TexasAIM Safe Care for Every Mother
A program of the Texas Department of State Health Services

Opioid and other Substance Use Disorders Innovation and Improvement Learning Collaborative
Key Driver Diagram

Aim Statement

AIM:
By August 2026, we will reduce the rate of OSUD-associated severe maternal morbidity among obstetric patients with in-hospital deliveries by 10% from baseline.

Primary Drivers

Secondary Drivers

Times when, places where, or steps in the process where readiness; recognition and prevention; responsiveness; and reporting for each primary driver are addressed.

Care Coordination

- Leadership support and resourcing
- Providing interdisciplinary care
- Partnership between clinical and community providers/services

Trust building in support of safe, respectful, equitable care

- Patient and family engagement
- Patient and family education
- Every care episode (touch point)

Prepared and responsive care team

- Entry into care and throughout prenatal care
- During any hospital encounter/admission
- Day of discharge
- Care transitions
- Multidisciplinary staff education

Culture of equity, safety and improvement

- Teamwork and communication
- Multidisciplinary case review of patients with OSUD
- Comprehensive case/care review process using equity framework

TexasAIM OSUD IILC - Care Coordination

PRIMARY DRIVER	SECONDARY DRIVER	CHANGE CONCEPTS AND STRATEGIES	CHANGE IDEAS
Care Coordination	**Leadership support and resourcing** **Providing multi-disciplinary care** **Multiple professionals and partners caring for patients**	• Interdisciplinary, team-based approach to care involving obstetrics, pediatrics, anesthesia, patient/family psychology, psychiatry, social work, addiction medicine, and other relevant disciplines • Community partnerships fostered to ensure interdisciplinary team-based approach to care • Teams supported with resources necessary to improve outcomes for patients with OSUD via structural changes, staffing, protocol development, etc. • Convene inpatient and outpatient providers and community partners, including those with lived experience in an ongoing way, to share successful strategies and identify opportunities to improve outcomes and system-level issues. • Standardize pain management practices to minimize narcotic use for all obstetric patients	❑ Conduct planning session with leadership/administrative team to confirm the aim for and commitment to improving outcomes for patients living with OSUD ❑ Establish a plan and process for review of quality improvement outcome and process data ❑ Test and evaluate care team membership quarterly to ensure comprehensive care management ❑ Provide care team with resources needed for in-house management of medication assisted treatment (MAT) ❑ Partner with community to provide “one-stop” access (in one clinic/setting) to comprehensive supports and resources for care of obstetric patients living with OSUD ❑ Establish specific prenatal, intrapartum and postpartum care pathways that facilitate coordination among multiple providers during pregnancy and the year that follows. ❑ Identify key contacts/champions for each part of the interdisciplinary team ❑ Assign team members to coordinate care transitions (prenatal, intrapartum, postpartum, and post-pregnancy care) ❑ Hold monthly (minimum quarterly) multi-disciplinary quality meeting to review care management processes and outcomes for all OSUD delivery stays ❑ Use failure-mode-effect-analysis (FMEA) to investigate charts and address system failures or near misses ❑ Use standardized tool(s) to assess and track pain

