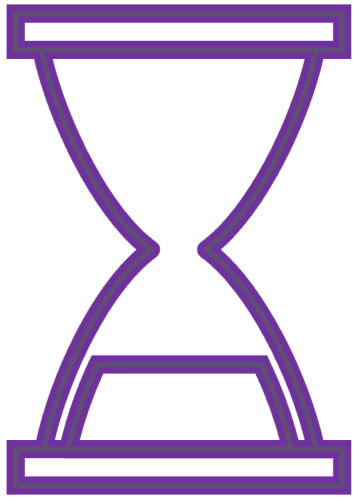
Introduction to CPQCC and Friends

October 4, 2023

Welcome!

- We will begin shortly.
- Please review the following slides for important information.
- Introduction to the presenters



Webinar Logistics

All attendees are muted upon entry.

Please use the Q & A function – we will do our best to answer questions during the webinar.

We welcome your feedback and recommendations for improving future webinars.

Webinar Logistics

- Attendees will be eligible for contact hours through the Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PAC/LAC) . This webinar series is being jointly provided by CPQCC and PAC/LAC. PAC/LAC is an approved provider by the California Board of Registered Nursing, Provider number CEP 5862.

- If you attend as a team, please create a sign-in sheet and send it to info@cpqcc.org to be eligible for contact hours/CEU.

- Please complete the survey which will be available immediately following this webinar.

- The slides and webinar recording will be sent out after the webinar and will also be posted on the CPQCC website at **https://www.cpqcc.org/engage/annual-data-training-webinars-2023** .

Presenters

REBECCA ROBINSON, MFA
CPQCCC ADMINISTRATIVE DIRECTOR

COURTNEY BREAULT, RN, MS, CPHQ
ASSOCIATE DIRECTOR OF QUALITY

Agenda

DURATION	TOPIC	PRESENTER
12:00 – 12:05 PM (5 min)	Welcome & Introductions	Communications Team
12:05 – 12:35 PM (30 min)	CPQCC and CCS – Goals and Intentions, Mission NICU Population – Who do We Track and Why? Transport HRIF Population	Rebecca Robinson
12:35 – 12:45 PM (10 min)	QI Activities	Courtney Breault
12:45 – 1:00 PM (30 min)	What's Next for CPQCC?	Rebecca Robinson
1:00 – 1:10PM (10 min)	Q&A Panel	Group

Vision Statement

We are committed to improving the **quality and equity of care**, **centering the voices of lived experience** and collaborating with **families** and with **all interdisciplinary members of the health care team.**

Our vision is to consider both the infant's stay in the NICU and broader health improvement by extending our vision to the **family** and to the **continuum of care** from **pregnancy** through **early childhood**.

A Bold Vision and Big Promise

1997

To create the nation's **first** state-wide perinatal quality improvement collaborative: **CPQCC.**

Beginning in 1997, we built a collaborative of 138 NICUs caring for more than 95% of California's NICU infants.

Stakeholder Value 1997

CA Association of Neonatologists (CAN)

- Organized QI as a possibility

State Maternal and Child Health Branch (MCAH)

- Need for morbidity assessment

CA Children's Health Services (CCS)

- Need for NICU medical quality assurance

Pacific Business Group on Health (PBGH)

- Consumer-oriented quality assessment

Packard/Vermont Oxford Network (VON)

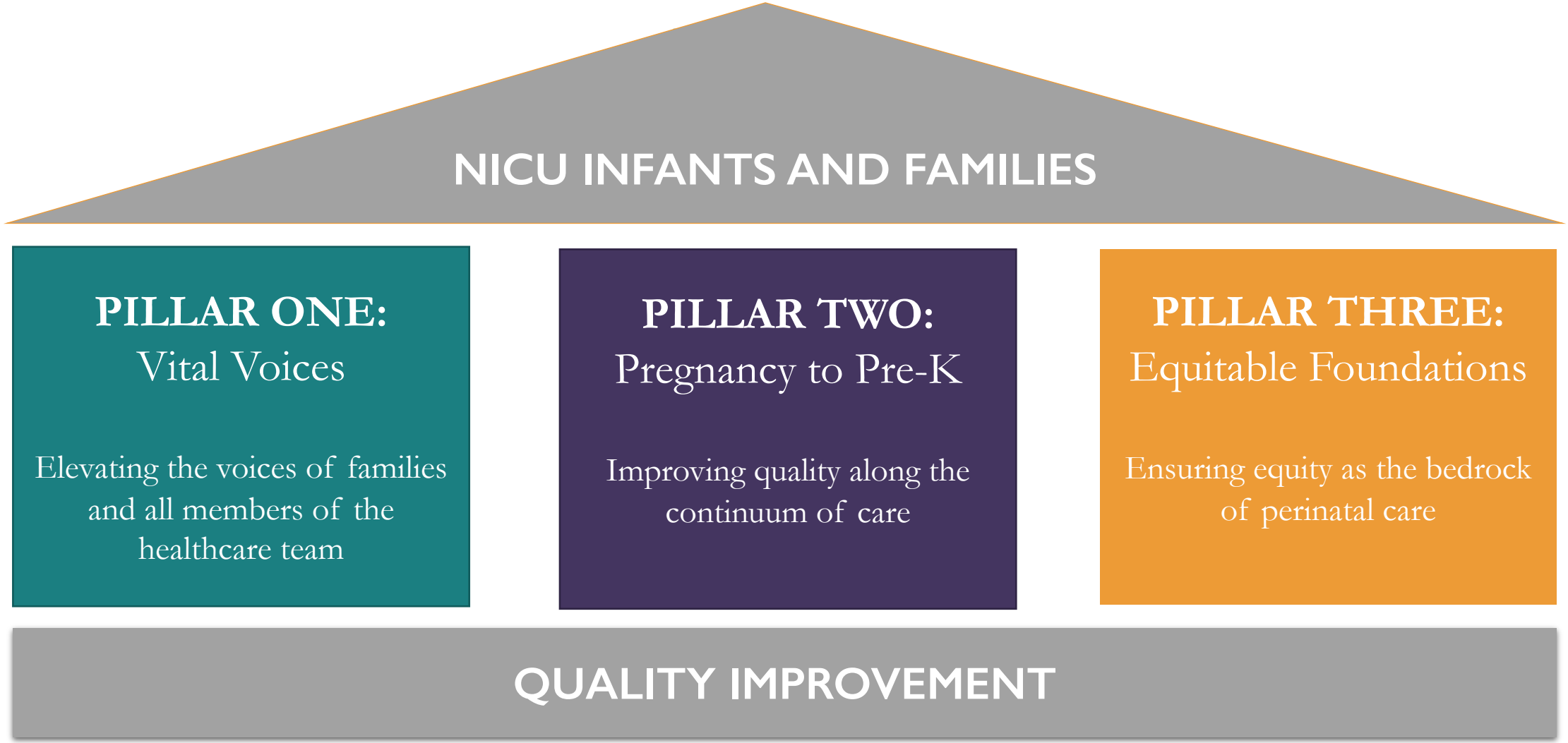
- Statewide application of VON

2023 – Statewide CPQCC Family Advisory Council (FAC)

CPQCC's Organizational Philosophy

- Quality improvement is a worthwhile activity
- Team-oriented approach, listening to front line staff and families
- Maximize value for families, member NICUs, front line staff, and community as well as traditional stakeholders

Strategic Initiatives: Three Pillars



Continuum of care structure – unique to California!

Neonatal Transport Data

CMQCC Data

All Baby Data
High Risk Data
Maternal Exposures

RPPC Data

HRIF Data

By the numbers

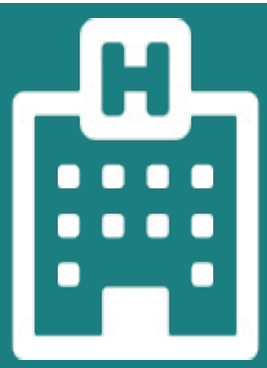
500K

BIRTHS

CMQCC

100K/17K

NICU/HIGH RISK ADMITS



140/220

NICUs/BIRTH HOSPITALS

CPQCC/CMQCC

7K

ACUTE NEONATAL TRANSPORTS

CPeTS

9K

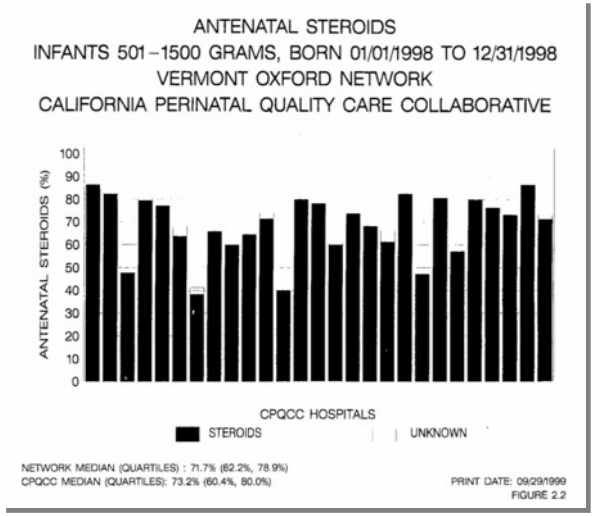
HIGH-RISK INFANTS REGISTERED

HRIF

CPQCC Database Quality

- Range and logic checks
- Data sharing between NICUs for transported infants
- Audit for excessive missing data
- Annual data training sessions
- Data Committee Advisory Group (DCAG)
- Optional tracking of substance exposed infants, Family Centered Care measures

CPQCC's NICU Database Development



1998 VON < 1500 Grams

2000 High risk > 1500 Grams

2007 Real Time Reporting + Neonatal Transport

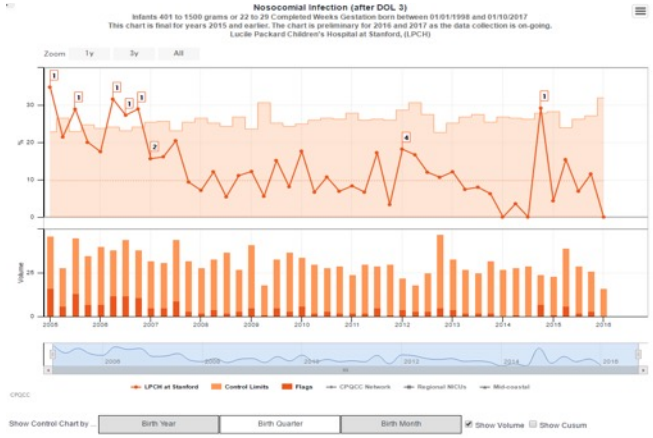
2008 Infants linked across NICUs

2009 Statewide High-Risk Follow-up till age 3

2013 NICU based Follow-up reports

2017 Real-Time Control Charts

2021 All Admits Focusboard



Live Births	Inborn Admission Percent	NICU Admissions	CPQCC Small Babies	CPQCC Big Babies
28,217	10.35 %	3,307	506	569

Acute Transports-In	TRIPS @ NICU Admit	TRIPS Change Eval to NICU Admit	Out-the-Door Time [AcTrsIn]	With at least 1 Major Surgery
249	9.91	0.13	1 Hour 7 Minutes	126

VON Small Babies

Survival w/out Major Morbidity	Growth Velocity	Median PMA at Home Discharge	ANS (JC) Treatment	ROP Exam at Appropriate PMA
63.78 %	13.50	38 Weeks / 1 Day	99.64 %	97.47 %

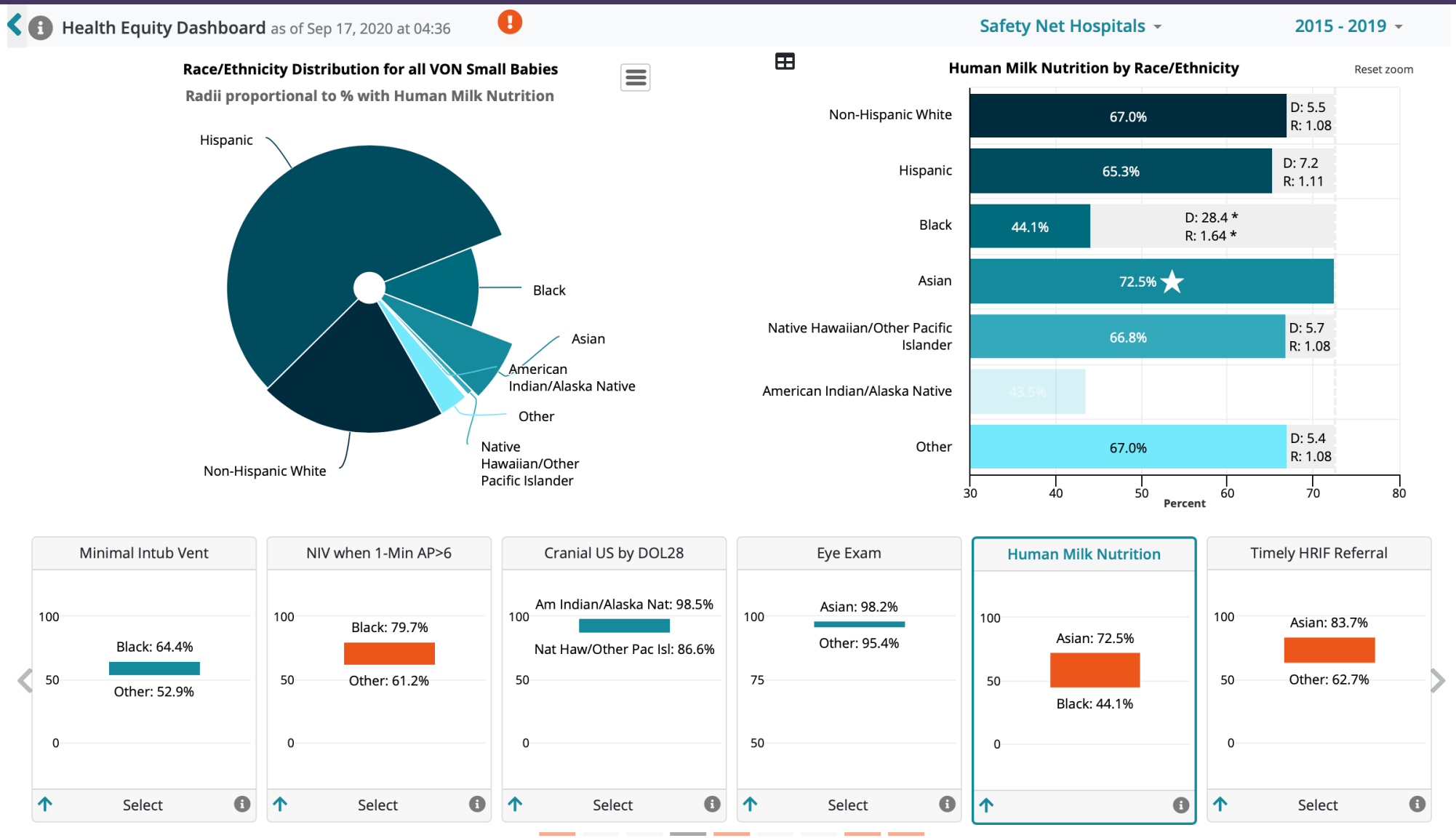
Chronic Lung Disease	NEC	Home on Human Milk Nutrition	Normothermic
24.09 %	3.08 %	76.05 %	70.34 %

