A Birth Center Primer for Hospitals: Achieving Seamless Collaboration and Advancing Equity Through Community-Based Care

Primary Maternity Care
Start here.

California Quality Collaborative

Learning Series: 6 sessions designed to meet hospital needs and priorities

Session 1: Assessing Readiness and Centering Equity in Your Hospital's Birth Center Strategy	**Friday, September 8 · 1:00 – 2:30pm EST**
Session 2: Developing Eligibility Criteria and Collaborative Care Guidelines	Wednesday, September 20 · 6:00 – 7:00pm EST
Session 3: Designing Transport Workflows and Maximizing Collaboration Across Facilities	Tuesday, October 3 · 1:00 – 2:00pm EST
Session 4: Beyond Transfer: Exploring Financial, Programmatic and Administrative Integration Between Birth Centers and Hospitals	Thursday, October 19 · 2:00 – 3:00pm EST
Session 5: Preventing and Learning From Sentinel Events	**Monday, October 30 · 3:00 – 4:00pm EST**
Session 6: Planning and Conducting Effective Emergency Drills for Community Birth	Monday, November 13 · 4:00 – 5:00pm EST

Financial Disclosures

- With respect to the following presentation, there have been no relevant (direct or indirect) financial relationship between the presenters/activity planners and any ineligible company in the past 24 months which would be considered a relevant financial relationship.
- The views expressed in this presentation are those of the presenters and may not reflect official policy of Moses/Weitzman Health System, Inc. or its Weitzman Institute.
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In support of improving patient care, this activity has been planned and implemented by Primary Maternity Care and Moses/Weitzman Health System, Inc. and its Weitzman Institute and is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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inspiring primary care innovation

- Weitzman takes an innovative approach to CE Accreditation for Interdisciplinary Teams
- Register at https://education.weitzmaninstitute.org/ to create an account with Weitzman Institute today!
  - Navigate to A Birth Center Primer for Hospitals: Promoting Seamless Collaboration Between Hospital and Freestanding Birth Centers | Weitzman Institute Education and register for the activity.
- Access recordings, decks, critical readings, and claim CE credits.
  - CE credits can only be claimed once to receive 6.5 credits be sure to attend all 6 sessions.