TexasAIM OSUD IILC- Trust Building for Safe, Respectful, Equitable Care

PRIMARY DRIVER	SECONDARY DRIVERS	CHANGE CONCEPTS AND STRATEGIES	CHANGE IDEAS
Trust building in support of safe, respectful, equitable care	**Patient and family engagement** **Patient and family education** **Every episode of care (touch point)**	• Access to comprehensive treatment support via counselors, psychologic/behavioral therapy, and psychiatric treatment • Eat, sleep, console via education and structural changes for couplet care • Provide education to obstetric patients related to substance use disorder (SUD), naloxone use, harm reduction strategies, and care of infants with in-utero substance exposure • Incorporate patient preferences and voices across the care continuum • Patient/family education on SUD and neonatal withdrawal syndrome/neonatal opioid withdrawal syndrome (NWS/NOWS) • Care team educated and practiced in use of motivational interviewing (MI) and screening, brief intervention, referral and treatment techniques (SBIRT) • Engage local Department of Family Protective Services (DFPS), Child Protective Services (CPS) in use of Plan of Safe Care (POSC)	❑ Embed triggers to promote standardized care (i.e., screening, pain protocols, supportive education and community resource connectivity) ❑ Provide patient and family information on how to access all available support resources, locally and/or regional ❑ Provide breastfeeding education and support for every pregnant and postpartum patient/ family during prenatal and hospital episodes of care ❑ Use NWS/NOWS scoring partnership with obstetric patients and nursing staff ❑ Offer a peer support program across the continuum of care ❑ Offer group prenatal care and parenting support groups, as appropriate ❑ Include the patient voice in quality improvement planning, testing and implementation ❑ Engage all obstetric patients and their family in developing care plans, starting in the prenatal setting ❑ Facilitate introductions and coordination between patients with SUD and pediatric team (POSC, inpatient-peds/neo, outpatient-peds) to support understanding of and trust in neonatal care procedures (ideally occurs prenatally/antepartum) ❑ Identify discharge coordinator within the care management team to facilitate respectful discussion with patient/family about concerns, needs, and level of confidence at discharge ❑ Identify telemedicine opportunities to improve access to interdisciplinary care ❑ Create checklist for hospital antenatal visits to identify opportunities to empower, encourage, support and educate in a positive environment (pregnancy norms, breastfeeding, healthy eating, activities, etc.) ❑ Offer patient/family links to needed social service support (WIC, housing, childcare, group support) ❑ Use strengths-based approaches such as asking the with patient and family “what matters to you” when co-creating a discharge plan of care

TexasAIM OSUD IILC- Prepared and Responsive Care Team

PRIMARY DRIVER	SECONDARY DRIVERS	CHANGE CONCEPTS AND STRATEGIES	CHANGE IDEAS
Prepared and responsive care team	**Entry into care and prenatally** **During any hospital stay/ admission** **Day of discharge** **Care transitions** **Multi-disciplinary staff education**	• Standardize processes for using of screening, brief intervention and referral to treatment (SBIRT) for SUD, social determinants of health (SDOH), and plans of safe care (POSC) during prenatal care and throughout care continuum • Universally assess and respond to social needs • Design and adopt clinical pathways including pain protocols • Individualized pain protocols for patients with SUD • Develop a communication plan, practices to reduce narcotic prescriptions, and process to ensure continuity of care • Ensure lactation support is provided for obstetric patient with SUD • Provide clinical and non-clinical staff education on optimal care for obstetric patients with SUD, including federal, state, and local notification guidelines for infants with in-utero substance exposure and comprehensive family care plan requirements. • Offer comprehensive reproductive life planning discussions and resources • Trauma-informed care protocols, anti-racism, stigma, and implicit bias training for all staff	❑ Test/evaluate care team membership to ensure comprehensive care management ❑ Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for patients/families for social determinants of health needs, behavioral health supports, and SUD treatment ❑ Screen all patients for SUDs using validated self-reported screening tools and methodologies, linked with MI techniques, during prenatal care and during the delivery admission (i.e., SBIRT, SDOH) ❑ Use protocols to develop a plan of safe care (POSC) ❑ Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans and provide linkage to resources ❑ Establish partnership with CPS and family course liaisons ❑ Embed electronic health record (EHR) with triggers, standardized screening tool, clinical pathways, pain care plan ❑ Provide breastfeeding education and support for every obstetric patient/family during prenatal care, hospital episodes of care and care transfers ❑ Offer comprehensive reproductive life planning discussions and resources ❑ Establish and active referral network for MAT, mental health and social service supports ❑ Used Enhanced Recovery After Surgery (ERAS) protocols and individualized care plans ❑ Assist patients with SUD to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive in an intersectional manner and, discuss readiness to start treatment, as well as referral for treatment with warm hand-off and close follow-up ❑ Establish partnership to support treatment for at least one year postpartum ❑ Provide staff education and support with using clinical pathways ❑ Use briefs, huddles and debriefs to support interdisciplinary care coordination during the hospital stay and for post-care evaluation ❑ Provide naloxone and naloxone counseling and education for obstetric patients with OSUD and families ❑ Establish and maintain warm handoffs at discharge for transfer to care including POSC Provide skills-based clinical and non-clinical department-wide training grounded in respectful and equitable care (Modules with content on Trauma Informed Care, SUD, validated screening tools, maternal and neonatal outcomes, SBIRT interventions, patient interaction tools, National Culturally and Linguistically Appropriate Services (CLAS) Standards in Maternal Health Care, MAT, State laws and protocols, Judicial System, DFPS protocols, Prenatal and Intrapartum: Support Infrastructure in TX; Level of Care policies; Pain management for SUD obstetric patients; and breastfeeding)

