

# Infant Mortality Work Group Meeting

July 19, 2019

## *Maryland Patient Safety Center: Past Programs and New Initiatives*

### I. Who are we?

An independent not-for-profit, 501(c)(3) organization committed to improving patient safety in the state and region. Facilitators and managers of the Maryland Perinatal/Neonatal Quality Collaborative. Provide education and conferences on patient safety to healthcare providers across the healthcare continuum, and to the community. We coordinate statewide quality improvement initiatives, and manage the Mid-Atlantic Patient Safety Organization, a federally listed PSO.

### II. Significant Dates

- March 2007: MPSC assumed facilitation of the Maryland PQC
- January 2009 to December 2014: Collaborative to reduce elective Caesarean sections and inductions less than 39 weeks without medical indication
- February 2009: CareFirst funded “Golden Hour” neonatal collaborative
- May 2009 to June 2010: Golden Hour collaborative to decrease neonatal mortality by 10%, chronic lung disease by 10%, and LOS by 10% through standardized resuscitation and stabilization of the neonate in the first hour of life (Golden Hour)
- **Fall 2011 to Spring 2016:** Perinatal/Neonatal Collaboratives merged to form the P/N Learning Network; Focused on 3Rs Project: Risks, Referrals and Readmissions Toolkit; Aim: to improve identification of mothers and infants at risk prior to discharge and increase numbers of referrals and decrease readmissions less than 30 days. In FY 2015 provided education to identify strategies to reduce maternal mortality from OB Hemorrhage and reduce neonatal cases of necrotizing enterocolitis (NEC).
- **Fall 2015:** Second state in the nation to become an AIM state
- **June 2016 to June 2018:** Safely Reducing Primary C-Sections Collaborative
- **October 2016 to September 2018:** Neonatal Abstinence Syndrome: Improving Care to Improve Outcomes Collaborative; partnered with the Vermont Oxford Network
- **February 2019 to January 2021:** OB Care of Women with OUD Collaborative (AIM project)
- **March 2019 to February 2021:** Safe Infant Sleep Collaborative