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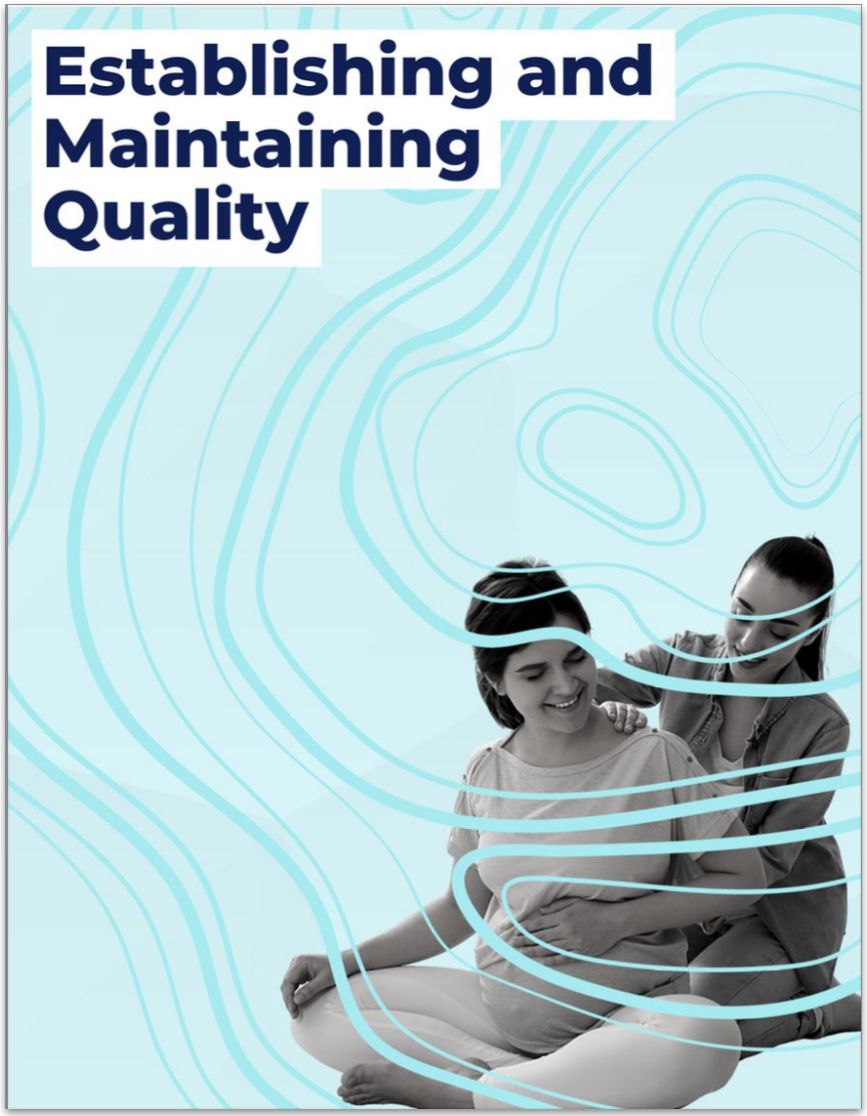
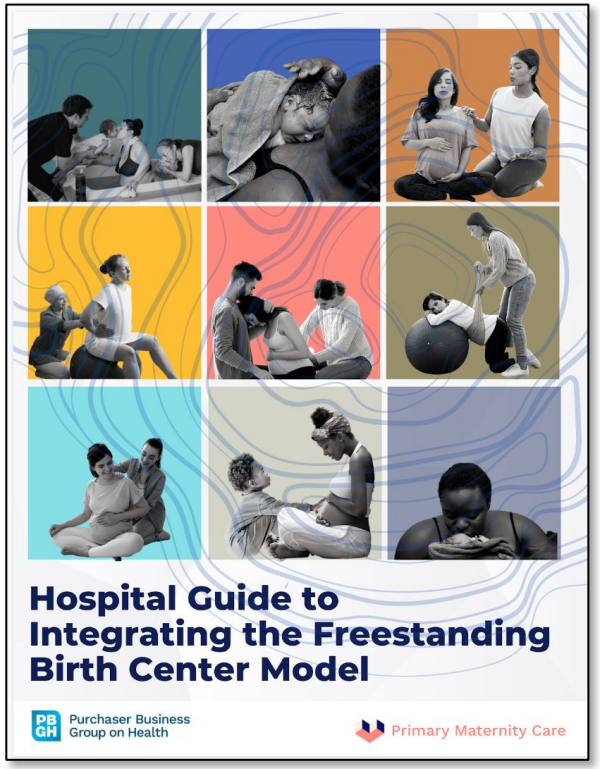
Today’s Agenda

- Learning Series Review
- Meet Our Expert Panelists
- Critical Concept Review
- Facilitated Discussion with Panelists
- Q+A



A Comprehensive Program to Drive Integration

Guide → **Learning Series** → **Action Collaborative**



Action Collaborative

STEP UP TOGETHER

Join us for a Step Up Together Action Collaborative in January 2024!

We will host an action collaborative of interdisciplinary teams from hospitals & birth centers. Participants will receive **group education, coaching and implementation tools** to conduct a **full transfer drill** that begins in the birth center, uses emergency transport, and ends in the operating room or NICU.

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Session 5: Preventing and Learning From Sentinel Events

Session Objectives

1. Articulate the **Commission for the Accreditation of Birth Centers (CABC) definition of sentinel event** and describe related reporting requirements for accredited birth centers.
2. Access American Association of Birth Center (AABC) consensus standards for birth center continuous **quality improvement, patient safety, and emergency preparedness**.
3. Interpret **trends and implications from data reported to CABC** about sentinel events in accredited birth centers.
4. Discuss **ways hospitals can collaborate with birth centers** to minimize sentinel events and support system improvement and team resilience when sentinel events do occur.

Introducing Expert Panel

Dr. Susan Stapleton, CNM, DNP, FACNM
Commission for the Accreditation of Birth Centers (CABC)

Dr. Dale Reisner, MD
Smooth Transitions

Dr. Tim Fisher, MD, MHCDS;
NNEPQIN

Amy Romano MBA, MSN, CNM, FACNM
Founder and CEO, Primary Maternity Care
Co-Facilitator

Melissa Denmark, MA, LM
Smooth Transitions

Alexa Dougherty, CNM, PHN, MSN
Clinical Operations Specialist
Co-Facilitator

Session Concepts + Tools

Concept Review

- Reframing the “train wreck”
- Overview of sentinel events in birth centers
- Prevention strategies
- What to do when sentinel events do occur

Tools

- AABC National Standards
- CABC Accreditation Program
- Smooth Transitions
- Step Up Together Action Collaborative

Reframing the “Train Wreck”

Hospital personnel may **fear integration** with community birth services due to **fear of a “train wreck” transfer**.

