88%
- Qtr 2: 89%
- Qtr 3: 94%

Average # of days to first SSC episode

- Qtr 1: 2.8
- Qtr 2: 2.7
- Qtr 3: 2.3

The family caregiver felt......

- Comfortable in the environment where skin-to-skin care was provided
- That the NICU team prepared them well for their first skin-to-skin
DIGNITY AND RESPECT

% of caregivers that reported talking to the NICU team in detail about what to expect while in the NICU

- Qtr 1: 63%
- Qtr 2: 79%
- Qtr 3: 91%
- Qtr 4: 100%

The family caregiver felt that the NICU team...

- Attempted to understand their culture or background
- Talked with them in ways that respected their culture and background
- Helped with their family’s needs other than the medical care of their baby
- Respected their family the same way other families and caregivers were respected

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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</thead>
<tbody>
<tr>
<td>Attempted to understand</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Talked with them in ways</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Helped with their</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Respected their family</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

% respondants
The family caregiver felt that the NICU doctors...

- Admitted when they did not have an answer to a question
- Answered questions in a caring way and in a way that caregivers could understand
- Wanted to communicate with them regularly
- Worked with them on a plan to communicate regularly

The family caregiver felt that the NICU nurses...

- Admitted when they did not have an answer to a question
- Wanted to fully answer their questions
- Answered questions in a caring way and in a way that caregivers could understand
## Average of caregivers' rating of how well prepared they felt about...

<table>
<thead>
<tr>
<th>Year</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Qtr 1</td>
</tr>
<tr>
<td>% Taking care of baby at home</td>
<td>100</td>
</tr>
<tr>
<td>% Breastfeeding</td>
<td>73</td>
</tr>
<tr>
<td>% Bottle feeding</td>
<td>100</td>
</tr>
<tr>
<td>% Providing general newborn care</td>
<td>100</td>
</tr>
<tr>
<td>% Giving medications</td>
<td>100</td>
</tr>
<tr>
<td>% Managing equipment</td>
<td>90</td>
</tr>
<tr>
<td>% Baby is medically ready to go home</td>
<td>100</td>
</tr>
<tr>
<td>% Know what to do in an emergency</td>
<td>100</td>
</tr>
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QI MONTHLY CYCLE

Identify opportunities *PDSA*

Coaching Call

Submit Data

Review Data Report

Discuss and Disseminate Data Report

QI REPORTS

• Aim
• Run Charts
• Tracks Process, Structural and Outcome Measures
• Add your PDSAs
Questions?

fpqc@usf.edu
www.fpqc.org

“To improve the health and health care of all Florida mothers & babies”
Conducting Neonatal Quality Improvement with a Health Equity Lens

Meg Parker, MD MPH
Professor of Pediatrics
Academic Chief of Neonatology, UMass Memorial Medical Center
Co-Director- Neonatal Side
Perinatal Neonatal Quality Improvement Collaborative of Massachusetts

Florida PQC PAIRED Initiative
November 3, 2022
Disclosures

• I have no conflicts of interest.

Meg Parker contact info:
Email: Margaret.parker@umassmemorial.org
Twitter: @Meg_Parker_MD
Topics

• Quality Improvement and Equity
• Using a health equity lens in neonatal QI
  • Data measures
  • Family members as partners
  • Standardized and non-standardized approaches
• Equity in skin to skin care in the NICU setting
Six Domains of Health Care Quality

• Institute of Medicine
  • Safe
  • Effective
  • Patient-centered
  • Timely
  • Efficient
  • Equitable

https://www.ahrq.gov/talkingquality/measures/six-domains.html
Six Domains of Health Care Quality

- Institute of Medicine
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status

https://www.ahrq.gov/talkingquality/measures/six-domains.html
AHRQ: 2018 National Healthcare Quality and Disparities Report

- When reviewing racial and ethnic disparities in quality measures, most have persisted or worsened since 2000
- This occurs with pediatric and adult healthcare quality measures
Racial/Ethnic Disparities in Neonatal Care Quality

• Examination of “Baby-MONITOR” NICU quality measure score among California NICUs according to race/ethnicity

• Stark racial/ethnic disparities in Baby-MONITOR scores, which varied dramatically by center

Like other areas of healthcare, social disparities in neonatal care quality exist.
1) NICU care quality contributes to NICU outcomes

2) NICUs vary in the degree of social disparities in care quality and subsequent outcomes. This means that there are things we can do better in the NICU to address this
1) NICU care quality contributes to NICU outcomes

2) NICUs vary in the *degree* of social disparities in care quality and subsequent outcomes. This means that there are things we can do better in the NICU to address this

*Use QI Methods!!*
What is the Role of Quality Improvement?

• **Quality improvement** is the framework to systematically improve care.

• **Quality improvement** seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations.

• **Key elements:**
  • Track changes over time
  • Systematically trial interventions
  • Usually involves multidisciplinary teams
What Impact Does QI Have on Social Disparities in Care Delivery?
Three Scenarios

Quality Improvement is a Very Powerful Framework!