Big Babies

Early Sepsis	Moderate/Severe HIE	Active Therap. Hypothermia Volume	High Acuity
0.11 ‰	1.44 ‰	67	82.95 %

Infection Control

CPQCC EQUITY DASHBOARD



Stanford MEDICINE

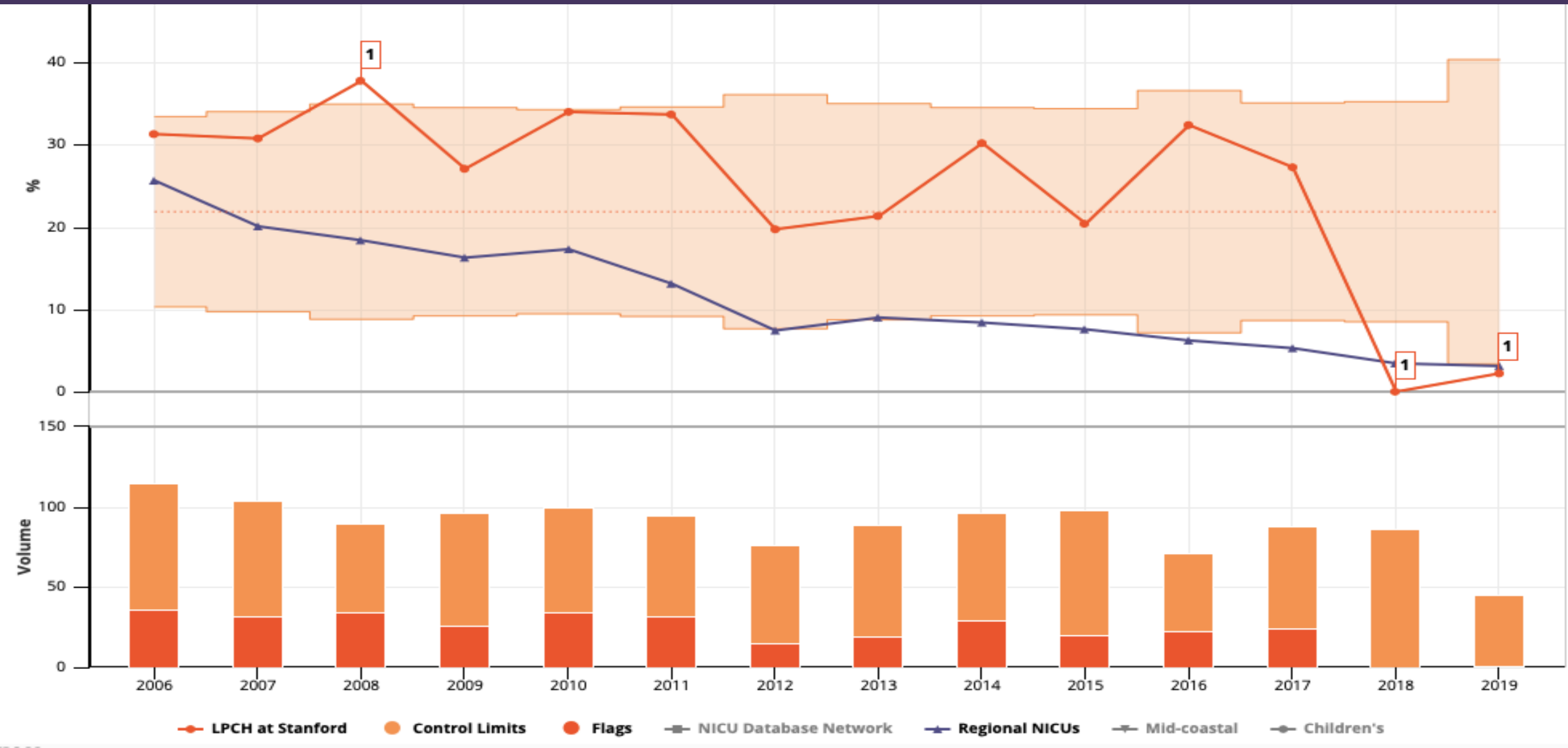
california perinatal quality care collaborative

cpqcc

Hypothermic Newborns (Body temperature at NICU admission <36°C)

Inborn Infants 401 to 1500 grams or 22 to 29 Completed Weeks Gestation Born in 2006-2019

CPQCC SPC CHARTS



All NICU Admissions Database 2023

1

CPQCC/VON Data Set

CPQCC/VON high-risk infants comprise 30% CA NICU admissions.

2

QI for other 70%?

CCS requests minimal data collection for low acuity babies – in CPQCC All NICU Admissions database.

3

Diagnoses and Data

For both high and low risk infants, we can quantify discharge diagnosis info in terms of number, ranking, average length of stay, total work days.

4

CCS Report

CPQCC can submit data on low acuity infants as part of new CCS reporting mandate.

376

*NICU Admits of Infants born in 2022 **

Top 3 Problems during NICU Stay

The All NICU Admits DB for Demo Center used for this focusboard includes birth dates through 12/31/2021.
* New and continuing care NICU admits included.

Explore charts of inborn or lower acuity inborn NICU admits over time ... Go

Explore charts of inborn or lower acuity inborn NICU admits by birth year ... Go

Explore heat maps of admit reasons by birth weight or gestational age, source, acuity and birth year ... Go

Explore daily occupancy charts ... Go

Explore summary tables of admit reasons or of problems during the NICU stay for NICU admits by source, acuity and year of birth ... Go

Explore summary tables of NICU admits by source, acuity, birth weight and year of birth ... Go

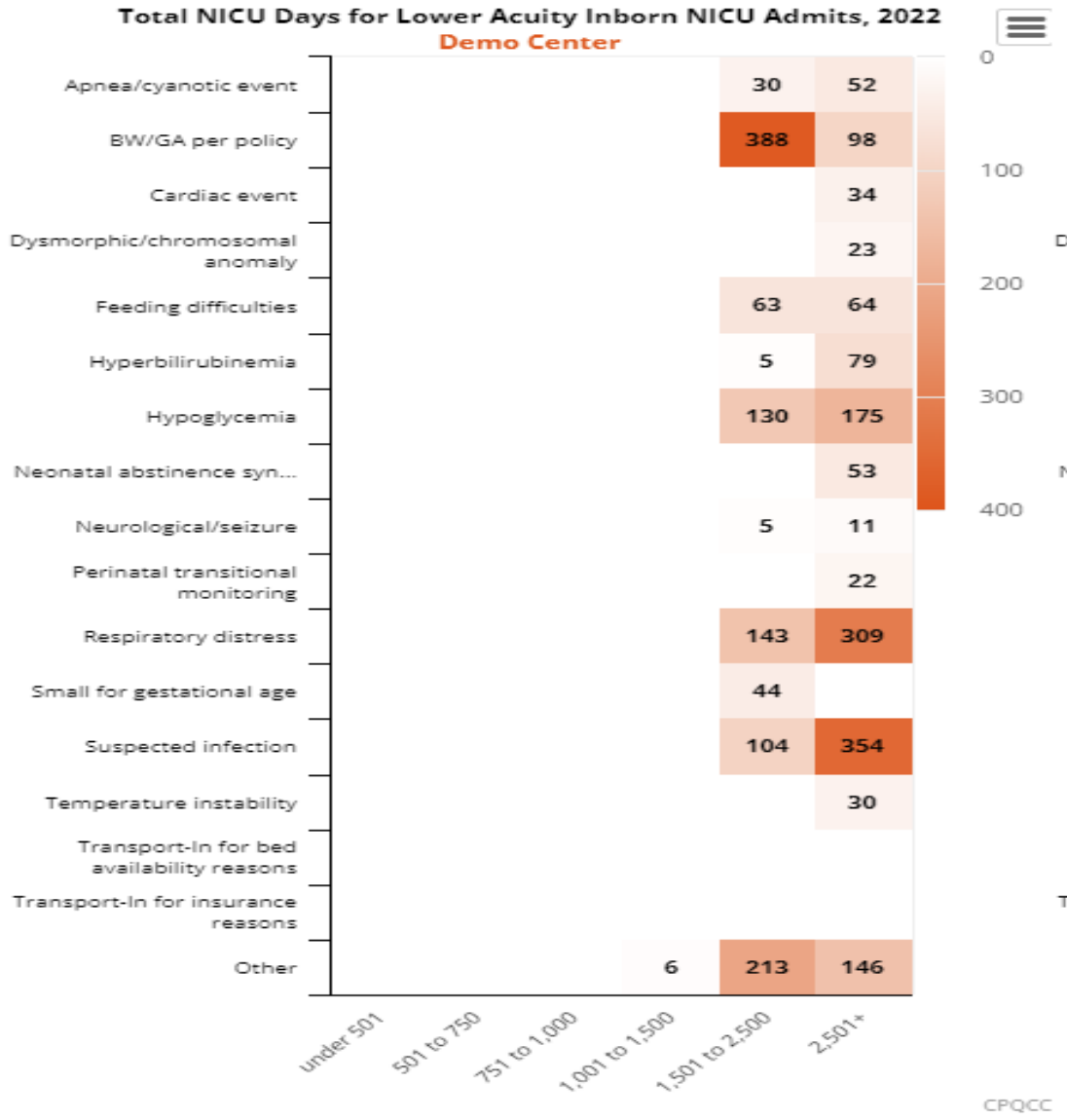
Explore summary tables of NICU admits by source, acuity, gestational age and year of birth ... Go