BUT…***Let’s reframe the train wreck***.

After real train wrecks, we DO[1]:

- gather **facts and timeline** from all available sources
- have mechanisms to invite **input from all relevant parties**
- systematically analyze **probable causes**
- synthesize **safety recommendations**
- provide information and support to **survivors, family, and other loved ones**
- prepare **reports for the public**
- maintain a public **database of root causes and safety recommendations**
- **testify and advocate** for system changes

After real train wrecks, we DON’T

- assume train travel is **inherently unsafe**
- assume the train **conductor must be at fault**
- **blame passengers** for taking the train instead of driving

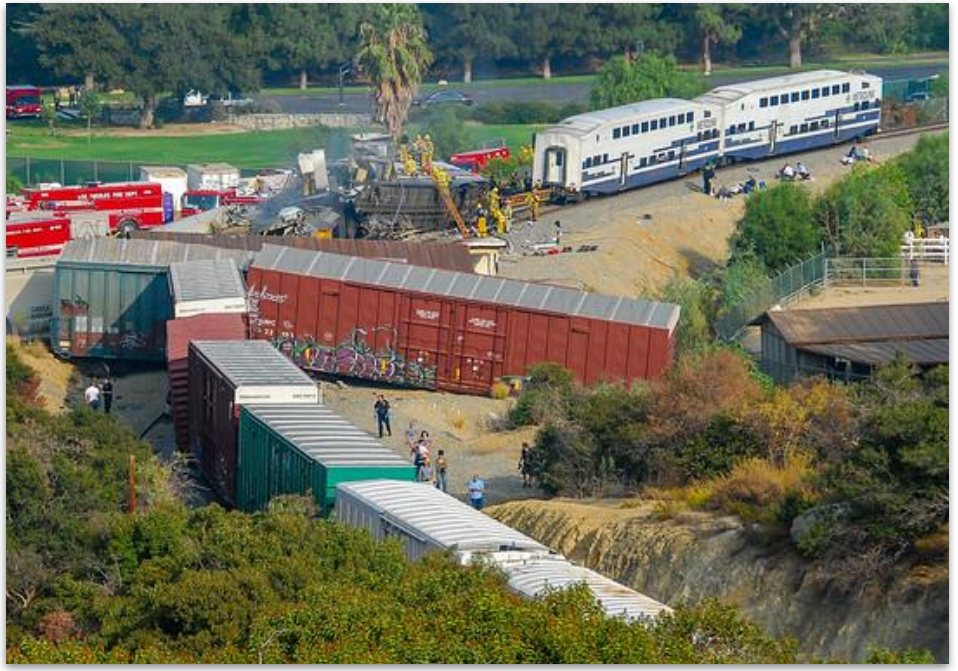


image source: https://www.flickr.com/photos/kkanouse/2851517953

1. National Transportation Safety Board. https://www.ntsb.gov/investigations/process/Pages/default.aspx

Panel Question

How should hospitals be thinking about their role in preventing and responding to sentinel events in community birth to avoid the proverbial “train wreck”?

Overview of sentinel events in birth centers

Birth Center Standards Related to Sentinel Events

"There is an effective system for collection and analysis of data which includes…standardized review of sentinel events including, but not limited to:

- Neonatal Apgar <7 at 5 minutes
- Postpartum hemorrhage of >1000cc
- Birth weight <2500gm or >4500gm
- Shoulder dystocia
- Emergent transfers of mother or newborn
- Neonatal intensive care unit admissions
- Maternal intensive care unit admissions
- Maternal, fetal or neonatal mortality
- Deviations from written protocols"[1]

CABC Indicators of Compliance with AABC Standards

Required Indicators of Compliance:

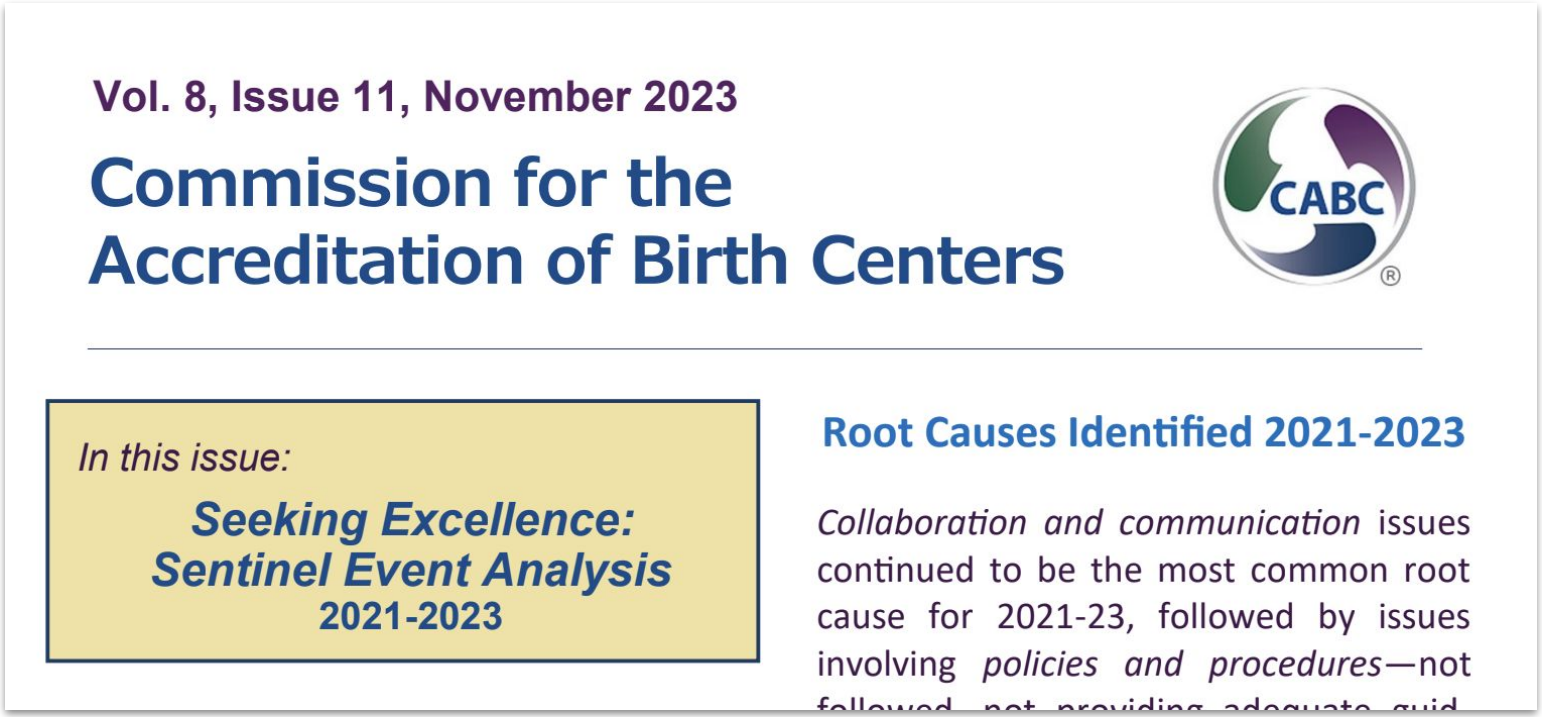
- Documented **regular review of all unusual events** and outcomes, including a list of sentinel events that will trigger case review.
- All sentinel events are **reported to CABC** and other state regulated reporting authorities.
- **Root cause analysis** for all sentinel events and recurring events.
- Documentation of case and transfer reviews indicates **participation by all Clinical Staff**

Additional Best Practice Indicators:

- CABC recommends that birth centers maintain a **resource list and/or the provision of professional counselors** who can assist with critical incident debriefing for the team or for individual staff members following any near miss or sentinel event.

Review of Sentinel Events Reported to CABC

- CABC Accredits 103 freestanding birth centers and 4 Alongside Midwifery Units in 33 states.
- Review of sentinel events reported in 2021-2023 (n=225) forthcoming in November CABC Newsletter.



Vol. 8, Issue 11, November 2023

Commission for the Accreditation of Birth Centers

CABC

In this issue:

Seeking Excellence: Sentinel Event Analysis 2021-2023

Root Causes Identified 2021-2023

Collaboration and communication issues continued to be the most common root cause for 2021-23, followed by issues involving *policies and procedures*—not

Access newsletters at: https://birthcenteraccreditation.org/news/

Commission for the Accreditation of Birth Centers
Supporting Standards & Inspiring Excellence through Learning