How Do You Address Health Equity Using Quality Improvement?
1) Data Measurement Selection

- Many times people don’t know that social disparities exist because measurement of social factors is lacking
- You can’t address disparities unless you know they exist!
- When you find out, it can be incredibly revealing!
- Example: MA Human Milk Project 2015-2017
Example of Hospital-Level Racial/Ethnic Disparities

MA Human Milk QI Project 2015-2017

Centers Ranked Lowest to Highest on Overall Rate of Any Mother’s Milk at Discharge/Transfer

Parker et al, Pediatrics 2019
Hospital Variation in Disparities

Centers Ranked Lowest to Highest on Overall Rate of Any Mother’s Milk at Discharge/Transfer

Black/White Disparities

Parker et al, *Pediatrics* 2019
Barriers to QI Project Data Collection that Enable Tracking by Social Factors

• Data reporting by social factors is burdensome
  • Can be time intensive
    • Individual-level data collection
    • More intense data regulatory requirements

• Measures of social factors are inaccurate or missing
  • Example: Limited English Proficiency
STS on Chart Audit Days According to Race/Ethnicity
MA Human Milk Collaborative 2015-2017
2) Include Family Perspectives

• Even though everyone agrees that family member perspectives are important, they are often left out of multidisciplinary teams

Survey to MA NICU Teams in March 2020 to 15 hospitals: Only 20% routinely involve family members on their QI teams
How to Involve Family Partners

• Zoom
• Compensation
• Diverse family types
• Make accommodations for schedules
3) Intervention Approach

• **Standardized Approach:** “One-size-fits-all” model: introduce a standardized set of interventions to all groups

• **Non-standardized Approach:** “Culturally competent QI” model: introduce interventions that are tailored to the particular needs of a given group

Standardized Approaches to Care

• This can be highly successful
• Reduces variation
• Example: CHAMPS

Baby-Friendly Ten Steps introduced in Southern US maternity hospitals

Merewood et al, 2019
Skin to Skin Care: Standardized Approaches

• Consistent guidelines for eligibility within a center
• AAP guidance
  • STS can be safety performed for infants with secured umbilical lines, ventilated infants, and those receiving positive pressure ventilation

Baley J; Skin to skin care for term and preterm infants in the neonatal ICU; AAP COFN; Pediatrics 2015
Survey to 15 MA NICU/SCNs in 2020: What is your approach to skin to skin in the following clinical scenarios?

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Prohibited</th>
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<th>Encouraged</th>
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<tbody>
<tr>
<td>ELBW in the first 72 hours of life</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Infant on a regular ventilator</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Infant on a high-frequency ventilator</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Infant on CPAP</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Infant with UAC</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Infant with UVC</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>3</td>
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<tr>
<td>&quot;Feeder and grower&quot; maintaining temperature in an open crib</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>0</td>
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<tr>
<td>Infant with symptoms of NAS</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>

There isn’t a consistent approach and in many cases care does not align with AAP guidance.
MA Family Engagement Project: STS by Center 2020-2022

Hospitals with less than 5 infants in measure period are excluded.

Percent of Newborns with greater than 75 % Skin to Skin with Mother on NICU Chart Audit Days

Large variation among centers indicates more standardized approaches are needed.
PDSAs to Standardize Approach to STS

• Update guidelines or consistently use guidelines
• Prompts in daily rounds or nursing hand-offs
• Prompts in patient facing materials (crib cards)
• Document STS
• Standardize approach to help transfer infants into STS position
• Kangaroo-a-thon
Crib Card

I’m eligible for Skin-to-Skin Care!

- Skin-to-Skin Care is when you hold your baby when he or she is naked, with only a diaper, on your bare chest
- Skin to Skin Care can help premature babies keep the right body temperature, breathe and sleep better and help mothers make more breast milk

*Ask your medical team for more information*

Goal population: premature infants < 44 weeks corrected gestational age

Kangaroo-a-thon
Documentation of STS

Please document Kangaroo Care (KC)
on the front of the flowsheet under "Position."

Don't forget to document a Mum or Dad
KMC
KCE
Skin to Skin Care: Standardized Approaches

• Consistent education to families

• Benefits
  • Breast milk
  • Bonding
  • Physiologic stability

• Practical aspects
  • Clothing
  • Length of time
Educational Materials

- https://www.neoqicma.org/educational-materials
But sometimes standardized approaches aren’t enough...
MA Human Milk Project 2015-2017

Goals: Among VLBW infants in MA:
1) Increase any/exclusive mother’s milk at discharge
2) Reduce racial/ethnic disparities in provision of mother’s milk

www.neoqicma.org
Prenatal Human Milk Education

Improvement

Parker et al, *Pediatrics* 2019
Process Measures

First Milk Expression ≤ 6 Hours of Birth

Parker et al, Pediatrics 2019
Any Skin-to-Skin in First Month

Parker et al, Pediatrics 2019
Main Outcome

Any Mother’s Milk at Discharge/Transfer

Parker et al, Pediatrics 2019
Any Mother’s Milk According to Day of Hospitalization

Racial/ethnic disparities emerged after day 21

Parker et al, Pediatrics 2019
Our “standardized” approaches early the hospitalization did not lead to reductions in racial/ethnic disparities

Parker et al, Pediatrics 2019
Different rates of STS according to race/ethnicity
What did we do next?

• We knew we needed to pursue non-standardized approaches to STS care and provision of MOM

• Qualitative interviews of Black and Hispanic mothers
• Examination of family engagement practices across centers
• Review existing literature
Logistical challenges to mother-infant separation are enormous

Transportation, parking

Hospital providers are an important source of support when:

Sufficient time is spent
Interactions perceived as unbiased
Communication in primary language

Parker et al. *Breastfeeding Medicine*, 2018
“If you run out of money because you are not working so that you can be with your baby you have to make sacrifices, sometimes that means not buying a meal”

“The hospital isn’t far from where I live, but I couldn’t go back and forth.. Because I don’t have a car.”