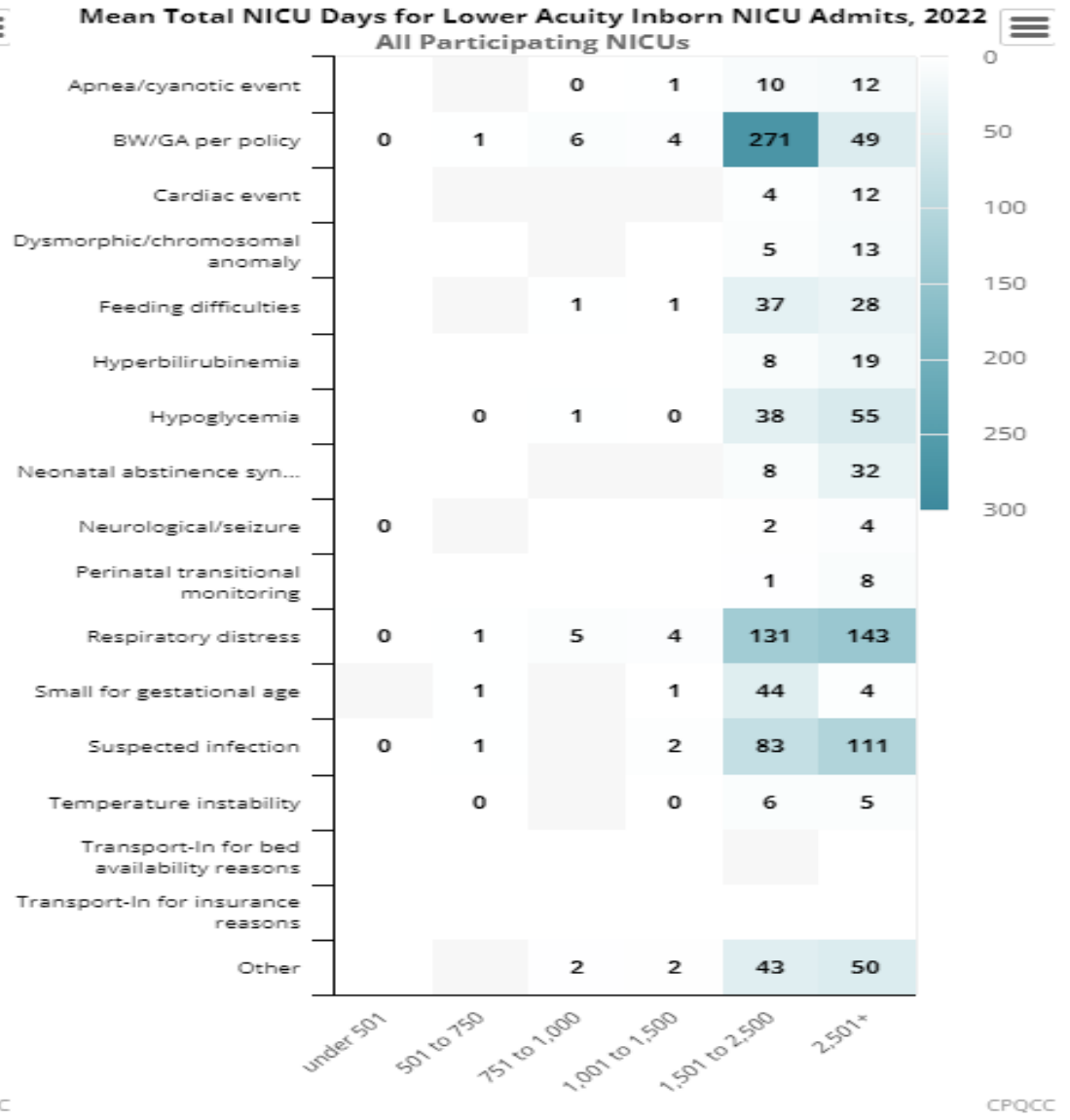
ANAD Reporting

Admission Reasons ▾ | 2022 ▾ | Lower Acuity Inborn NICU Admits ▾

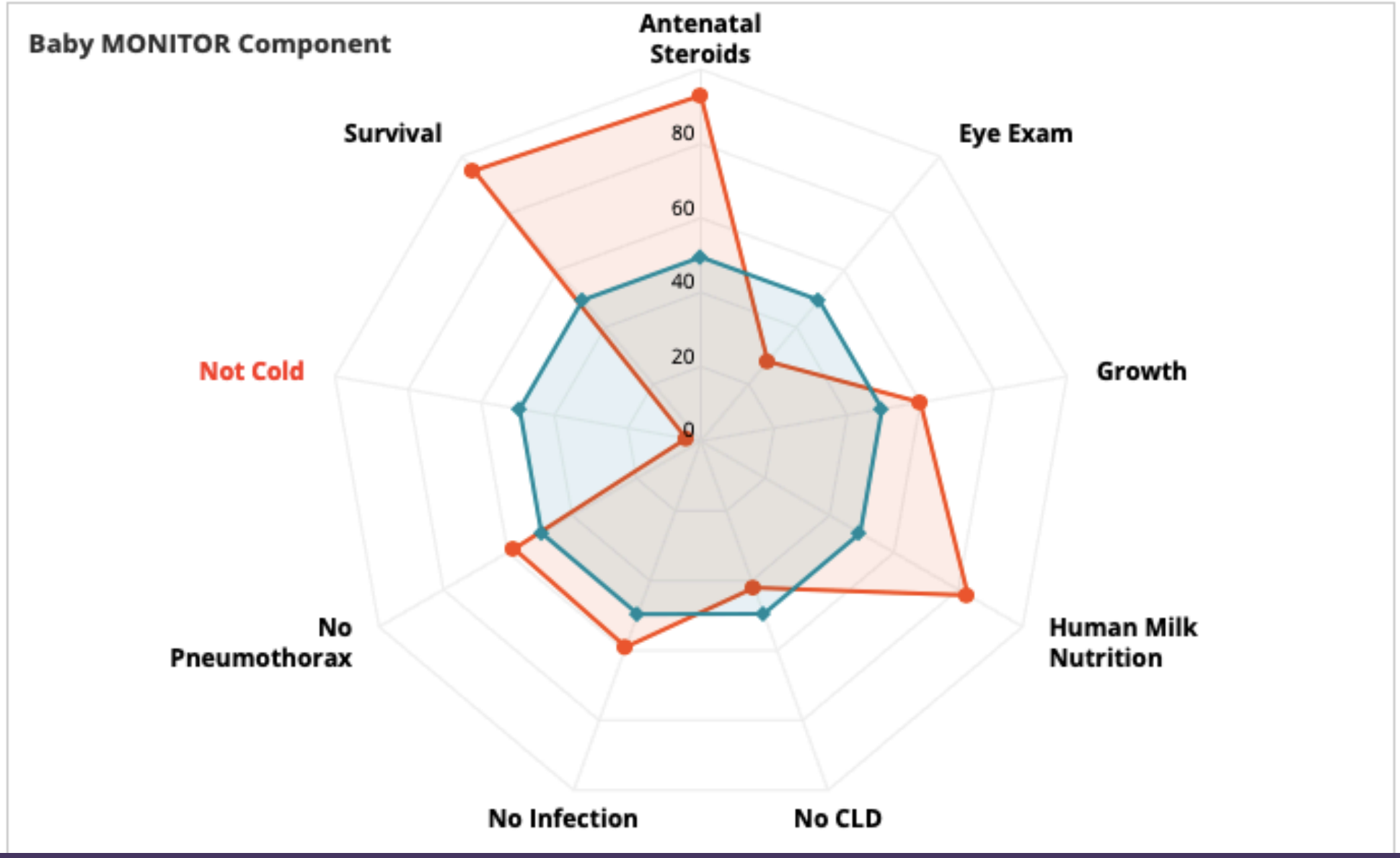
	Demo Center (N=183)						All Participating NICUs (N=7,458) ▾					
Admission Reason	N	%	N w/ LOS	Mean LOS	Min LOS	Max LOS	Mean N	%	Mean N w/ LOS	Mean LOS	Min LOS	Max LOS
Suspected infection	62	33.9	59	7.8	1	30	23	28.6	21.4	9.2	1	73
Respiratory distress	59	32.2	57	7.9	1	30	32.1	40.1	30	9.5	1	117
Hypoglycemia	40	21.9	39	7.8	1	30	11.8	14.7	11.1	8.4	1	71
BW/GA per policy	36	19.7	31	15.7	2	30	25.3	31.5	22.3	14.9	1	117
Hyperbilirubinemia	14	7.7	14	6.0	2	13	4.1	5.1	4	6.7	1	74
Feeding difficulties	12	6.6	12	10.6	2	27	6.2	7.7	5.9	11.2	1	61
Cardiac event	10	5.5	10	3.4	1	6	2.4	3.0	2.3	6.8	1	46
Apnea/cyanotic event	6	3.3	6	13.7	2	30	2.5	3.1	2.4	9.6	1	62
Neonatal abstinence syndrome, exposure to drugs/alcohol	6	3.3	6	8.8	2	23	3.1	3.8	2.9	13.8	1	74
Small for gestational age	6	3.3	6	7.3	2	16	4.6	5.7	4.3	11.5	1	73
Dysmorphic/chromosomal anomaly	5	2.7	5	4.6	2	11	2.1	2.7	1.9	9.2	1	44
Perinatal transitional monitoring	5	2.7	5	4.4	1	9	1.9	2.4	1.9	5.0	1	39
Neurological/seizure	5	2.7	5	3.2	1	5	1.1	1.4	1	5.5	1	36
Temperature instability	1	0.5	1	30.0	30	30	1.8	2.3	1.8	6.6	1	39
Transport-In for insurance reasons	0		0				0		0			
Transport-In for bed availability reasons	0		0				0	0.1	0	3.0	3	3
Other	45	24.6	43	8.5	1	46	13.4	16.7	12.3	7.9	1	100

Admission Reasons ▾ | 2022 ▾ | Lower Acuity Inborn NICU Admits ▾ | Total NICU Days ▾ | By Birth Weight ▾ | All Participating NICUs ▾





Demo NICU: Composite Score: 69

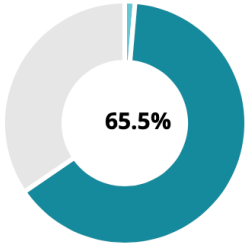


CPQCC BABY-MONITOR

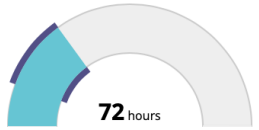
Focusboards: Family Centered Care

Family Centered Care (FCC) Focusboard, Demo Center, Birth Year 2021 or Later as of Sep 27, 2023 at 06:07 Tour

Priming with Oral Colostrum at this NICU



Percent with Oral Colostrum



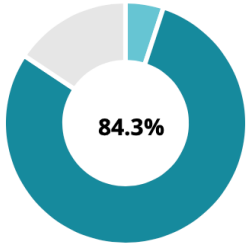
Median Hours to Oral Colostrum

The practice of priming with oral colostrum confers benefits to VLBW infants and signals NICU culture and commitment to use of mother's milk for nutrition.

The percent and median shown are based on all inborn infants who were hospitalized at your hospital for at least 48 hours, who did not have anomalies affecting the ability to prime with oral colostrum, and who were not exposed to maternal substance use during fetal life.

Explore this topic ... Go

Skin-to-Skin at this NICU



Percent with Skin-To-Skin

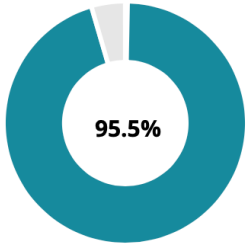
Median Days to Skin-To-Skin

Skin-to-skin care is protective against a variety of adverse neonatal outcomes. SKS requires holding of the infant by a family member. Positive touch is not counted. Infants that are transferred are included.

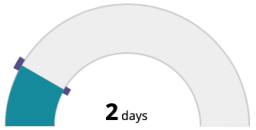
The percent and median shown are based on all inborn infants, who were hospitalized at your hospital for at least 5 days, and who did not have anomalies affecting the ability to provide skin-to-skin admitted to your NICU, and who never experienced high frequency ventilation.

Explore this topic ... Go

Social Worker Visit at this NICU



Percent with Social Worker Visit



Median Days to First Social Worker Visit

Timely social worker assessment is critical to identifying psychosocial and material needs of NICU families and to connect families to appropriate supportive services. Timely social worker contact, within 2 days of NICU admission, is also mandated by CCS regulations in California. The goal of this measure is to examine whether the needs of families are being assessed in a timely manner and to identify opportunities for improvement.

The percent and median shown are based on all inborn and outborn infants who were hospitalized for at least 3 days.

Explore this topic ... Go

What about our 7000 high risk neonatal transports?

2007

CORE CPETS ACUTE INTER-FACILITY- NEONATAL TRANSPORT FORM

REFERRAL		
C.1 Transport type ☐ Requested Delivery Attendance ☐ Emergent ☐ Urgent ☐ Scheduled ☐ Other **C.2** Indication ☐ Medical Services ☐ Surgery ☐ Insurance ☐ Bed Availability		
PATIENT IDENTIFICATION/HISTORY:		
C.3 Birth weight ___ ___ ___ ___ grams **C.4** Gestational Age ___ ___weeks____ days **C.5** ☐ Male ☐ Female ☐ Unknown		
C.6 Prenatally Diagnosed Congenital Anomalies ☐ Yes ☐ No ☐ Unknown Describe:		
C.7 Maternal Gravida **C. 8** Steroids ☐ Yes ☐ No ☐ Unknown		
C.9 Surfactant Given ☐ Yes ☐ No ☐ Unknown ☐ Delivery Room ☐ Nursery		
TIME SEQUENCE	**Date**	**Time**
C.10 Maternal Admission to Perinatal Unit or Labor & Delivery		at
C.11 Last Antenatal Steroid Administration (last dose)		at
C.12 Infant Birth		at
C.13 Surfactant (first dose)		at
C.14 Referral (and Referring Hospital Evaluation)		at
C.15 Acceptance		at
C.16 Transport Team Departure from Transport Team Office/NICU for Referring Hospital		at
C.17 Arrival of Team at Referring Hospital/Patient Bedside and Initial Transport Evaluation		at
C.18 Initial Transport Team Evaluation		at
C.19 Arrival at Receiving NICU and Initial Evaluation		at

California Perinatal Transport System (CPeTS)

- **Underutilization of maternal transport**
  - Percentage of births that were transferred
- **Delayed decision to transport infant**
  - Birth to initiation of transport interval
- **Difficult to obtain transport**
  - Initiation of transport to acceptance interval
- **Too long a wait for the team to arrive**
  - Acceptance to out the door time
- **Team competency not always optimal**
  - Arrival to completion change in clinical status

CPQCC
HRIF

HRIF Visits: Number and Timing

- Provides for **3 "standard" or core visits**
  - #1 – 4 - 8 months
  - #2 – 12 - 16 months
  - #3 – 18 - 36 months
  - Additional visits covered by CCS as determined to be needed by HRIF team
- There is **no financial eligibility requirement** for HRIF services if the patient is medically-eligible.