Classification of SE's Reviewed in 2021-2023 (YTD) N = 225

	2021	2022	2023
Antepartum Fetal Death	4 (4%)	5 (5%)	3 (7%)
Intrapartum Fetal Death	7 (8%)	5 (5%)	4 (9%)
Maternal Death or Serious Injury or Illness or Need for Significant Intervention	39 (43%)	26 (28%)	8 (19%)
Near Miss	7 (8%)	6 (6%)	4 (9%)
Neonatal Death	3 (3%)	6 (6%)	2 (5%)
Process Variation for Which Recurrence Would Carry Significant Risk of Adverse Outcome	4 (4%)	4 (4%)	5 (12%)
Serious Fetal or Neonatal Injury or Illness or Need for Significant Intervention	27 (30%)	42 (46%)	16 (38%)

Commission for the Accreditation of Birth Centers
Supporting Standards & Inspiring Excellence through Learning

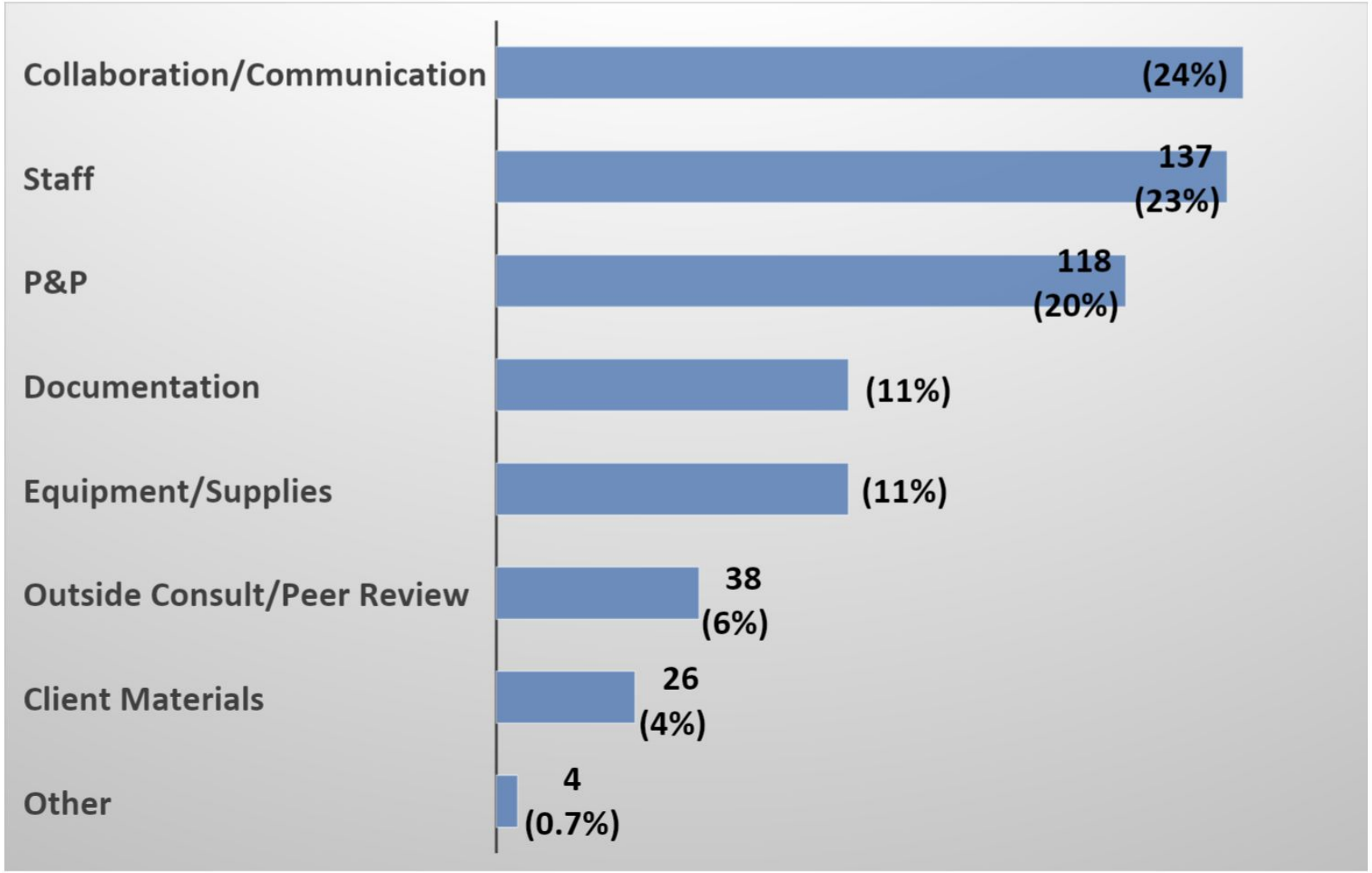
Categorized Root Causes Identified 2021-2023