“I live only 12 minutes away so I tried to be there as much as I could but I also had to take care of other children at home.”

“The hardest thing was the transportation. I went every day, but sometimes it was difficult because I didn’t have money for gas or I couldn’t spend a lot of time at the hospital because I couldn’t afford the parking; sometimes I didn’t eat in order to go to the hospital.”

Cordova Ramos, *in progress*
Social Disparities in NICU Visitation

- Families need to physically visit the NICU to do STS, pump milk and directly breastfeed

- Household income <$50,000 vs. >$100,00 was associated with less frequent NICU visitation. Bourque et al. *Hospital Pediatrics* 2021
Family Engagement Practice Survey to MA QI NICU Teams

• Major variation in:
  • Sibling and non-sibling child visitation
  • Presence of family support meetings
    • (No hospital offered this routinely in Spanish)
  • Meals for breastfeeding or non-breastfeeding mothers
  • Parking costs
  • Interpreter services
Non-Standardized Approaches to Addressing Social Disparities in STS

• Screening and referral for social determinants of health
• Support for food, parking, transportation for families with hospitalized infants
• Cash assistance
Boston Medical Center Example: Standardized Screening and Referral
Results: Adverse SDH Identified

1+ unmet need: 74/91 (81%)

2+ unmet needs: 55/91 (60%) (range 2 to 5)

Total unmet needs: 173

Desired assistance for need: 146/173 (84%)

<table>
<thead>
<tr>
<th>Unmet need</th>
<th>n (%)</th>
<th>want assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>53</td>
<td>41 (77)</td>
</tr>
<tr>
<td>Employment</td>
<td>24</td>
<td>17 (70)</td>
</tr>
<tr>
<td>Utilities</td>
<td>20</td>
<td>17 (85)</td>
</tr>
<tr>
<td>Food</td>
<td>22</td>
<td>22 (100)</td>
</tr>
<tr>
<td>Housing</td>
<td>14</td>
<td>14 (100)</td>
</tr>
<tr>
<td>Transportation</td>
<td>23</td>
<td>23 (100)</td>
</tr>
<tr>
<td>Caregiving</td>
<td>10</td>
<td>8 (80)</td>
</tr>
<tr>
<td>Medications</td>
<td>7</td>
<td>4 (57)</td>
</tr>
</tbody>
</table>
Results: Connection with Resources

B

%Families that received resources among those that reported a need and requested assistance

Connected with resources Among Families with Referrals


CL

POS A 1

POS A 2

POS A 3

POS A 4

POS A 5

UCL

84%

90%

45%
Cash Transfer RCT of Medicaid-Eligible Mothers with Hospitalized Preterm Infants (n=46)

- 2017-2018; Tufts Medical Center
- Mothers randomized to receive $200 a week x 3 weeks maximum vs. control (usual care)
- Intervention group received a one time “label” stating that cash was intended to help mothers visit the NICU

RCT of Labelled Financial Transfers to Medicaid-eligible NICU Mothers, n = 46

Daily NICU caregiving behaviors among the control and financial transfer group shown; estimates are adjusted for baseline maternal and infant characteristics.
Cash Transfer RCT continued

- What did mothers use the money for?
  - Food 45%
  - Transportation 35%
  - Infant related expenses (e.g. car seats, formula) 30%
  - Other (e.g. rent) 20%

- In summary, provision of $200 a week for a maximum of 3 weeks led to significant differences in breastfeeding, skin-to-skin, and NICU visitation.

- *This is dramatically less than the cost of a typical NICU hospitalization (~$2,000 a day for a <32 weeker)*

- **New grant:** NIH R01 (MPI Parker/McConnell): Effect of Support for Low-Income Mothers of Preterm Infants on Parental Caregiving in the Neonatal Intensive Care Unit (NICU)” (HD109293)
  - RCT of cash transfers of $160/week to mothers with hospitalized preterm infants to examine impact on breastfeeding and skin-to-skin care
Next Steps in MA

• Family engagement and social disparities collaborative
  • Addressing social disparities in hands on care and visitation

• CDC PQC grant- SDH screening/referral in the NICU setting
  • Year 1 is starting in 5 NICUs/SCNs serving large proportions of low-income families

• (Outside MA) Larger R01 (Parker/Garg/Drainoni): Implementation-effectiveness grant to study SDH screening/referral in the NICU Setting
Using QI with an Equity Lens Pearls

<table>
<thead>
<tr>
<th>Approach</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make reducing disparities a main aim of the project</td>
<td>“We aim to reduce black/white differences in breastfeeding by 10% at our hospital within a year”</td>
</tr>
<tr>
<td>Include diverse perspectives on your multi-disciplinary team, especially family members</td>
<td>A team holds multi-disciplinary QI meetings by zoom to enable increased attendance by family members</td>
</tr>
<tr>
<td>Track outcome, process, and balancing measures by social factors of interest (e.g. language status or r/e)</td>
<td>A team conducts a project to promote earlier discharge and tracks the extent that English and non-English speaking families perform similarly</td>
</tr>
<tr>
<td>Conduct PDSAs that enables standardized care</td>
<td>A team sets up a process to ensure families are updated daily, even if they are not present on rounds</td>
</tr>
<tr>
<td>Conduct PDSAs specifically targeted at socially vulnerable groups</td>
<td>A team implements a screening and referral system for unmet basic needs</td>
</tr>
</tbody>
</table>
Acknowledgements