- HRIF Health Equity Dashboard
- COVID tele-medicine protocols
- COVID Family Impact Study

Resource and Service Use After Discharge Among Infants <26 weeks EGA at the first High Risk Infant Follow-Up (HRIF) Visit in California

Vidya V. Pai, MD[1]; Tianyao Lu, MS[2]; Erika Gray, BA[2]; Susan R. Hintz, MD[2, 3]

1. East Bay Newborn Specialists, UCSF Benioff Children's Hospital Oakland. 2. Stanford University School of Medicine 3. Division of Neonatal and Developmental Medicine

HRIF HIGH RISK INFANT FOLLOW-UP

BACKGROUND

- Little is known about resource use among extremely premature infants in the early months after discharge
- Understanding post-discharge functional and medical outcomes including service utilization can aid in appropriately counseling families and caring for these infants after discharge

AIM

- Among infants born 22+0 to 25+6/7 weeks in California between 2010-2017 and attending the 1st HRIF visit, examine medical and functional outcomes, medical service (MS) and special service (SS) use after discharge

METHODS

- Retrospective analysis of population-based cohort
- Linked California Perinatal Quality Care Collaborative (CPQCC) and CPQCC-California Children's Services HRIF databases include >95% of VLBW infants and contain longitudinal data from NICU admission to HRIF visits
- Evaluated rates of hospitalization, surgeries, medications, equipment, MS and SS use and referrals at the first HRIF visit
- Multivariable logistic regression used to examine factors associated with receiving 2+ MS and 1+ SS
  - Final model included variables found to be significant in univariate analyses and individual models that evaluated maternal factors and infant factors (variables included in the final model are shown)

RESULTS

- 5284/9213 survived to discharge home
  - 3941/5284 received a HRIF visit by 12mo corrected age
- Earlier GA infants had greater use of medications, equipment (Fig 1), MS and SS use and referral (Table 1)
- Maternal, infant and NICU characteristics were associated with high medical service (Table 2) and special service use (Table 3)

CONCLUSIONS

- Extraordinarily premature infants have substantial medical and resource use after discharge
- Increased MS and SS utilization were associated with maternal and sociodemographic factors, in addition to expected clinical factors
- Early functional and service use information is extremely valuable to parents and underscores the need for NICU providers to appropriately prepare and refer families

RESULTS

TABLE 1. RATES OF MEDICAL AND SPECIAL SERVICES USE AND REFERRALS

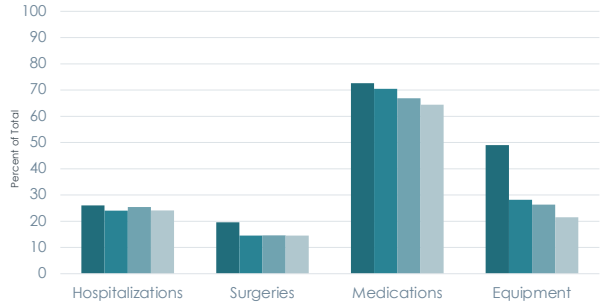
	22 weeks EGA (N=51)	23 weeks EGA (N=532)	24 weeks EGA (N=1470)	25 weeks EGA (N=1888)
Receiving medical services*				
None	8 (15.7%)	79 (14.9%)	299 (20.3%)	437 (23.2%)
1	10 (19.6%)	100 (18.8%)	351 (23.9%)	523 (27.7%)
2+	**33 (64.7%)**	**353 (66.4%)**	**820 (55.8%)**	**928 (49.2%)**
Receiving special services*				
None	19 (37.3%)	221 (41.5%)	671 (45.7%)	933 (49.4%)
1+	**32 (62.8%)**	**311 (58.5%)**	**799 (54.4%)**	**955 (50.6%)**
Referral made to medical services at HRIF visit				
Yes	**13 (27.5%)**	**83 (15.6%)**	**189 (12.9%)**	**235 (12.5%)**
No	37 (72.6%)	449 (84.4%)	1281 (87.1%)	1653 (87.5%)
Referral made to special services at HRIF visit				
Yes	**24 (47.1%)**	**194 (36.5%)**	**518 (35.2%)**	**609 (32.3%)**
No	27 (52.9%)	338 (63.5%)	952 (64.8%)	1279 (67.7%)

*Medical services include any medical subspecialty (e.g. Cardiology, Ophthalmology, Pulmonology, Neurology). Special services include services for development, occupational therapy, physical therapy, speech, hearing, behavior, feeding, nutrition, nursing, social work.

TABLE 2. ASSOCIATION OF FACTORS WITH RECEIVING 2+ MEDICAL SERVICES BY THE FIRST HRIF VISIT

	Number of Medical Services		
	1 or fewer (N=1807)	2 or more (N=2134)	Adjusted OR (95% CI)
Maternal/Sociodemographic Characteristics			
Maternal race			
Non-hispanic white	367/1797 (20.4%)	486/2126 (22.9%)	ref
Hispanic white	927/1797 (51.6%)	1004/2126 (47.2%)	0.91 (0.75, 1.10)
Black	295/1797 (16.4%)	289/2126 (13.6%)	**0.75 (0.59, 0.96)**
Asian/Pacific Islander	176/1797 (9.8%)	292/2126 (13.7%)	1.14 (0.88, 1.47)
Other	32/1797 (1.8%)	55/2126 (2.6%)	1.32 (0.78, 2.22)
Maternal age			
<20 years	142/1806 (7.9%)	97/2131 (4.6%)	**0.58 (0.42, 0.80)**
20-29	771/1806 (42.7%)	935/2131 (43.9%)	ref
30-39	790/1806 (43.7%)	974/2131 (45.7%)	0.91 (0.78, 1.06)
>40	103/1806 (5.7%)	125/2131 (5.9%)	0.83 (0.61, 1.14)
Maternal education			
Less than high school	387/1708 (22.7%)	345/2027 (17.0%)	0.84 (0.70, 1.02)
High school/GED or some college	907/1708 (53.1%)	1030/2027 (50.8%)	ref
College or graduate degree	395/1708 (23.1%)	635/2027 (31.3%)	**1.33 (1.11, 1.60)**
Unknown	19/1708 (1.1%)	17/2027 (0.8%)	0.61 (0.29, 1.28)
Caregiver concern			
Yes	587/1800 (32.6%)	969/2119 (45.7%)	**1.61 (1.41, 1.89)**
No	1213/1800 (67.4%)	1150/2119 (54.3%)	ref
Infant/Clinical Characteristics			
Sex			
Female	948/1807 (52.5%)	957/2134 (44.9%)	**0.77 (0.67, 0.89)**
Male	859/1807 (47.5%)	1177/2134 (55.2%)	ref
Major morbidity			
Yes	1116/1807 (61.8)	1555/2134 (72.9%)	**1.54 (1.32, 1.79)**
No	691/1807 (38.2%)	579/2134 (27.1%)	ref
Any surgery during NICU stay			
Yes	796/1804 (44.1%)	1350/2130 (63.4%)	**1.69 (1.47, 1.96)**
No	1008/1804 (55.9%)	780/2130 (36.6%)	ref
Discharging NICU Characteristics			
CCS level			
Regional	631/1764 (35.8%)	1214/2063 (58.9%)	ref
Community	1118/1764 (63.4%)	842/2063 (40.8%)	**0.40 (0.35, 0.47)**
Intermediate/Non-CCS	15/1764 (0.9%)	7/2063 (0.3%)	**0.23 (0.09, 0.63)**

FIGURE 1. RATES OF HOSPITALIZATIONS, SURGERIES, MEDICATION AND EQUIPMENT USE



*Medications included anti-reflux, bronchodilators, dietary supplements, oxygen, synagis, diuretics, steroids, other Equipment included supplies for enteral feeding, tracheostomy or ventilator, ostomy, nebulizers, other

TABLE 3. ASSOCIATION OF FACTORS WITH RECEIVING 1+ SPECIAL SERVICES BY THE FIRST HRIF VISIT

	Number of Special Services		
	None (N=1844)	1 or more (N=2097)	Adjusted OR (95% CI)
Maternal/Sociodemographic Characteristics			
Primary language			
English	1370/1834 (74.7%)	1544/2091 (73.8%)	0.92 (0.71, 1.20)
Spanish	342/1834 (18.7%)	396/2091 (18.9%)	1.18 (0.87, 1.60)
Other	122/1834 (6.7%)	151/2091 (7.2%)	ref
Maternal education			
Less than high school	382/1743 (21.9%)	350/1992 (17.6%)	**0.81 (0.67, 0.98)**
High school/GED or some college	942/1743 (54.0%)	995/1992 (50.0%)	ref
College or graduate degree	401/1743 (23.0%)	629/1992 (31.6%)	**1.42 (1.21, 1.67)**
Unknown	18/1743 (1.0%)	18/1992 (0.9%)	1.07 (0.50, 2.29)
Caregiver concern			
Yes	596/1827 (32.6%)	960/2092 (45.9%)	**1.69 (1.47, 1.96)**
No	1231/1827 (67.4%)	1132/2092 (54.1%)	ref
Infant/Clinical Characteristics			
Multiple birth			
Yes	368/1844 (80.0%)	512/2097 (75.6%)	**1.22 (1.03, 1.22)**
No	1476/1844 (20.0%)	1585/2097 (24.4%)	Ref
Major morbidity			
Yes	1200/1844 (65.1%)	1471/2097 (70.2%)	**1.18 (1.02, 1.37)**
No	644/1844 (34.9%)	626/2097 (29.8%)	ref
Any surgery during NICU stay			
Yes	933/1841 (50.7%)	1213/2093 (58.0%)	**1.23 (1.08, 1.43)**
No	908/1841 (49.3%)	880/2093 (42.0%)	ref
Discharging NICU Characteristics			
CCS level			
Regional	909/1802 (50.4%)	936/2025 (46.2%)	ref
Community	883/1802 (49.0%	1077/2025 (53.2%)	**1.28 (1.11, 1.47)**
Intermediate/Non-CCS	10/1802 (0.6%)	12/2025 (0.6%)	1.18 (0.48, 2.90)

cpqcc california perinatal quality care collaborative

Stanford MEDICINE

california perinatal quality care collaborative

Utilization of telehealth in high-risk infant follow up (HRIF) in California during the first months of the COVID pandemic

SR Hintz[1,2] T Lu[1.2] EE Gray[1,2] MA Jocson[3] for the CPQCC CCS HRIF Health Equity and Telehealth Guidance Work Groups

[1]Pediatrics, Stanford University School of Medicine; [2]California Perinatal Quality Care Collaborative (CPQCC); [3]California Department of Heath Care Services

Background

- The COVID pandemic has required rapid adaptations to healthcare delivery.
- HRIF visits have traditionally been in-person, but the pandemic has required expanded approaches.
- Telehealth uptake and factors associated with utilization across a statewide HRIF system in the first months of COVID have not been described.

Objectives

In the California statewide HRIF network, we 1) explored clinic and regional differences in telehealth deployment, and 2) characterized sociodemographic and program-level disparities associated with HRIF visit by telehealth during the first 10 months of the COVID pandemic.

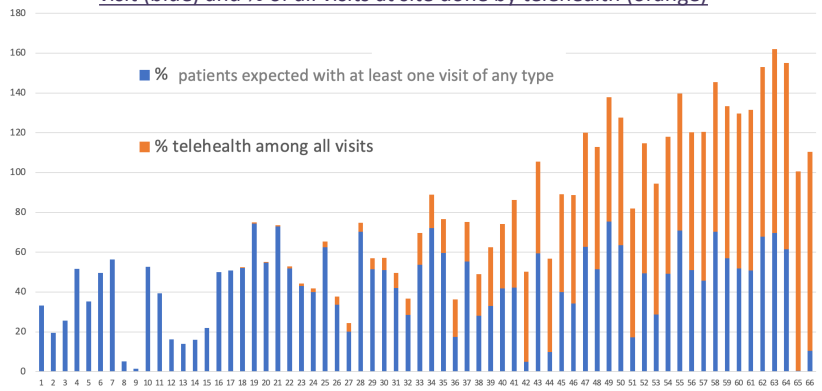
Methods

- The CPQCC is a network of 140+ NICUs, that partners with the California Children's Services (CCS) to lead an integrated, statewide system of HRIF clinics.
- Eligible infants are referred to HRIF at NICU discharge for HRIF visits through 3 years (extended to 42 months due to COVID).
- Queries were added to HRIF data collection in March 2020 to determine if visit was in-person or via telehealth.
- We analyzed HRIF visits completed **4/1/2020 - 1/31/2021** to evaluate HRIF clinic and regional telehealth uptake.
- Multivariable logistic regression was used to examine factors associated with receiving a telehealth.

Results

- Of 10,188 HRIF visits during the study period, 4274 (41.9%) were by telehealth.
- HRIF clinics varied broadly in use of telehealth [**Fig 1**].
- There was substantial regional variation in % of all HRIF visits done by telehealth [**Fig 2**].
- Multivariable analysis demonstrated factors independently associated with receiving telehealth visit [**Table**].

Figure 1. Proportion of patients expected by individual HRIF sites with at least one visit (blue) and % of all visits at site done by telehealth (orange)



Data presented as stacked bar chart. Thus, total may be greater than 100%.

Figure 2. Proportion of all HRIF visits in California regions done by telehealth by month