(YTD) N = 682

	2021	2022	2023
Collaboration/Communication	52 (19%)	54 (20%)	25 (19%)
Documentation	29 (11%)	22 (8%)	13 (10%)
Maternal Assessment	25 (10%)	27 (10%)	17 (13%)
P&P Inadequate or Not Followed	37 (13%)	43 (16%)	18 (13%)
Staff Issues	39 (14%)	28 (10%)	13 (10%)
Fetal/Neonatal Assessment	21 (8%)	28 (10%)	14 (11%)
Equipment/Supplies	20 (7%)	26 (9%)	18 (13%)
Transfer Initiation or Process	23 (9%)	25 (9%)	8 (6%)
NRP	9 (3%)	10 (4%)	4 (3%)
Risk Criteria Inadequate or Not Followed	3 (1%)	8 (3%)	2 (2%)
Other	13 (5%)	6 (2%)	2 (2%)

Commission for the Accreditation of Birth Centers
Supporting Standards & Inspiring Excellence through Learning

Actions Taken by Birth Centers as Result of RCA Findings – 2021-2023 (YTD) (n=595)



Panel Question

What are the most effective strategies for preventing sentinel events and promoting patient safety in planned birth center births and transfers?

Prevention Resources from this Learning Series

Prevention Strategy	Where to Deep Dive
Foundations of Collaboration	All sessions!
Eligibility Policies and Procedures	Session 2
Transfer and Transport processes	Session 3 and Action Collaborative
Drills and Skills	Session 6 and Action Collaborative
Continuous Quality Improvement	Session 6 and Action Collaborative

Find recordings and session resources at: https://www.primarymaternitycare.com/learningseries-materials-and-resources

The 3 Delays Framework

In community-integrated maternity care models, **preventable** morbidity and mortality are often related to one or more **delays**.

Binder P, Johnsdotter S, Essén B. Conceptualising the prevention of adverse obstetric outcomes among immigrants using the 'three delays' framework in a high-income context. *Soc Sci Med*. 2012;75(11):2028-2036. doi:10.1016/j.socscimed.2012.08.010

When Sentinel Events Do Occur

and THEY WILL!

- Reporting to CABC and other required entities
- Support for family and staff
- Debriefing and event review
- Continuous quality improvement

When Sentinel Events Do Occur

Family support

- Explain details of the event, allow for questions and ongoing communication
- Offer resources and ongoing care for emotional and physical healing
- Respect their wishes

Staff support

- Peer support groups
- Institutional social work or counseling referral
- Employee assistance programs
- Ongoing drills and skills

Panel Question

What are methods to build team resilience and support staff when sentinel events occur?

When Sentinel Events Do Occur

Debriefing and event review

- Critical to improving individual, team, and interdisciplinary performance
- Non-punitive
- Regular practice; not just after sentinel events
- Utilizing debriefing tools: TALK, PEARLS, REFLECT

COMMUNITY DEBRIEF

What happened here?

What went well?

What needs attention or improvement?

What changes are needed to processes or procedures?

Structural Challenges to Reviewing Sentinel Events

Universal to all healthcare settings

- Fear of reprisal
- Time constraints
- Lack of trust in follow-up action
- Blame culture
- Legal discovery challenges

Specific to birth center - hospital partnerships

- Misconceptions around birth center safety and standards
- Lack of foundation of collaboration and trust
- Legal discovery challenges arising from separate facility governance

Panel Question

What are ways to overcome these structural challenges to drive quality improvement from sentinel events?