**PNQIN**
**MA PNQIN Hospital Teams**
Patrice Melvin, MPH
Aviel Peaceman, MPH
Munish Gupta, MD
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Donna Stickney
Cheryl Slater
Tami May
Judy Burke
Chadni Jain
Erica Dota
Bharati Sinha

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- W.K. Kellogg Foundation (PI Parker)
- Centers for Disease Control (PI Diop)
- NICHD R01HD104772 (PI Parker/Garg/Drainoni)
- NICHD R01HD109293 (Parker/McConnell)
Break
Collaborating on Ideas and Solutions: Round Robin Session
Lunch
Round Robin Report Out
## Infant Eligibility for SSC

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Visual reminders</td>
<td>• Staff turnover</td>
</tr>
<tr>
<td>• Color coordinated bed cards</td>
<td>• Nurse/RT resistance and divergent comfort levels</td>
</tr>
<tr>
<td>• Post pictures in hallways</td>
<td>• Recommend: education, discover their barriers;</td>
</tr>
<tr>
<td>• Tags on badges: “Ask me about kangaroo care”</td>
<td>know your staff and enlist resisters</td>
</tr>
<tr>
<td>• Milestone keepsakes: “Beads of Bravery”, “Tides of Hope”</td>
<td>• Logistics with dads not wanting to remove shirt</td>
</tr>
<tr>
<td>• Staff prepared</td>
<td>• Thin shirt is better than not doing SSC</td>
</tr>
<tr>
<td>• Established protocol; 2-4 am/pm quiet hours</td>
<td>• Plan for next day with suggestions on what to</td>
</tr>
<tr>
<td>• SSC during touch time/cluster care</td>
<td>wear</td>
</tr>
<tr>
<td>• Care rounding: ask about SSC</td>
<td></td>
</tr>
<tr>
<td>• Family prepared</td>
<td></td>
</tr>
<tr>
<td>• Info in parent scrub in area</td>
<td></td>
</tr>
<tr>
<td>• Classes for families; empower to speakup</td>
<td></td>
</tr>
<tr>
<td>• Push dad involvement</td>
<td></td>
</tr>
</tbody>
</table>
### SSC Education of Staff and Parents

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Having a champion</td>
<td>• Not having a standard practice</td>
</tr>
<tr>
<td>• Making time to be involved</td>
<td>• Buy-in, inconsistency, generational differences</td>
</tr>
<tr>
<td>• Physician involvement</td>
<td>• Getting families to visit and stay a while</td>
</tr>
<tr>
<td>• Utilizing support staff: occupational therapists, social workers, etc.</td>
<td>• Cultural differences regarding privacy</td>
</tr>
<tr>
<td>• Mandatory education for parents</td>
<td>• Staff shortage</td>
</tr>
<tr>
<td></td>
<td>• <strong>Recommendations:</strong></td>
</tr>
<tr>
<td></td>
<td>• Daily rounds</td>
</tr>
<tr>
<td></td>
<td>• Use of equipment: Boppy/borrowing</td>
</tr>
<tr>
<td></td>
<td>• Empowering the fathers</td>
</tr>
<tr>
<td></td>
<td>• Including siblings</td>
</tr>
<tr>
<td></td>
<td>• Decreasing emotional anxiety</td>
</tr>
</tbody>
</table>
## Length of SSC

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cards with STS tips for families</td>
<td>• Competing and conflicting priorities</td>
</tr>
<tr>
<td>• Rewards system for nurses and caregivers</td>
<td>• Workflow barriers</td>
</tr>
<tr>
<td>• Ensure that personal needs are attended to first</td>
<td>• Differences between ELBW and LBW perceptions of care needs</td>
</tr>
<tr>
<td></td>
<td>• Scheduling times to STS to address limited space</td>
</tr>
<tr>
<td></td>
<td>• Bedside huddles</td>
</tr>
<tr>
<td></td>
<td>• Pictureboard for increased visibility</td>
</tr>
</tbody>
</table>
## Race, Ethnicity, Birth Weight Considerations for SSC

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Language services: translating documents, using interpreters, best in-person or tablets, convenience of interpreter services from staff phones; certify and incentivize bi/multilingual staff</td>
<td>• Funding to address issues with SDOH</td>
</tr>
<tr>
<td>• Providing resources (bus passes, gift cards, waiver for discounted transportation services)</td>
<td>• Grants, in-house resources (case managers), Cerner → “Find Help”</td>
</tr>
<tr>
<td></td>
<td>• Literacy - Health literacy</td>
</tr>
<tr>
<td></td>
<td>• Use more videos; take advantage of PNQIN materials</td>
</tr>
<tr>
<td></td>
<td>• Cultural barriers, dialects</td>
</tr>
<tr>
<td></td>
<td>• Connect families with staff with similar backgrounds (language, country of origin)</td>
</tr>
</tbody>
</table>
## Caregiver Surveys

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| • Ask the family to complete the survey as part of discharge rounds.  
• Have the doctors ask and share the QR code during rounds.  
• Add the QR card to the discharge packet. | • Have/ask the caregivers to complete at the time QR code is given  
• Challenges with discharge planning process, content and timing.  
  • More than one person responsible for asking, reminding, and following up about the survey.  
• No follow up on survey completion.  
  • Discharge phone call and text follow up  
  • Incomplete caregiver survey. |
PDSA and Small Tests of Change