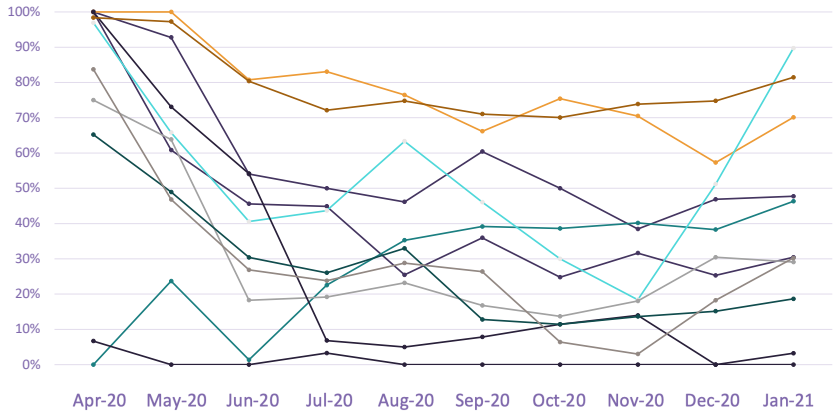


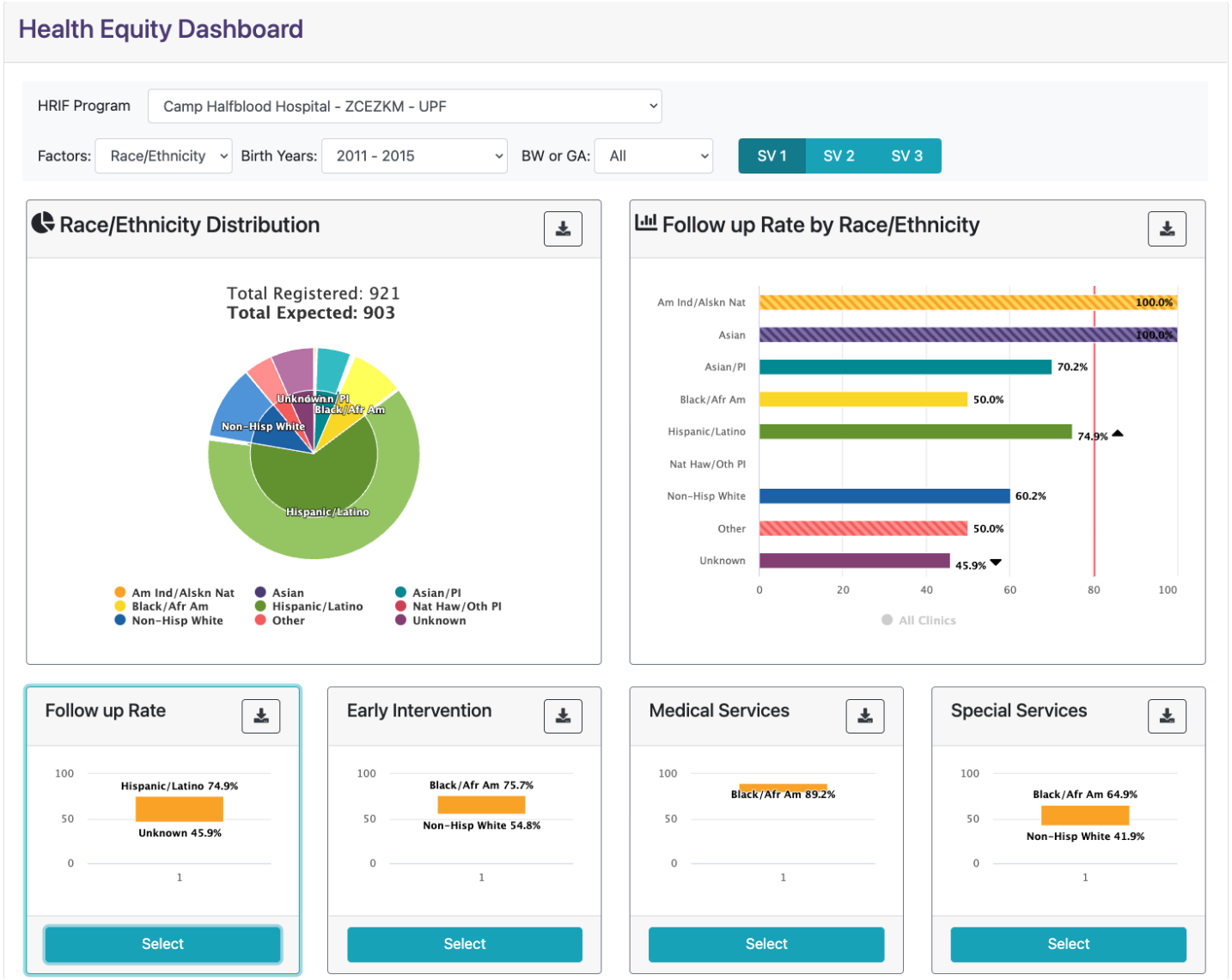
Table. Results of multivariable logistic regression analysis for receiving a telehealth visit among those with any HRIF visits 4/1/2020 to 1/31/2021

Variable		Adjusted OR (95% CI) for telehealth visit		
		OR	95% CI	p-value
Estimated gestational age at birth				<0.0001
	< = 26 weeks	0.74	(0.64, 0.86)	
	27 – 30 weeks	0.83	(0.75, 0.92)	
	> = 31 weeks	Reference		
Maternal race	Black	1.23	(1.02, 1.48)	<0.0001
	Hispanic	0.81	(0.72, 0.92)	
	White	Reference		
	Asian	1.4	(1.19, 1.64)	
	Native American, Other	0.9	(0.69, 1.17)	
Caregiver education	Less than high school	1.32	(1.05, 1.66)	0.00002
	College degree or Graduate degree	1.11	(0.95, 1.28)	
	Unknown or Other	1.33	(1.16, 1.52)	
	High school GED or Some college	Reference		
Caregiver employment				
	Full-time	Reference		
	Part time, temporary	1.3	(1.05, 1.61)	<0.0001
	Not currently employed	1.28	(1.11, 1.48)	
	Unknown	1.82	(1.58, 2.11)	
Home arrangement	Both parents	0.81	(0.73, 0.9)	0.0002
	Single Parent	Reference		
	Others or relatives	0.97	(0.54, 1.75)	
	Foster/ adopted	0.66	(0.48, 0.91)	
Distance to HRIF Clinic				
	1st quartile (shortest distance)	Reference		
	2nd quartile	0.75	(0.65, 0.87)	<0.0001
	3rd quartile	1.18	(1.03, 1.36)	
	4th quartile	2.0	(1.74, 2.31)	
HRIF clinic volume	1st quartile	0.54	(0.38, 0.76)	<0.0001
	2nd quartile	0.43	(0.36, 0.51)	
	3rd quartile	0.59	(0.52, 0.67)	
	4th quartile (highest volume)	Reference		
Insurance type	HMO/PPO - without-CCS	2.25	(1.72, 2.95)	< 0.0001
	HMO/PPO - with CCS	Reference		
	CCS or MediCal only	1.37	(1.04, 1.8)	
	OTHER including self pay	3.03	(2.13, 4.31)	

Conclusions

- This statewide analysis demonstrated heterogeneity of telehealth use during the first months of COVID. Multiple factors were independently associated with receiving a telehealth visit.
- Findings may be reflective of early challenges in launching telehealth, concerns about care and service with telehealth visits, and differing timelines to reinstituting in-person visits.
- CPQCC-CCS HRIF has developed telehealth guidance and expanded telehealth-validated instrument options **cpqcc.org** → *Follow-Up* → *HRIF Data Resources*

HRIF Health Equity Dashboard (new!)



Continuum of care structure – unique to California!

Neonatal Transport Data

CMQCC Data

All Baby Data
High Risk Data

RPPC Data

HRIF Data

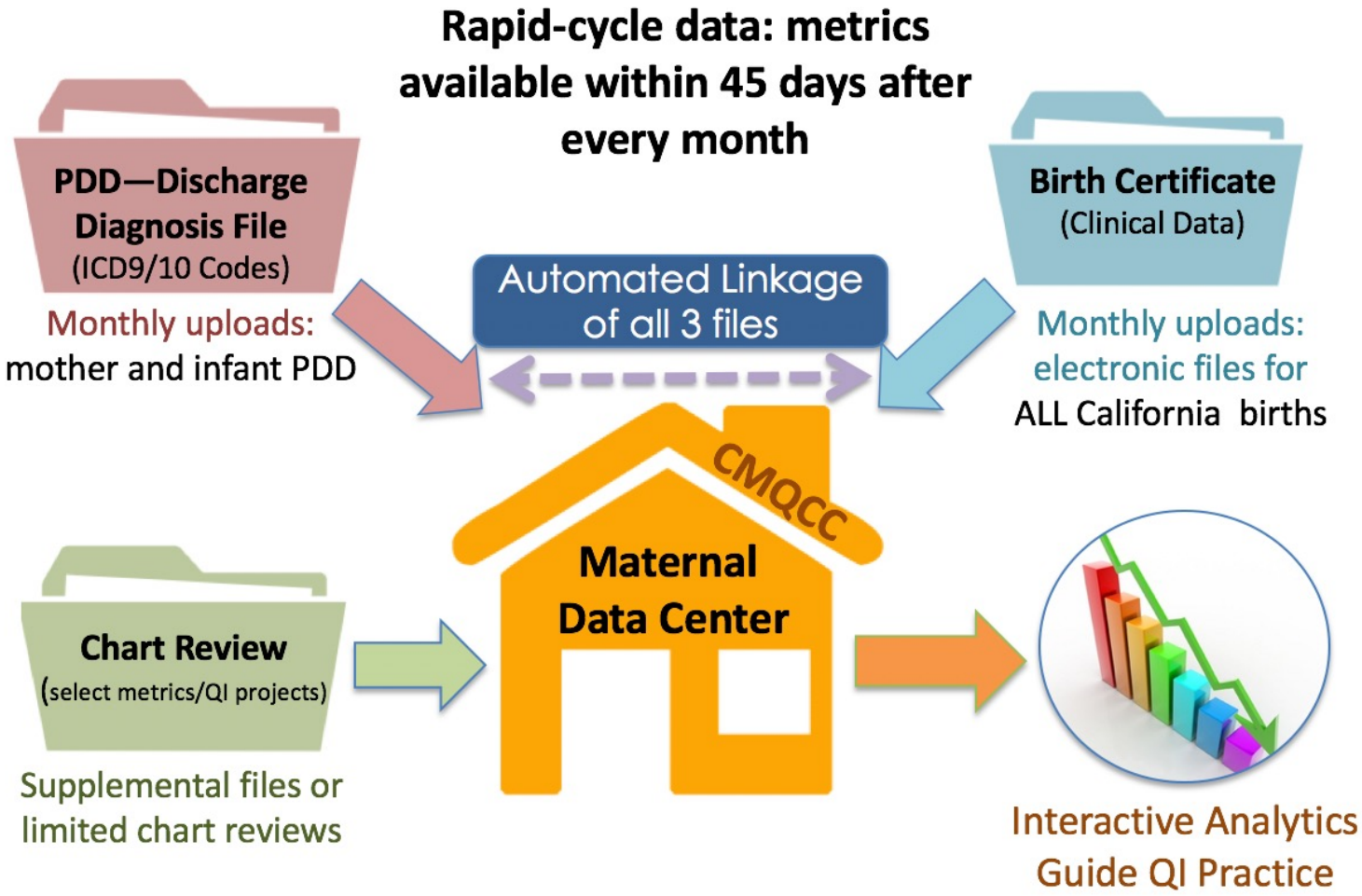
CMQCC Team

California Maternal Quality Care Collaborative (CMQCC)

Mission: End preventable morbidity, mortality and racial disparities in California maternity care.

- Research and maternal mortality review data, recommendations.
- Quality improvement toolkits and collaboratives.
- Innovative Maternal Data Center.

CMQCC Maternal Data Center



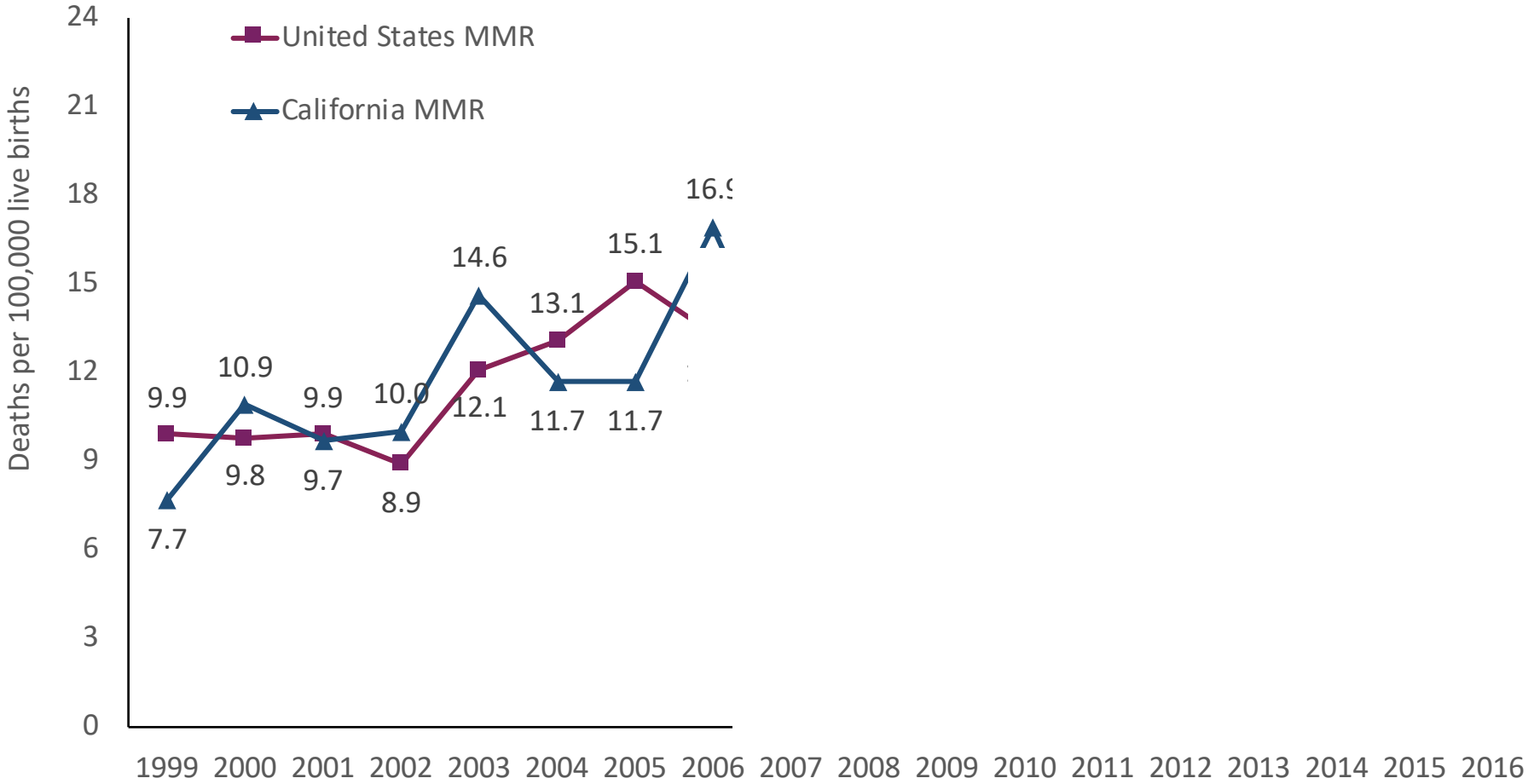
Links over 1,000,000 mother/baby records each year!