Local Options

- Dartmouth Hitchcock experience

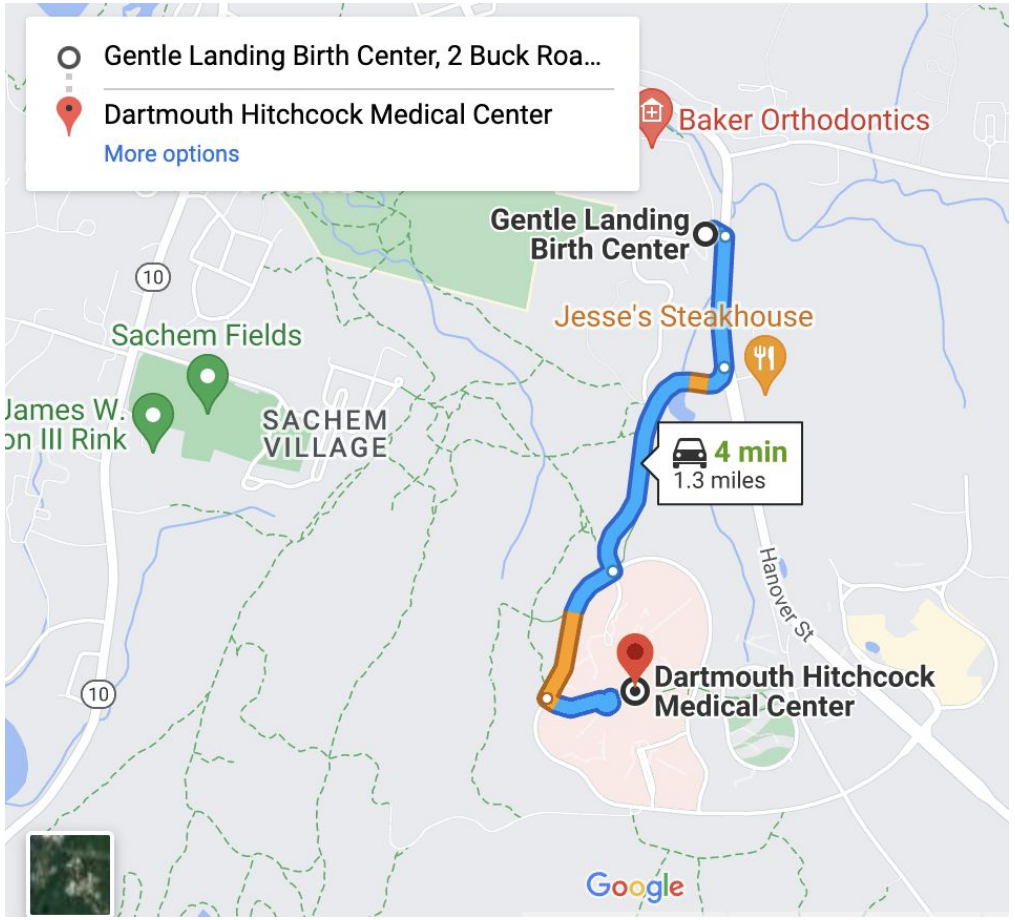
State + Regional Approaches (PQCs)

- NNEPQIN
- Smooth Transitions

Dartmouth-Hitchcock Experience

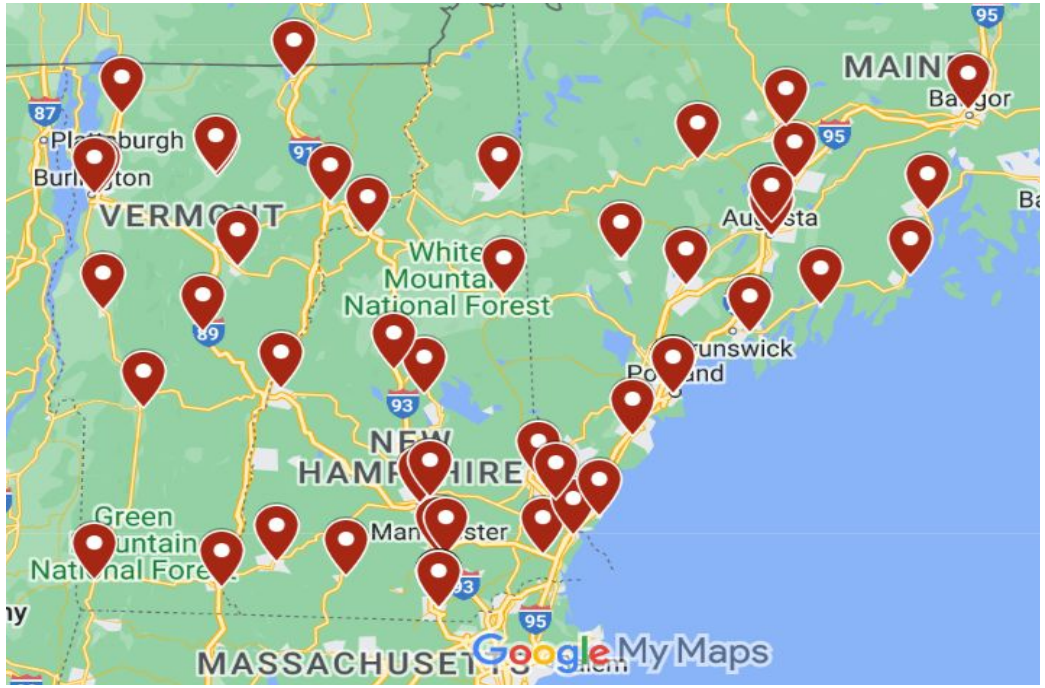
Local collaboration & QI

- Conversations with DHMC clinician leaders and administrators started in 2017. GLBC opens 2019
- Face-to-face to meetings during construction (Ob's, CNM's & RN's)
- Meeting with local EMS leadership
- Meeting with Ob/Gyn residents
- Ad-hoc hospital QI protected meetings to review outcomes and OFI
- Refinement of transfer process for urgent/emergent transfers