Susan M. Bowles, DNP, APRN-CNS, RNC-NIC, CBC
Nurse Consultant PAIRED Initiative
Florida Perinatal Quality Collaborative
Disclosures

• Nurse Consultant for Educational Projects, WaterWipes
• Nurse Consultant for Quality Projects, AngelEye Health
• Member Speakers’ Bureau Abbott Labs
Model for Improvement

FPQC PAIRED QI Snippet: PDSA

2021-03-19 12:08 UTC

Maya Balakrishnan, MD, CSSBB
FPQC Director of Quality
Director, Quality & Safety, USF GME
Professor, College of Medicine

https://usf.box.com/s/wdha0afm8252hh08s43my7k1rrfzdnuz
The Goal:
Test potential improvements to the unit's care processes that have the potential to transform care in large and small ways

Why is this important?
Small-scale tests of change help determine whether an idea could result in sustainable improvement. Changes should be tested under multiple conditions and with a variety of staff before being implemented

Example: Babies on ventilators
Principles for Test of Change

**How To Do It:**

1. Understand the testing process—PDSA
2. Determine which staff will be involved
3. Predict the outcome
4. Be specific
5. Be forward thinking and flexible
• Make sure tests of change are very defined and limited in scope, particularly when first implementing.

• 1 patient, 1 nurse, 1 day is an acceptable way to begin a test of change.
How to keep it simple?

Ask yourself:

• What is one thing that we are not doing that the evidence suggests we should be doing to improve our performance?

• How can we test ideas about this one thing?
## Research vs. Quality Improvement

<table>
<thead>
<tr>
<th></th>
<th>Quality Improvement Used to learn</th>
<th>Research Used to Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Bring learning into daily practice</td>
<td>Discover new knowledge</td>
</tr>
<tr>
<td><strong>Tests</strong></td>
<td>Many cycles sequential and observable</td>
<td>One large “blind” test</td>
</tr>
<tr>
<td><strong>Biases</strong></td>
<td>Stabilize biases from test to test</td>
<td>Control for as many as possible</td>
</tr>
<tr>
<td><strong>Data</strong></td>
<td>Just enough</td>
<td>Just in case</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Small tests of significant changes accelerates rate of improvement</td>
<td>Can take a long time</td>
</tr>
</tbody>
</table>
Test—Implement—Spread
Why Test?

• To see if the idea will work in your setting
• To understand if the test results in the desired outcome
• Learn how to adapt the change to conditions in the local environment
• Evaluate costs and side-effects of the change
• Minimize resistance upon implementation
What not to do!

- Write a policy and procedure
- Take many months to get it approved
- Train your staff
- Go live
Pilot standing transfers with two stable ventilated babies

Review five 34-week infants and assess how often they go S2S

Pilot the S2S competency with one RN bedside care provider and one RT bedside care provider and assess performance
1. What are you testing?
2. Who is doing the test?
3. When will the test occur?
4. Where will it occur?
5. What do you think will happen?
6. What would make this test successful?
7. What else do you need to conduct this test?
8. When are you going to evaluate the results?
Common Traps

- Plan Do, Plan Do
- Do Act, Do Act
- No testing, only data collection
- No ramps of tests, random PDSAs
- Undisciplined PDSAs, no documentation
- No Prediction – what are we going to learn
- Beware of cycles longer than 30 days
Failure is an Option

“I did not fail one thousand times; I found one thousand ways how not to make a light bulb.”
Review the case study on your table. Discuss the PDSA example as a group and answer these questions.

1. What is being tested?
2. Is the scale of the test as small as possible for the first cycle?
3. What does the team predict will be the outcome of the test?
4. How will data/feedback be collected? Is this specific enough?
5. How will the data/feedback collected be used to plan the next cycle?
6. What is your recommendation for the next cycle?
   • How large?
   • What should be kept, changed or abandoned?
Testing changes is a continuous process: Completion of a PDSA cycle leads directly to the start of the next cycle.

A team learns from the test:

- What worked and what didn't work?
- What should be kept, changed, or abandoned?
- Uses the new knowledge to plan the next test.
- The team continues linking tests in this way, refining the change until it is ready for broader implementation.
Next Steps

• Look at your data! Where should you focus your efforts?
• Revisit the FPQC Family-Centered Care PAIRED Toolkit and driver diagram to identify potential opportunities for improvement
• Plan your next PDSA Cycle
• www.fpqc/paired/toolbox
Break
Parent Power | the POWER of empowering parents to be active participants in their baby’s NICU care.

Successful NICU Outcomes Occasioned by Clinical Care

NICU Healthcare Teams' Clinical Outcomes + Parental Involvement
Agenda

- How I Got Here
- Learning of a NICU Admission
- Common Phases Parents Go Through
- 3 Truths for (Almost!) Every Family
- What Parents Have to Say [Video!]
- 10 Parent Pro Tips

Q & A
Feedback
Receiving the news ...

“Your baby is being sent to the NICU.”