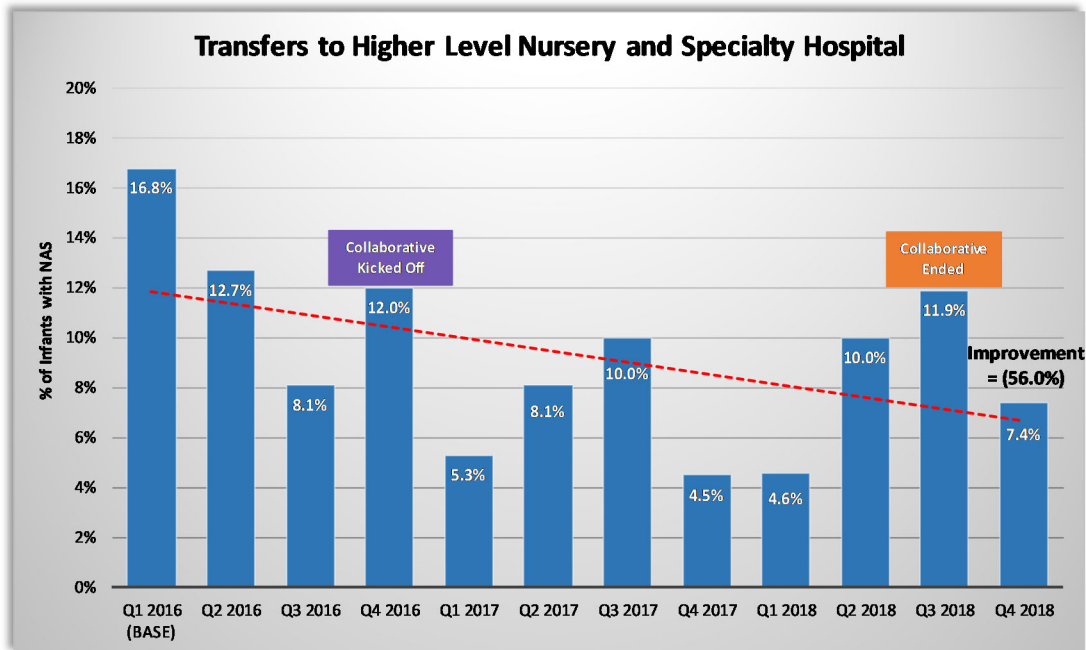
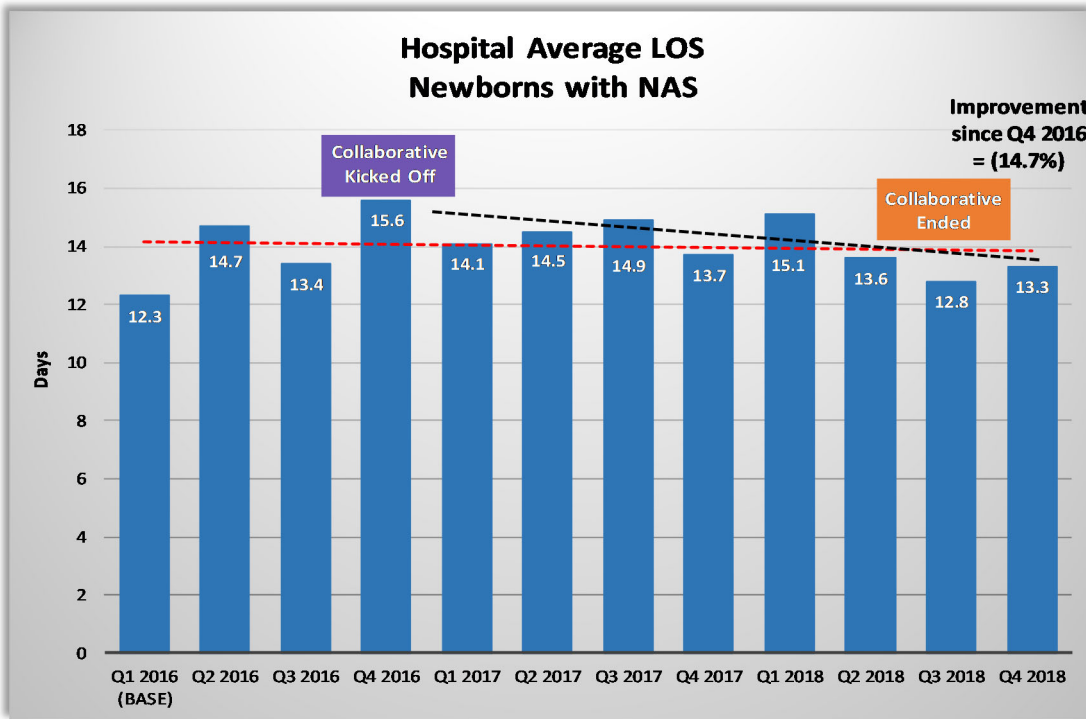
### III. Infant Initiative Outcomes

- Golden Hour:

Golden Hour Measures				
	Baseline 7/1/09 - 9/30/09	10/1/09 - 9/30/10 (Rolling 12 mos)	10/1/10 - 11/30/11 (Rolling 12 months)	Goal
Pulse Oximetry (Reported Monthly)	24%	38% (58% improvement over baseline)	49% (104% improvement over baseline)	80%
1-Hour Surfactant (Reported Monthly)	81%	85% (5% improvement over baseline)	86% (6% improvement over baseline)	100%
Axillary Temperature (Reported Monthly)	36%	20% (44% improvement over baseline)	13% (64% improvement over baseline)	0%
Average Initial LOS (Reported Monthly)	20 days	15 days (25% reduction from baseline)	31 days (55% increase over baseline)	10% relative reduction from baseline
1-Hour Antibiotics (Reported Monthly)	36%	30% (17% decline from baseline)	56% (56% improvement over baseline)	100%
1-Hour Surfactant (Reported Monthly)	81%	85% (5% improvement over baseline)	86% (6% improvement over baseline)	100%
	Baseline 1/1/09 - 6/30/09	7/1/09 - 6/30/10 (Rolling 12 mos)	7/1/10 - 6/30/11	
Chronic Lung Disease (Reported Quarterly)	15%	11% (27% reduction from baseline)	7% (53% reduction from baseline)	10% relative reduction from baseline
Mortality Rate (Reported Quarterly; results are per 100 live births meeting gest. age criteria in study)	5 per 100	6 per 100*	5 per 100	10% relative reduction from baseline