NNEPQIN CRIB

- 50+ member organizations including tristate CPM's
- Multidisciplinary CE, Guidelines, PI projects, AIM
- Identified need for high quality expert review of unanticipated adverse perinatal outcomes
- Confidential Review and Inquiry Board (CRIB) developed with legal guidance
- Process includes extramural QI protected review team, formal recommendations back to referring organization
- In person meetings coincident with quarterly CE events to include review team, NNEPQIN leadership and organizational reps



NNEPQIN

NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

CRIB Reports Include

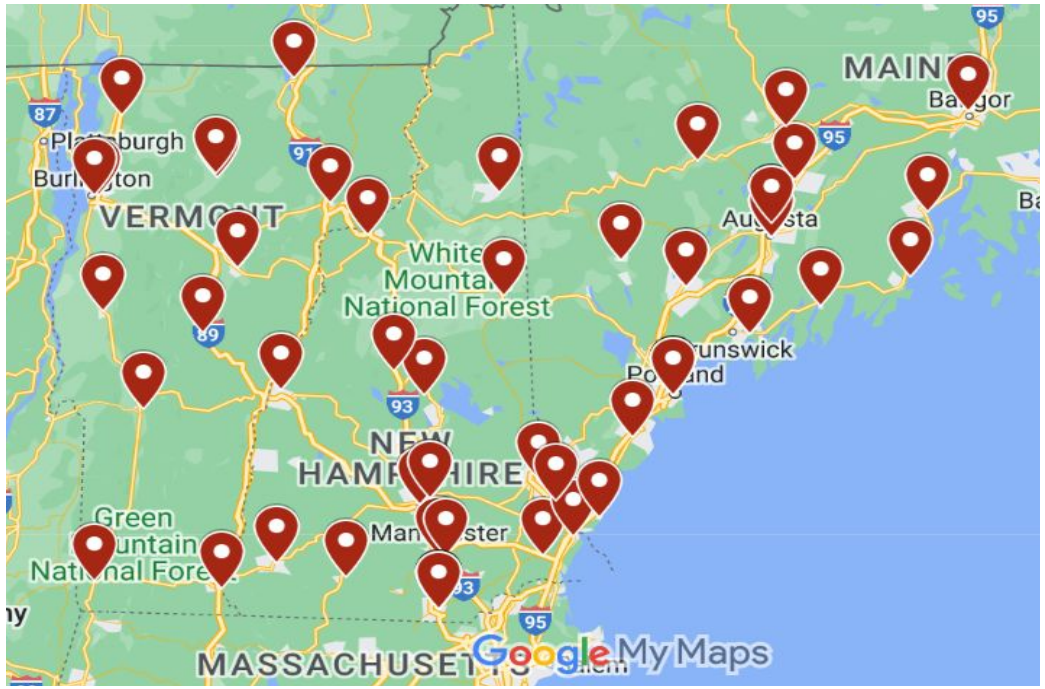
Case summary from medical records and FHR tracings

Management issues

- Patient factors
- Practitioner factors
- Task management factors
- Working conditions and team factors

Review team recommendations, including relevant literature, guidelines, policies from other institutions

Sent via Certified Letter to responsible organizational representative



NNEPQIN

NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Protected Reviews

Smooth Transitions

INTERNAL

Perinatal Transfer Committee Meetings

- Focus on systems-level improvement-protocols, interprofessional communication, feedback from surveys

Individual Incident Reviews

- Review of a single case with the hospital providers, community midwife and staff involved.
- Addresses clinical issues, including patient experience.
- Follows the protocol at facility and has a neutral mediator.
- Any improvement opportunities will be shared back to the appropriate hospital providers, staff, and community midwife.

EXTERNAL

- Neutral, 3rd party, multidisciplinary team of reviewers
- Focus on more controversial issues
- Examination of deidentified records
- Findings would be entered into an external review registry for the purpose of identifying educational opportunities or trends which could be shared with the state perinatal community

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