CMQCC Quality Improvement Activities

Year	QI Toolkits
2010	Eliminating Early Elective Deliveries
2010	Obstetric Hemorrhage
2014	Preeclampsia
2015	Obstetric Hemorrhage (2nd Ed)
2016	Reducing Primary Cesarean Birth (CHCF funded)
2017	Cardiovascular Disease
2018	Venous Thromboembolism
2019	Maternal Sepsis (CMQCC funded)
2020	Mother-Baby Substance Use (CA DHCS funded) – **joint with CPQCC**
2020	Birth Equity (CHCF funded)
2021	Improving Health Care Response to Hypertensive Disorders of Pregnancy (HDP)
2022	Low-Dose Aspirin Partnership Campaign Pilot

Years	QI Collaboratives
2009-10	CMQCC **Hemorrhage** QI collaboratives I and II
2010-11	CMQCC/CDPH **Preeclampsia** Task Force and QI collaborative
2011-14	HEN/CMQCC/CHA-HQI QI collaborative focused on **hemorrhage and preeclampsia**
2015-16	CMQCC/Merck for Mothers QI collaborative for **hemorrhage and hypertension** severe morbidity
2016-19	CMQCC QI collaboratives (3 cohorts) for Supporting Vaginal Birth and **Reducing Primary Cesarean Delivery**
2018--	CMQCC QI Academies (new multi-hospital cohort every 6 months: **QI science** "work-study")
2019--	**CMQCC/CPQCC/HMA** QI collaboratives (3 cohorts) for Mothers and Babies with Substance Use Disorder (focus on **Opioids**)
2019--	CMQCC **Birth Equity** QI collaborative (Pilot)
2021	Hypertensive Disorders of Pregnancy Task Force
2022	Critical Access Group (CAH)

Figure 1: Maternal Mortality Ratio in U.S. and California, 1999-2016



Maternal mortality ratio (MMR) = Number of maternal deaths per 100,000 live births, up to 42 days after the end of pregnancy. Maternal deaths in California were identified using ICD-10 cause of death classification for obstetric deaths (codes A34, O00-O95, O98-O99) from the California death certificate data (1999-2013) and the California pregnancy status errata file (2014-2016). Data on U.S. maternal deaths are published by the National Center for Health Statistics and found in the CDC WONDER Database for years 2008 or later (accessed at http://wonder.cdc.gov on February 25, 2020).

CA-PMSS Surveillance Report: Pregnancy-Related Deaths in California, 2008-2016. Sacramento: California Department of Public Health, Maternal,

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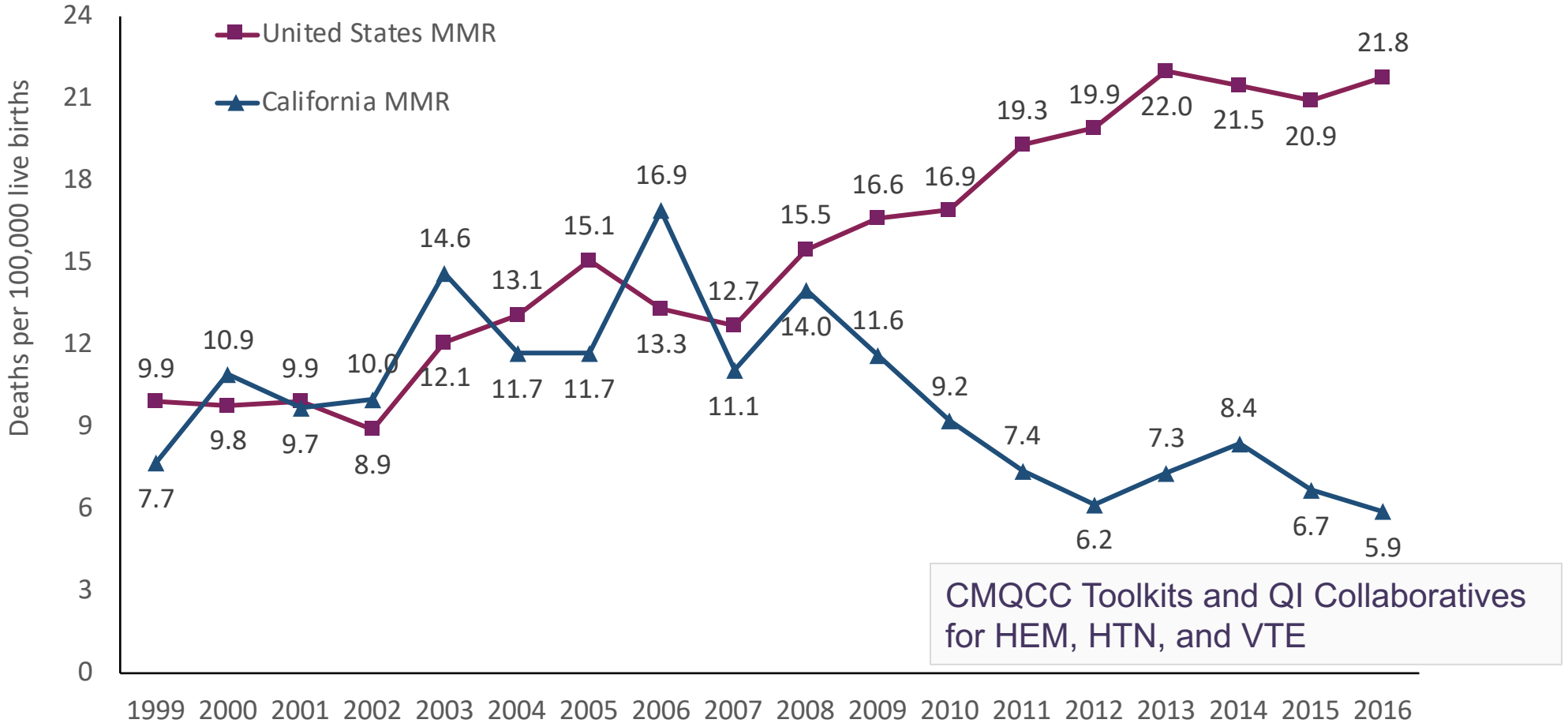

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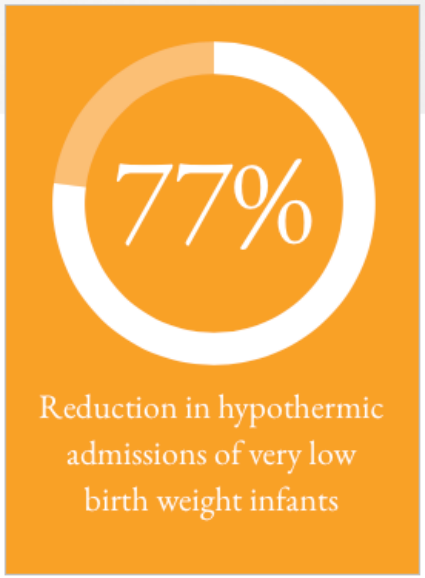
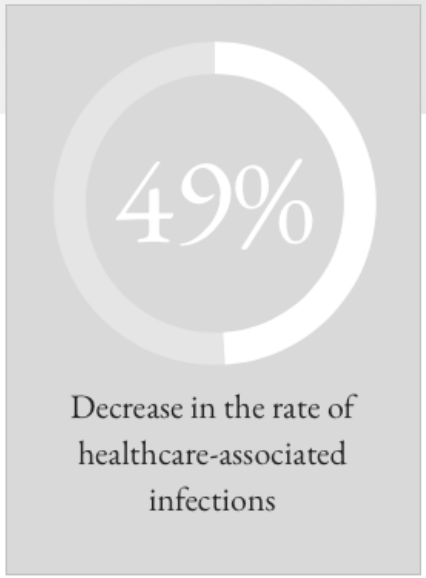
CA-PMSS Surveillance Report: Pregnancy-Related Deaths in California, 2008-2016. Sacramento: California Department of Public Health, Maternal,

Lots of activity but has it made a difference?

Improving the Quality and Equity of Care for California's Most Vulnerable Infants & Their Families





NICU Level Improvement Impact 2008-2017

Member hospitals reduced mortality rates for VLBW infants by

15%

An additional

9%

of babies were discharged without major morbidities like severe ROP, NEC, CLD, and severe IVH

And the rate of Necrotizing enterocolitis (NEC) decreased by

45%

Lee, Liu, Profit, Hintz, Gould.
J Perinatol. 2020 Jul;146(1):e20193865

NICU Level Improvement Impact

2008-2017

Member hospitals reduced severe intraventricular hemorrhage by

19%

36%

fewer infants with severe retinopathy of prematurity (ROP) or ROP surgery

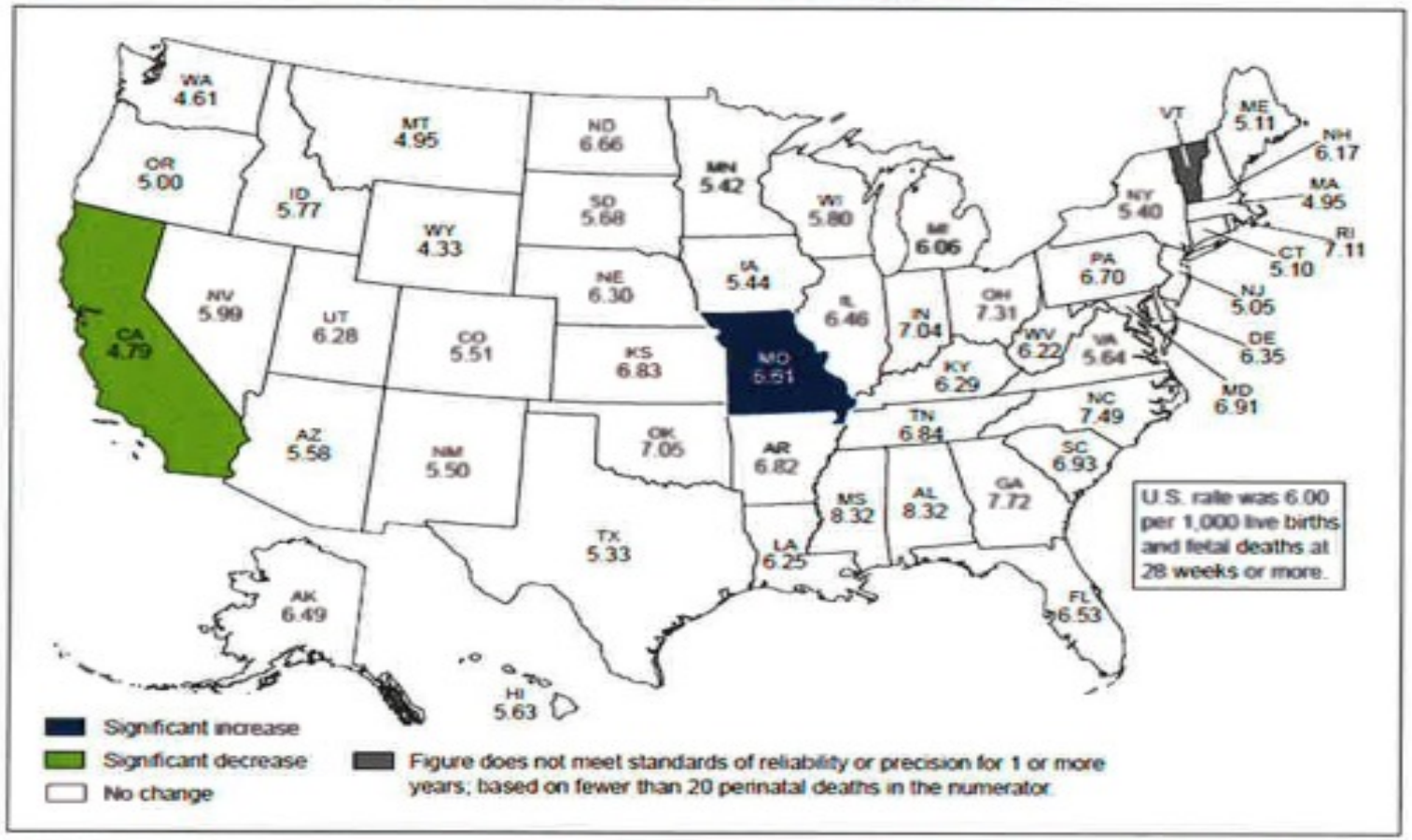
The rate of nosocomial infection declined by

44%

Our Impact

CDC report shows California as the ***only state to significantly decrease perinatal mortality*** between 2014 to 2016.