- I was shocked and couldn’t breathe.
- I was devastated.
- I thought my baby was going to die.
- My Husband called for a priest.
- I felt guilty.
Common Stages for Parents in the NICU

NICU Newbie

NICU Navigator

NICU Homebound

Credits to ICU baby’s Leah MG Jayanetti & Valerie Hernandez
3 Truths for (Almost!) Every NICU Family

1. All Families Have A Story
   ... & It's Complicated

2. Life Outside of the NICU
   is Complicated

3. Life Inside of the NICU
   is Complicated
All Families Have A Story 
... & It's Complicated

- Pregnancy Losses
- Infertility & Infertility Treatments
- Bedrest
- A condition diagnosed early on
- Several "false starts" and visits to triage
- Unexpected delivery
- Etc.

Quick Tip

Acknowledged that there is a story, both in your reaction to their reactions & in your interactions with them.
Life Outside of the NICU is Complicated

- Sibling Care
- Transportation
- Work and/or School Commitments
- Emotional Wellness
- Financial Stressors
- Safety
- Access to Care
- Etc.

Quick Tip
Avoid Assumptions.
Life Inside of the NICU is Complicated

- Teams
- Terms
- Sights, Sounds, Smells
- Routines
- Other Babies & Other Parents
- The Hospital
- Etc.

Quick Tip
Recognize that they are in a foreign land that has a different culture, language & dynamic.
How Are We Going to Empower Our Parents?

| Question Asked |

What do the doctors and nurses do to make you feel like you are part of your baby’s care?
10 Parent Pro Tips | Parents Want to ...

1. Feel Informed
2. Feel Heard
3. Feel Like a Partner
4. Feel Needed
5. Feel Included
6. Feel Able
7. Feel Successful
8. Feel Healthy
9. Feel Well
10. Feel United
The Power of Information

- Regularly communicate ... even if there is nothing to say
- Be clear about possible setbacks
- Make sure they understand what you are telling them
  - linguistically accessible information
  - comprehensible words
- Often, it’s not what you say, it’s how you say it
- Consider parents’ emotional state, language, culture & education

PARENT PRO TIP
No. 1 | Feeling Informed
The Power of a Voice

- Some will not speak up without an invitation
- Can't always make decisions ...
- Can be involved in the decision making process
- Invite questions
- Encourage conversation
The Power of Your Power

- Afraid to speak up
- Fear of retaliation
- Want to be liked

- Be aware of elevated role
- Practice humility & approachability

PARENT PRO TIP
No. 3 | Feeling Like a Partner
The Power of Parents' Presence

- Parents don't know what they don't know.
- We know the benefits of their presence, they don't.
- Tell them how important their presence is.
- Encourage them to be there by engaging them when they do come.

PARENT PRO TIP
No. 4 | Feeling Needed
Barriers

- Geographics - 100 miles away
- Social determinants of health
- Zip codes with generational poverty
- Work, sibling care, transportation, emotional health & poor health

Mitigating the Barriers

- Utilize social worker & community resources
- Connect with a mentor
- Integrate technology
- Leverage family & friend support
The Power of a Purpose

- Give parents a developmentally appropriate role
- Parents are uniquely positioned to do things, healthcare teams cannot

Voice
Smell
Touch During Touch Times
Skin-to-Skin Care
Provide Breastmilk

PARENT PRO TIP
No. 5 | Feeling Included

Importance of including the non-birthing parent
The Power of Learning New Skills

- Parents have the opportunity to learn
- They will model your good care
- Encourage behaviors that will help them when their baby is released
- Write down the baby’s progress, questions and information.
- Information, communication, engagement

PARENT PRO TIP
No. 6 | Feeling Able
The Power of Feeling Effective

- Set them up for success
- Prepare them for set-backs
- Manage expectations
- Celebrate small victories
- Mark milestones*
- Caution milestone mania

PARENT PRO TIP
No. 7 | Feeling Successful
The Power of Self-Care

- Self-care can feel selfish or self-centered
- Self-care so they can be emotionally & physically well
- Maintain their stamina for the NICU journey
- Get into a rhythm for predictability
- Allow a support system to help
- Eat well, rest & breathe

PARENT PRO TIP
No. 8 | Feeling Well

Your unique ability to deliver the message so it's heard.
The Power of Emotional Wellness

- Social worker to bridge to services
- Mentor group
- Hand-to-Hold - https://handtohold.org
- MAMMHA - https://www.mammha.com
  - universal screening, referral & care coordination
- Healthy Start

PARENT PRO TIP
No. 9 | Feeling Well
The Power of People

- Humanize what is a foreign world
- It's never a routine case for parents
- Body language talks
- Put on the lens of a parent
- Highlight gifts from the community

PARENT PRO TIP
No. 10 | Feeling United
Parent Satisfaction
Parent Readiness
Parent Success

Improved NICU Outcomes
Improved Transition to Home
Improved Long Term Outcomes for Family Unit

MY NAME IS MOISES
I SPENT 99 DAYS IN THE NICU
I AM GOING HOME!
9 28 20
CHILDREN'S
<table>
<thead>
<tr>
<th>P</th>
<th>Participate with your baby’s healthcare team.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Ask questions. Allow yourself time to adjust to the NICU. Advocate for your baby and your family’s needs.</td>
</tr>
<tr>
<td>R</td>
<td>Read (or sing) to your baby. Ready yourself for creating a NICU routine.</td>
</tr>
<tr>
<td>E</td>
<td>Educate yourself by asking your healthcare team questions and using NEST resources. Embrace all resources available to help you and your baby.</td>
</tr>
<tr>
<td>N</td>
<td>Nurture yourself so that you can be there for your baby.</td>
</tr>
<tr>
<td>T</td>
<td>Touch times can help you bond with your baby. Talk with your baby’s healthcare team frequently to get more information.</td>
</tr>
<tr>
<td>S</td>
<td>Show up, Speak up, and Stand up for your baby and your family - you are their voice.</td>
</tr>
</tbody>
</table>
Ideas are only as good as your **execution**.