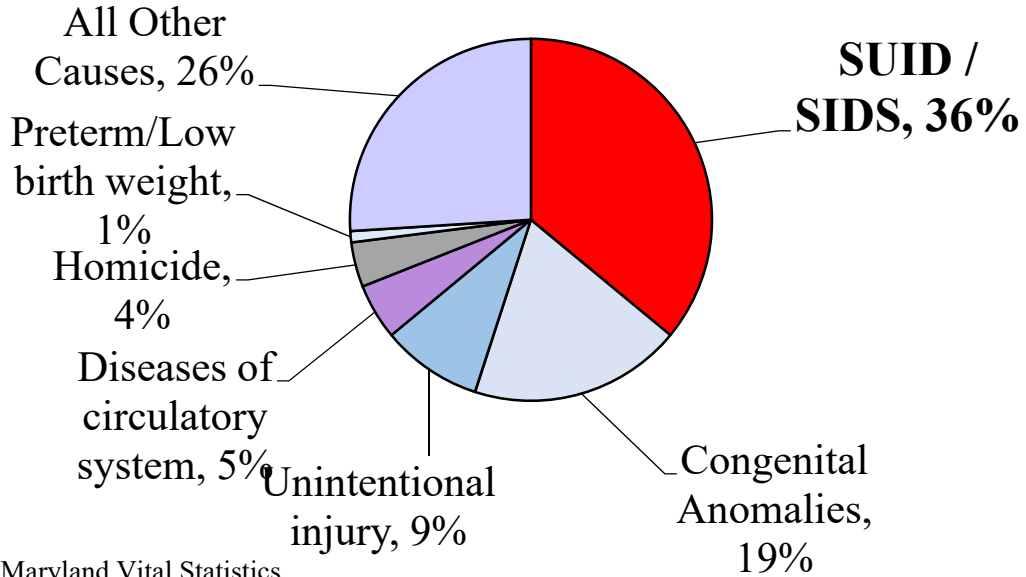
\* Change not statistically significant using Fisher's Exact Test. P = 0.707134

- Neonatal Abstinence Syndrome



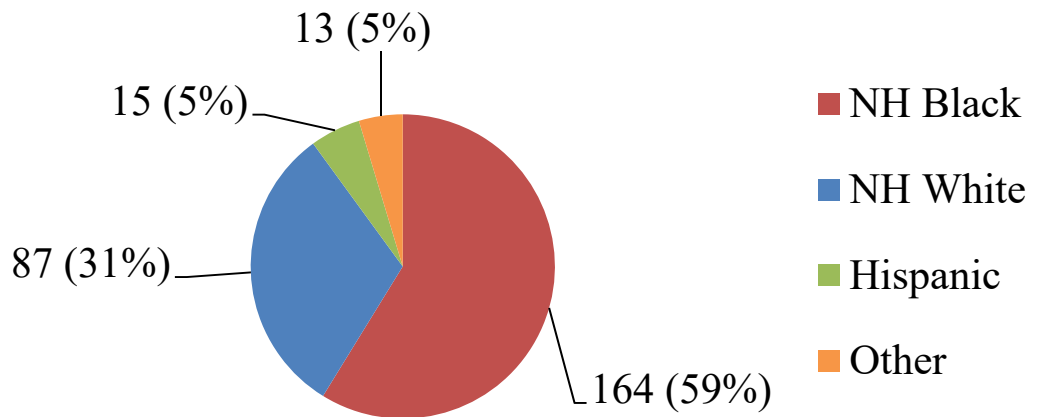
- Safe Infant Sleep- just getting started

## Leading Causes of Post-Neonatal Death (1 mo. - 1 yr.), Maryland, 2017



Source: Maryland Vital Statistics

## Number of SUIDs by Race and Ethnicity, Maryland, 2013-2017



Source: National Fatality Review Case Reporting System.

**IV. Questions?**

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