TexasAIM OSUD IILC- Equitable Care in Culture of Safety and Improvement

PRIMARY DRIVER	SECONDARY DRIVERS	CHANGE CONCEPTS AND STRATEGIES	CHANGE IDEAS
Equitable health care in culture of safety and improvement	**Teamwork and communications** **Multidisciplinary case review of patients with OSUD** **Comprehensive case/care review process using equity framework**	• Standardize teamwork communication • Track outcome and process measures: stratify, report and analyze data by race, ethnicity, language, payor and other key demographics • Develop and implement improvement and corrective action plans based on case review process • Develop trauma-informed protocols and bias reduction training to address health care team member biases and stigma related to SUDs. • Identify and monitor data related to SUD treatment and care outcomes and process metrics for obstetric patients with disaggregation by race, ethnicity, and payor as able • Understand and support safe cultural norms around pregnancy, delivery and infant care	• Use briefs, huddles and debriefs ❑ Link care episodes across the care continuum to facilitate up-to-date information at the point of care and to track outcomes: *"every patient, every provider, every care encounter"* ❑ Use a culture of safety survey (e.g., AHRQ's Surveys on Patient Safety Culture) ❑ Track experiences and the quality of communication/information sharing between partners to identify and use what is learned to close gaps ❑ Conduct planning session with leadership/administrative team to confirm the aim for and commitment to improving outcomes for obstetric patients experiencing OSUD ❑ Establish a plan and process for review of quality improvement outcome and process data ❑ Track and review quality measures linked to morbidity and mortality outcomes for obstetric patients with OSUD ❑ Conduct quarterly (at minimum) review of data to determine administrative support and resource needs ❑ Develop quality improvement tracking tool or EHR query to collect disparities data ❑ Incorporate discussions of how bias may have impacted or did impact care into debriefs and case review ❑ Assess pain management throughout stay to ensure goals are met ❑ Have systems in place to track: • adherence to standardized care protocols and outcomes through EHR • quality measures linked to severe morbidity and mortality outcomes for patients experiencing OSUD • That recommended practices in infant nutrition and care (e.g., immediate and uninterrupted skin-to-skin contact and support to initiate breastfeeding after birth; supporting breastfeeding initiation and maintenance, not providing breastfed newborns any foods or liquids other than breastmilk unless medically indicated, etc.) are supported at delivery and throughout the hospital stay • outcome and process indicators/data, disaggregated by race and ethnicity, with interdepartmental prenatal, birth and newborn providers and staff and community partners • adherence to prenatal visit schedule (if applicable) • "rooming in" during hospital stay and any reason for separation of couplet • percentage of patients/infants with the infant discharged to postpartum mother's care • patient experience by race and ethnicity ❑ Establish a sustainable plan for accurate documentation of self-identified race, ethnicity and primary