What's your Unit's philosophy of care? Does it mention inclusion of parents in care? Is it posted in your Unit?

Questions & Comments
Thank you for making parents a priority!

elizabeth@icubaby.org
icubaby.org
@icubaby_org
www.facebook.com/icubaby.org/
elizabethsimonton
Integrating Families Beyond Skin to Skin: PAIRED Plus

Samarth Shukla, MD
Physician co-lead
PAIRED Initiative, FPQC
Assistant Professor
Division of Neonatology
University of Florida college of Medicine, Jacksonville
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 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) family participation in care, 2) dignity and respect, 3) family collaboration, and 4) information sharing.
PAIRED Plus is the title given to the other PBPs that also contribute to FCC

- Inclusion of families in daily rounds
- Identifying infants and families by name
- Complex care conferences and early medical education
- Components may overlap and affect each other
- Units may already be working on certain PBPs to improve skin to skin care, which will also improve medical knowledge, family presence at rounds, etc
- Helps to integrate families in infant’s care beyond skin to skin
- FPQC will not collect data on outcome measures for these additional components
- Units are expected to work on these projects and monitor their own data
**Why to integrate families?**

- NICU has the most extended length of stay among all other hospital units
- One of the very few units where patients always need surrogates for medical decision making
- Our patients always rely on families for post-discharge care (for medical needs as well as development)
- It is prudent to keep families updated, informed, and involved in all aspects of care
- NICU families experience anxiety, depression, and grief to a significant proportion
- Families’ long term mental health requires to be addressed

**How Do We Achieve This?**

Pochard, F., & et al. (2001). Symptoms of anxiety and depression in family members of intensive care unit patients: Ethical hypothesis regarding decision-making capacity. Critical Care Medicine, 29, 1893–1897
Care Conferences
Care Conferences

- Communication!!!!
- Most important concern raised by families
- Interpersonal and informational communication has been found to be the most effective approach
- Interdisciplinary conferences are great for addressing family concerns and making shared decisions
- Helps with unbiased and unprompted disclosure of child’s health

**Altimier, L. Compassionate Family Care Framework: A new collaborative compassionate care model for NICU families and caregivers. Newborn and Infant Nursing Reviews, 2015
• Established benefits of early, frequent and effective communication between care providers and families
• Family meetings fail to occur as needed in most ICUs
• In a large multicenter study of 1500 patients who were treated for more than 2 weeks in ICUs, <40% reported discussion with their doctor about prognosis or treatment preferences
• Gap between what we know and what we practice

Barriers to Care Conferences

Time

• Average ICU in USA cares for 10 patients/day
• Number is much larger for NICUs
• Physician:Patient ratio
• Other than patient care, physician is responsible for documentation, teaching and administrative tasks
• Most parents visit later in the day

Barriers to Care Conferences

Turnover of Caregivers

- Caregivers work in shifts at most ICUs.
- Day and night time physicians/nurses are different.
- Day to day physicians/nurses may be different.
- Transfer of care among caregivers on days/nights/weekends.

Barriers to Care Conferences

Skills

• Effective communication with ICU families is complex
• Explain physiology in understandable terms, provide information on prognosis and treatment options
• Listen with patience and sympathy
• Address emotions like anger, grief, guilt, and work on conflict resolution
• Inadequate training of providers on communication skills

Barriers to Care Conferences

Cultural Sensitivity & Language Barrier

• Multicultural society
• Where is the training on cultural sensitivity?
• Country of immigrants->Different backgrounds and languages
• Interpreters may not be readily available, time consuming
• Arranging family meetings around these barriers becomes challenging

Barriers to Care Conferences

**Space**

- Lack of dedicated space for family meetings
- Many NICUs are open floor concept or have too small private patient rooms
- Not enough space around the patient for several caregivers
- Noisy and lack of privacy
- Providers may feel uncomfortable to discuss sensitive issues and avoid the topic altogether

Strategies to Improve Care Conferences

Maximize Time Efficiency

- Identify days and times that would be most convenient
- Start with something less frequent (may be once a week)
- Make the feasible times available to the families
- Gives framework for scheduling and gives appropriate notice to all stakeholders

Strategies to Improve Care Conferences

Maximize Time Efficiency

- Use printed informational material for common medical topics
- Not every care giver needs to be present for entire meeting
- Inform families of the physician/nurses’ role in the meeting and that the remaining discussion can happen with case management/lactation specialists/pastoral care/palliative care teams
- Physician time is a major barrier for care conferences. Making it less onerous for physicians, will make it happen more frequent

Strategies to Improve Care Conferences

Use Reminder Tools

- NICU is a complex and high intensity work place
- Simple reminders and triggers will improve practice of care conferences
- Add “Family meeting” to daily checklist, include the scheduled meeting date and time
- “Daily goals” form for families/nurses