Figure 4. Perinatal mortality rates by state for 2016 and change in 2016 compared with 2014



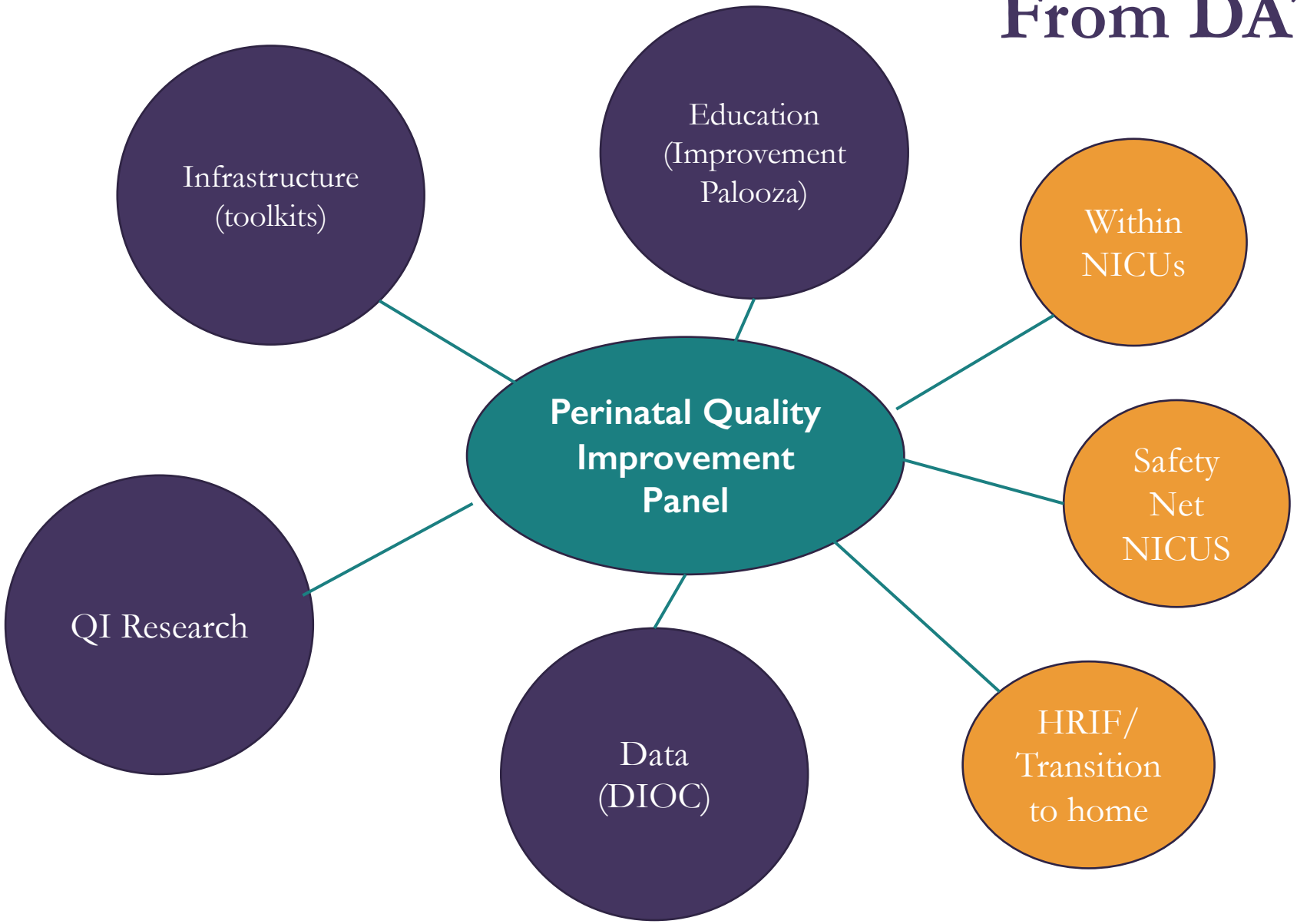
NOTES: Rate per 1,000 live births and fetal deaths at 28 weeks or more. Significant increase or decrease at $p < 0.05$. Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db316_table.pdf#4.
SOURCE: NCHS, National Vital Statistics System.

CPQCC Team

Perinatal Quality Improvement Panel (PQIP)

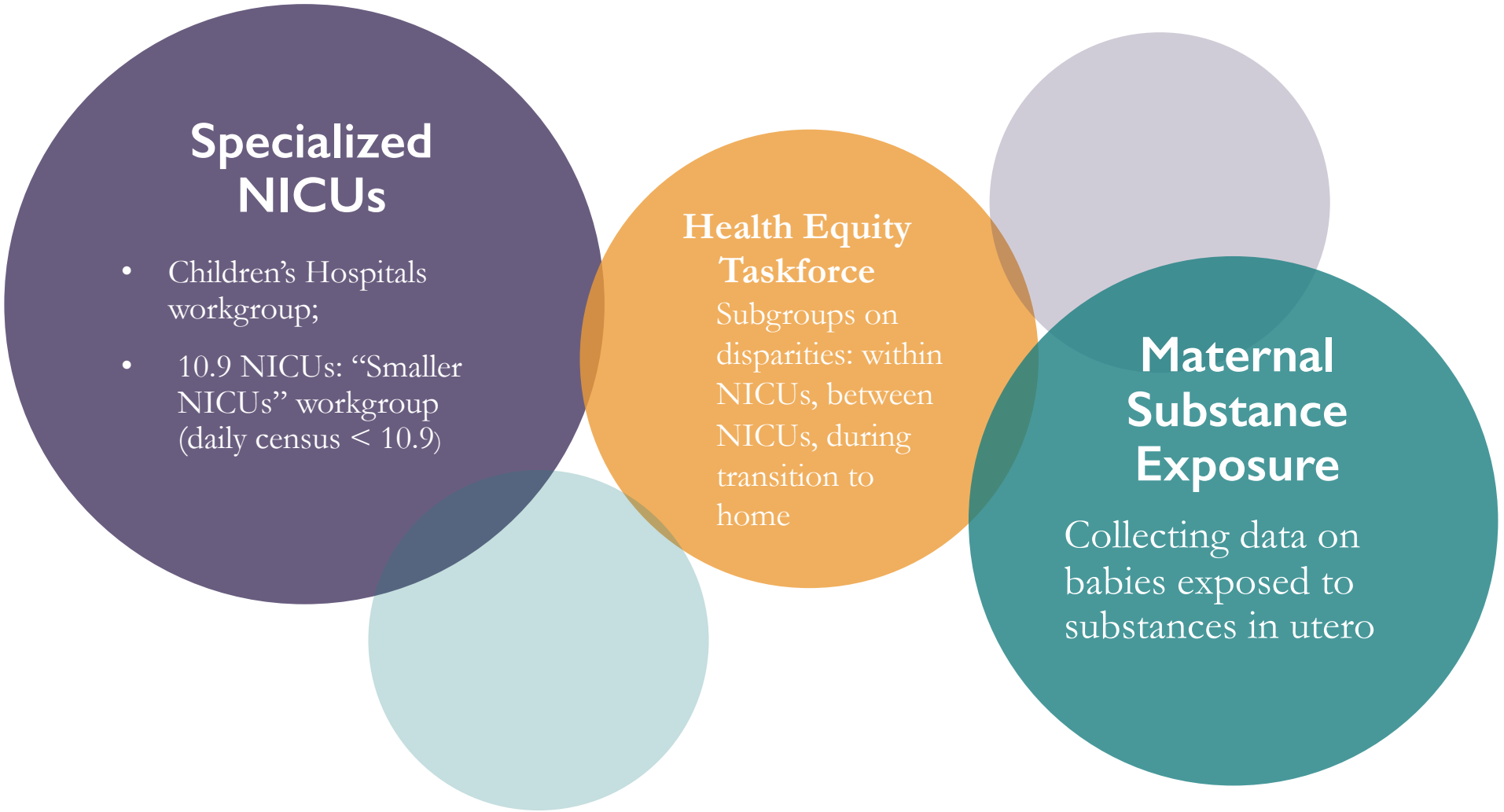
Courtney Breault,
MS, RN, CPHQ

From DATA to Action



Health Equity

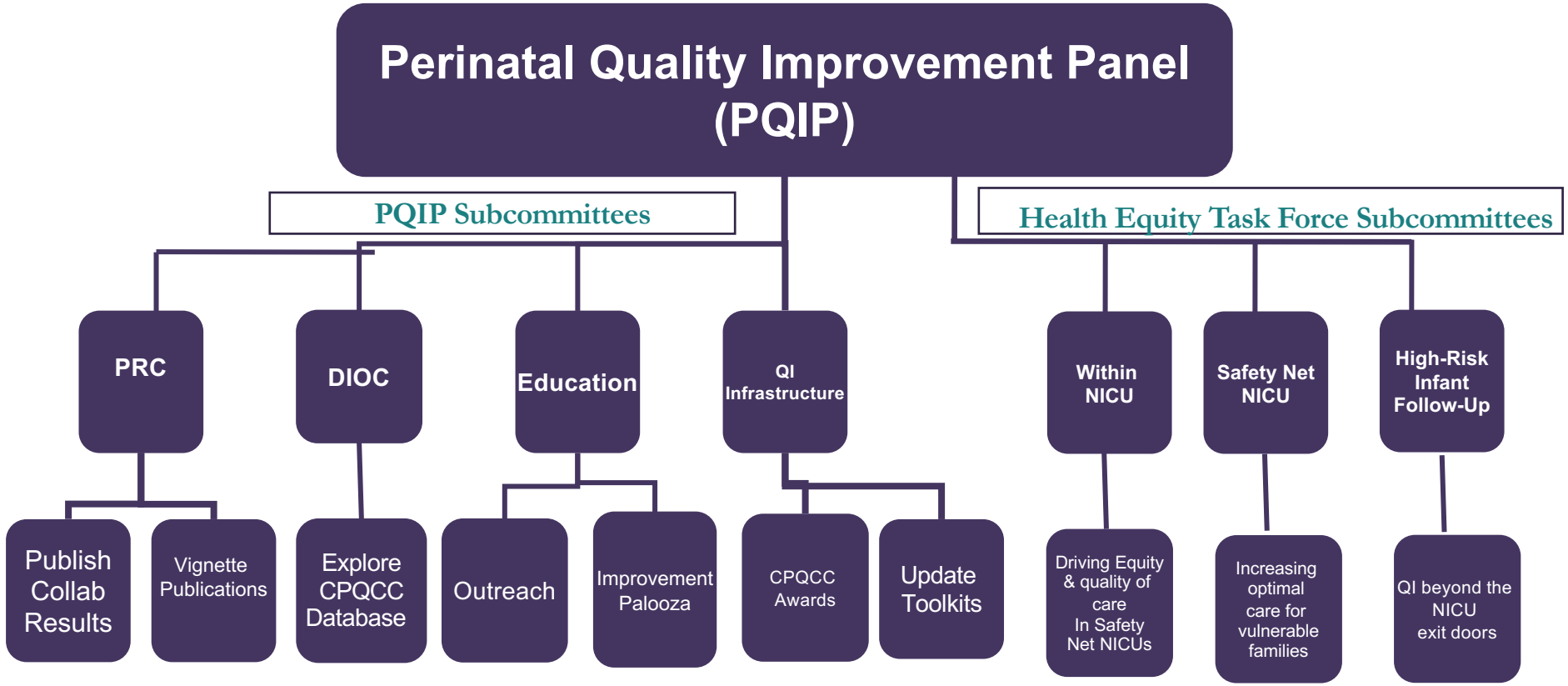
Member-Led Workgroups



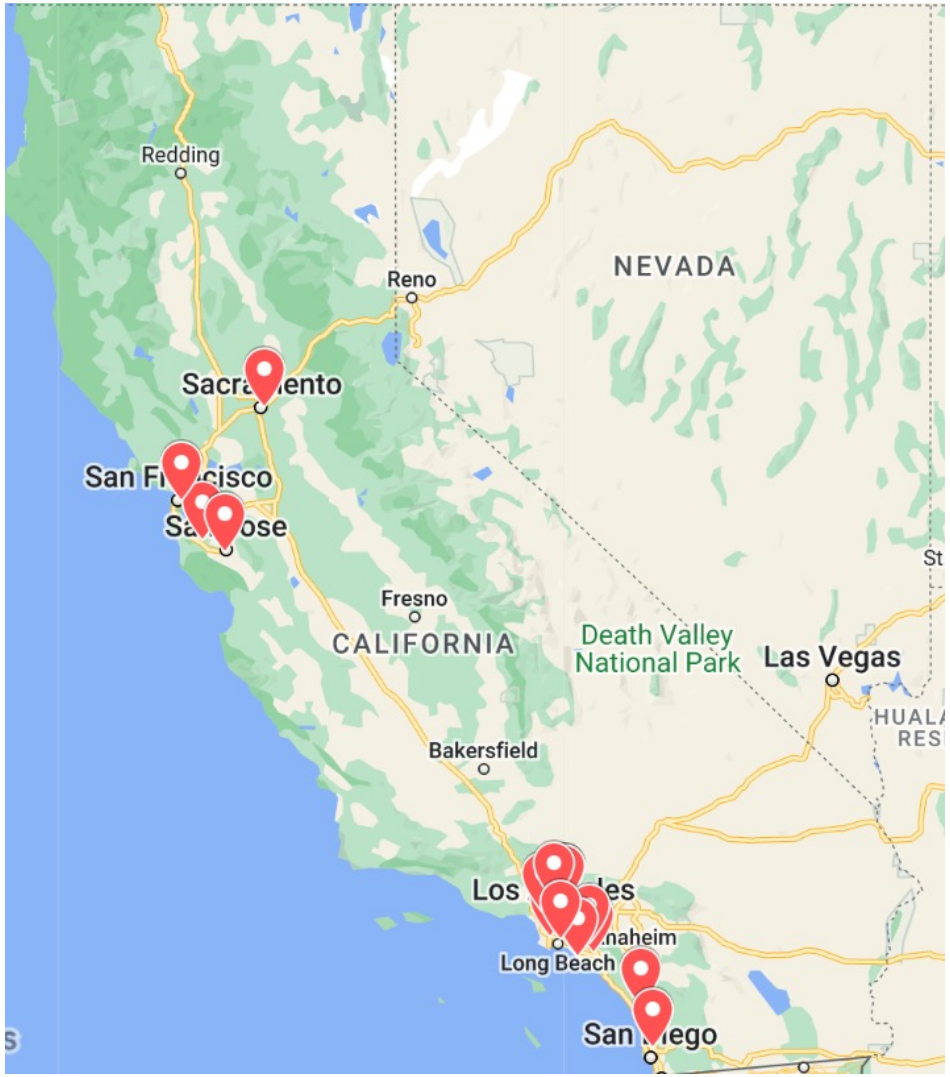
PQIP Structure

12 meetings per year
4 face-to-face meetings and monthly Zooms

PQIP Chair
Courtney Breault, MS,RN Associate Director of Quality



Perinatal Quality Improvement Panel (PQIP)



23 PQIP members

Irfan	Ahmad
Lisa	Bain
David	Braun
Malathi	Balasundaram
Jennifer	Canvasser
Priya	Jegatheesan
Ashwini	Lakshmanan
Maria A. L.	Jocson
Michel	Mikhael
Mindy	Morris
Guadalupe	Padilla-Robb
Kurlen	Payton
Pedro	Paz
William	Rhine,
Elizabeth	Rogers
Joseph	Schulman
Rachelle	Sey
Aida	Simonian
Tony	Soliman

CPQCC Faculty

Jeffrey	Gould
Henry	Lee
Jochen	Profit
Susan	Hintz

CPQCC QI Collaboratives

CPQCC QI Collaboratives

- Designed to help NICUs improve specific areas of care using evidence-based practices.
- We offer large, multi-site "collaborative" projects as well as smaller, more targeted approaches
- Quality improvement collaboratives are open to all CPQCC member hospitals.
- CPQCC leverages the Institute for Healthcare Improvement (IHI) Model for quality improvement.