Strategies to Improve Care Conferences

Clarify Goals at Every Meeting

• Every task is easier if appropriate goals are defined in advance
• Cannot discuss each and every topic at all meetings
• Care givers may appear lost if they are unaware of family expectations: Treatment/Prognosis/Surgical procedure, etc.
• Helps to identify appropriate priorities for discussion and have the appropriate participants

Strategies to Improve Care Conferences

Engage Nurses

• Bedside nurses are closest to the families, constantly present
• Engaging the bedside nurse reduces time burden on physician and improves family satisfaction
• Consistency of information provided to the family
• Nurses should include the topic of Family communication on daily rounds and their list of “daily goals”
• They can help arranging the time and goals for the meeting
• Focus the team’s attention on family needs

Strategies to Improve Care Conferences

**Involve Other Professionals**

- Case management/Social worker for family dynamics, emotional counselling, financial support, transition of care!!!!
- Pastoral care for spiritual support
- Palliative care/Ethics support, depending on the goals of the meeting
- Sub-specialty support

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Strategies to Improve Care Conferences

Training in Communication Skills

• Caregivers who are confident in communication skills are more likely to conduct care conferences
• Various educational programs like End-of-life education for physicians, End of life nursing education consortium, programs from National Palliative care research center, etc

Strategies to Improve Care Conferences

Relax Restrictions

• Patients and the families want to be with each other
• Presence of family members can be comforting to the patient and reassuring to the families
• Restrictions may be necessary during procedures/emergencies especially in open floor NICUs
• Ease of restrictions will keep families readily available for updates and family meetings
• Trainees will learn the improved communication skills

Performance Measurement & Feedback

- Define “family meeting” or “care conference”
- Document when a meeting is conducted
- Define the timeline. (e.g. Within 5 or 7 days of NICU admission)
- Monitor the data and obtain feedback from families/staff
- Share the data and feedback with staff
Medical Education
Medical Education

• Central to family centered care

• Several barriers: busy life, lack of accommodation, transportation, language/knowledge barrier, stress/anxiety, lack of knowledge and skills to take care of a sick infant

• Empowers the families and makes them feel involved and confident as primary care givers
Medical education for families can start before or soon after the birth
• Can be in-person sessions or virtual
• Verbal/audio-visual aids, printed or PDF handouts
• Involve families to decide what they would like to learn
• Intensity of education can vary from relaxed to a rigorous approach
Relaxed Approach

- HUGG group from Glasgow, UK
- Implemented family integrated care and parent education was a core component of the model
- Daily family awareness sessions on topics suggested by parents
- Led by nurses, physicians, therapists, pharmacists, dieticians, phycologists and graduated parents!!
- Informal sessions with time for Q&A
- Text reminders regarding the sessions and links to online resources

Medical Education

Medical Education

Intensive Approach

- Implemented family integrated model in Madrid, Spain
- Family education included structure of NICU, family self care, learning infant’s behavior, taking part in baby’s care, preparation for home
- Content was given in printed and electronic formats

Inclusion Criteria for Parents:
- Willing to spend at least 6hrs a day in NICU
- Active involvement in care for at least 21 days
- No language barriers
- Informed consent to participate

Medical Education

Tasks Included in Educational Sessions

- Hand hygiene
- Physiology and monitors
- IV lines
- Bathing
- Breast and other types of feeding techniques
- Kangaroo care
- Diaper changing

- Oral medication
- Mouth and skin care
- Stress and Pain response
- Interaction
- Invasive and non invasive respiratory support
- Care for NG/OG tube, ostomy, urinary catheters

Medical Education

“My answer is yes, a thousand times yes. This program was determinant to learn how to deliver the care that my baby needs. The program allowed us to behave as real parents and not mere observers of our baby’s life.”

Antenatal Counseling
Another component for family centered care approach
Having an infant in NICU is extremely stressful for families
Extreme preterm births present a medical and ethical challenge for providers and families
No universal agreement on approach and management
Family decision making is of utmost importance, but depends on quality of communication and counseling by providers
• Multiple opportunities to meet with the providers to share information and develop a care plan
• Reports where parents expressed disconnect between information provided and what they recall
• Information provided must be consistent and accurate
• Clear documentation
• Learning opportunity for trainees

Lemyre B, Moore G., Counselling and management for anticipated extremely preterm birth, Paediatrics & Child Health, September 2017
Strategies—Antenatal Counseling

Preparation

• Obtain all the relevant information
• Plan to have an interpreter if needed
• Have both parents available if feasible
• Avoid disturbance—Turn the pager off, close the door, etc
• Introduce yourself clearly
• Ask/address them by their names (including infant’s)
• Include trainees/less experienced staff in the discussion

Strategies—Antenatal Counseling

During Consultation

- Assess their knowledge
- Understand their cultural/social background, beliefs
- Provide accurate and most up to date medical information
- Present the choices clearly, include pros and cons
- Disclose the uncertainty
- Offer time to think
- Ask how you can help them

After Consultation

- Validate their difficult situation
- Provide support that they are not alone
- Provide any written information for parents to refer to
- Meet with them again, if possible, to resolve any questions

Strategies—Antenatal Counseling

Summary

- PAIRED plus helps to integrate families in patient care
- Different drivers of PAIRED plus interact with each other
- Successful implementation of PBPs for one driver will likely improve outcome measures for other drivers

- Improved family satisfaction
- Improved family readiness for infant care at home
- Improved quality of care and long term outcomes
Together we care!!

Thank you!!
Stump the PAIRED Advisors
Adjourn