QI Collaborative Goals:

1. Build practical improvement capacity based on the science of improvement into every CPQCC NICU, healthcare executive, and clinician
2. Drive innovation to dramatically improve performance at all levels of the health care system.

CPQCC Collaboratives Over the Past 15 Years

- Healthcare-Associated Infection (2008-2009): **11 sites**
- Breastmilk Nutrition (2009-2011): **19 sites**
- Delivery Room Management (2011-2012): **24 sites**
- Optimizing Length of Stay (2103 - 2104): **24 sites**
- Antibiotic Stewardship (2016-2017): **29 sites**
- Grow, Babies, Grow! (2018-2020): **25 sites**
- Simulating Success (2018-2020): **12 sites** (plus two out-of-state sites)
- Optimizing Antibiotic Stewardship (OASCN) (2021 - 2023): 31 sites
- Growth Advancement In the NICU (GAIN): Surgical (2021 – 2023): 6 sites
- Growth Advancement In the NICU (GAIN): Ten Point Nine (2021 – 2023): 8 sites
- NEOBrain (2022 – 2024): **26 sites**

CPQCC QI COLLABORATIVES

15 Years of Improvement

Healthcare-Associated Infections

February 2008 to January 2009

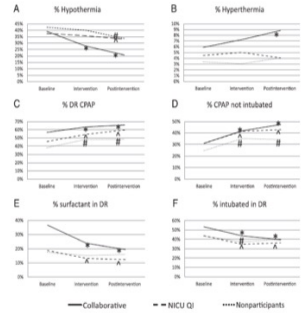
The 19 NICUs in the Healthcare Associated Infections Collaborative **decreased catheter-associated bloodstream infections (CABSIs) by 75% in infants with birth weights ≤ 1500 grams.** The project aimed to reduce the occurrence of CABSI to almost zero system-wide.

Delivery Room Management

June 2011 to November 2012

The 20 hospitals in the Delivery Room Management Collaborative saw a **collective decrease in hypothermia, delivery room intubation, and surfactant administration as a result of their participation**. The project aimed to improve management of high-risk deliveries through the implementation of a best practice bundle that included strategies to avoid hypothermia; establish lung volume in the least-invasive manner; and support teamwork with checklists, briefings, and debriefings.

Related publication: Implementation methods for delivery room management: a quality improvement comparison study



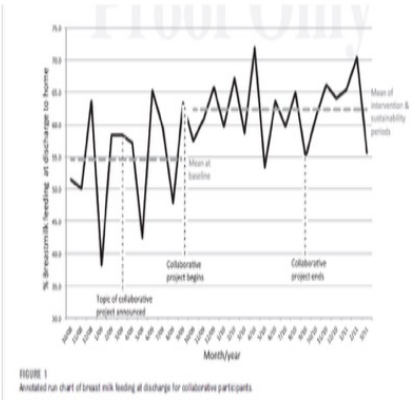
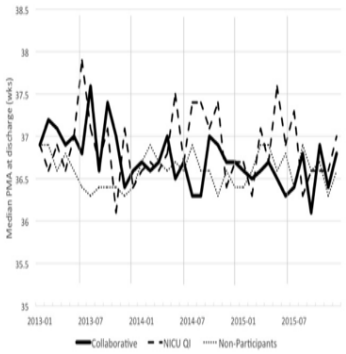


FIGURE 1
Annotated run chart of breast milk feeding at discharge for collaborative participants

Breastmilk Nutrition

September 2009 to April 2011

11 CPQCC NICUs participated in a collaborative designed to increase breastmilk feeding rates for VLBW infants through implementation of a set of best practices outlined in the CPQCC Nutritional Support of the VLBW Infant Toolkit. The toolkit was subsequently updated in 2018. By the end of the collaborative, **participants had increased breastmilk feeding at discharge to 64%, from 54.6% at the start of the collaborative.** Participants also saw a decrease in NEC rates from 7% to 2.4%.



Optimizing Length of Separation

June 2013 to May 2015

20 of our member NICUs participated in the Optimizing Length of Separation Collaborative, which aimed to reduce the length of hospital stay by three days for infants born between 27-32 weeks gestational age. Participants were encouraged to use a standardized approach to feeding, discharge planning, and apnea/bradycardia management in order to achieve this aim. By the end of the 18-month collaborative, **participants decreased length of separation by three days** and increased early discharge (before 36 weeks, 5 days) to 41.9% from 31.6%.

Antibiotic Stewardship

June 2016 to November 2017

CPQCC's Antibiotic Stewardship Collaborative included 28 of our member NICUs, the largest group to date, and aimed to reduce antibiotic utilization rates through the application of a bundle of best practices, including routine antibiotic "time-outs" 48-72 hours after obtaining cultures. Preliminary findings indicate that the collaborative group eliminated roughly 11,700 "antibiotic days" across California and **safely decreased the antibiotic utilization rate (AUR) by 13.8%.** These improvements helped to decrease the risk of antibiotic resistance and adverse drug events as well as the cost of care at these NICUs.

CPQCC QI COLLABORATIVES

15 Years of Improvement

Grow, Babies, Grow!

2018 - 2020

The Grow, Babies, Grow! project will help NICUs **optimize growth and nutrition** of VLBW infants, with the goal of reducing growth failure at discharge.

NICUs Enabling Optimal Brain Health (NEOBrain)

The NICUs Enabling Optimal Brain Health (NEOBrain) Collaborative aims to promote neuroprotective care for VLBW infants < 32 weeks gestational age.

Optimizing Antibiotic Stewardship in California NICUs

March 2021 – February 2023

The Optimizing Antibiotic Stewardship in California NICUs (OA Collaborative aimed to scale up dissemination of various nationally recommended interventions to improve antimicrobial stewardship NICUs in California using a blended QI collaborative and ECHO™ (Extension for Community Healthcare Outcomes) tele-learning model. ECHO™ is an evidence-based, American Academy Pediatrics-endorsed method of practice dissemination used globally focuses on faculty-facilitated, case-based learning tailored to how cli are inclined to learn and build practice consensus. QI collaboratives similarly including faculty facilitation and peer-learning, focus on supporting continuous quality improvement efforts by site implementation teams. OASCN was supported by a grant from the Agency for Healthcare Research and Quality (AHRQ Grant# R18HS26168-01A1) to implement and evaluate the collaborative.

In Situ Simulation

April 2018 – April 2020

Home

Growth Advancement in the NICU: Ten Point Nine

The GAIN: Ten Point Nine Collaborative aims to improve growth and nutrition for infants with a birth weight > 1500 grams in NICUs with an average daily census of ≤ 10.9.

Growth Advancement in the NICU: Surgical Patients

The Growth Advancement in the NICU (GAIN): Surgical Patients Collaborative aims to improve growth and nutrition for infants who have had intestinal surgeries.

2021-22 Quality Improvement Collaboratives

Launched from Member-Led Initiatives

Optimizing Antibiotic Stewardship in California NICUs (OASCN)
COLLABORATIVE GOAL

SAFELY REDUCE ANTIBIOTIC USE RATES in participating NICUs for infants of all gestational ages.

January 2021 – 29 sites

Growth Advancement in the NICU (GAIN): *Surgical Patients*
COLLABORATIVE GOAL

IMPROVE GROWTH AND NUTRITION for infants who have had intestinal surgeries in participating NICUs.

July 2021 – 8 sites

Growth Advancement in the NICU (GAIN): *Ten Point Nine*
COLLABORATIVE GOAL

IMPROVE GROWTH AND NUTRITION for infants > 1500 grams in participating NICUs with an average daily census of ≤ 10.9.

July 2021 – 6 sites

NICUs Enabling Optimal Brain Health (NEOBrain)
COLLABORATIVE GOAL

PROMOTE NEUROPROTECTIVE CARE for VLBWs in participating NICUs.

May 2022 – 27 sites

Record number: 70 hospitals participating in CPQCC QI collaboratives at one time!

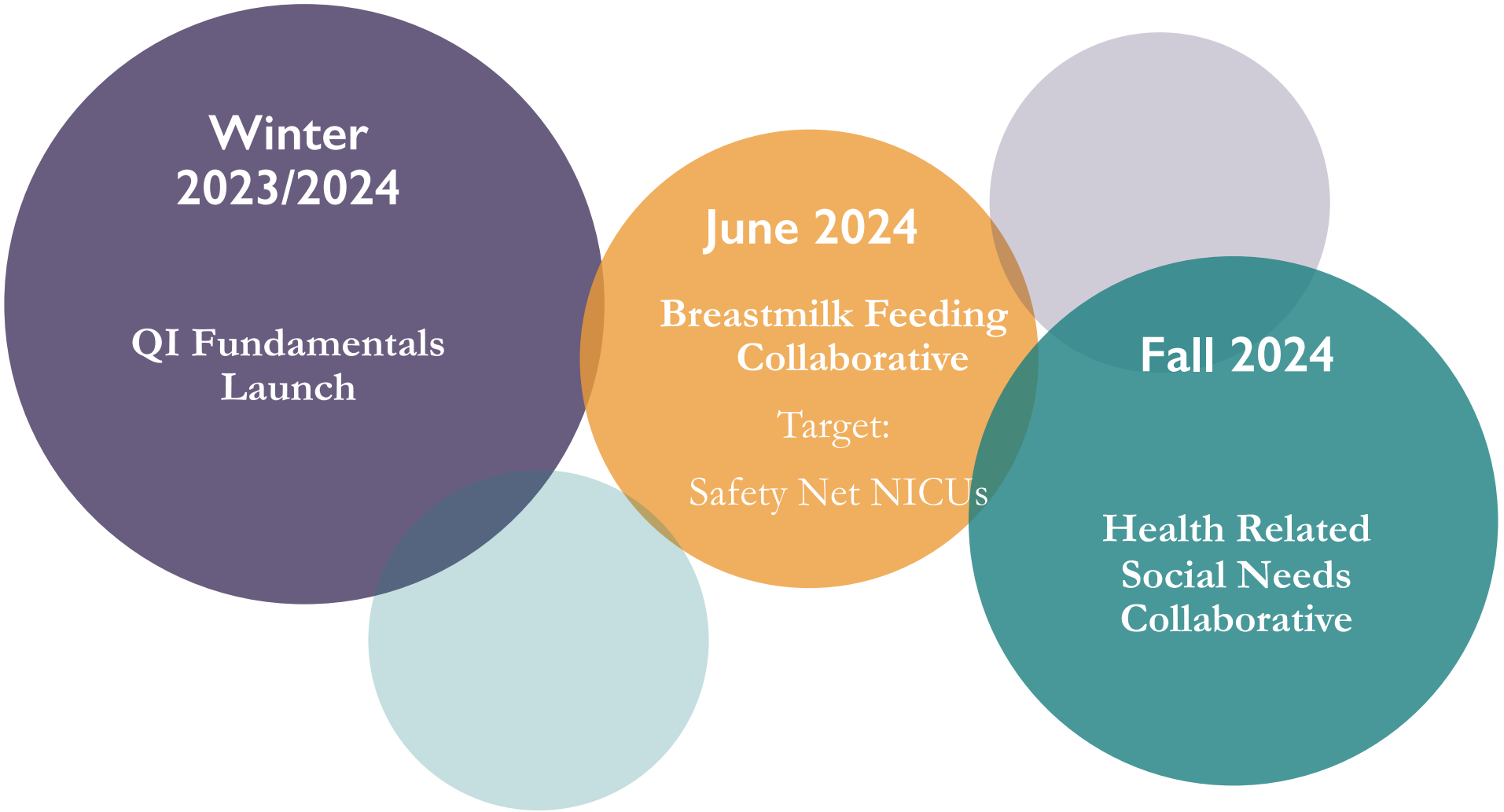
2021-2022 First Time Participating Centers in CPQCC QI Collaboratives

24 NICUs new to CPQCC QI Collaboratives!

1. Arrowhead Regional Medical Center
2. Children's Hospital LA
3. Community Memorial Hospital
4. Garfield Medical Center
5. Kaiser Permanente Baldwin Park Medical Center
6. Kaiser Permanente Medical Center Irvine
7. Kaiser Permanente Ontario Medical Center
8. Kaiser Permanente Riverside Medical Center
9. Kaiser Permanente West Los Angeles
10. KFH Orange County - Anaheim
11. KFH South Bay
12. LAC+USC
13. LPCH at Sequoia
14. O'Connor Hospital
15. Orange County Global Medical Center
16. Parkview Community Hospital Medical Center
17. Providence Cedars – Sinai Tarzana Medical Center
18. Providence Santa Rose Memorial Hospital
19. Salinas Valley Memorial Hospital
20. Santa Clara Valley Medical Center
21. Santa Monica – UCLA Medical Center
22. St. Francis Medical Center
23. Tri-City Medical Center
24. Watsonville Community Hospital

2024 CPQCC QI Opportunities

CPQCC's Upcoming QI Offerings

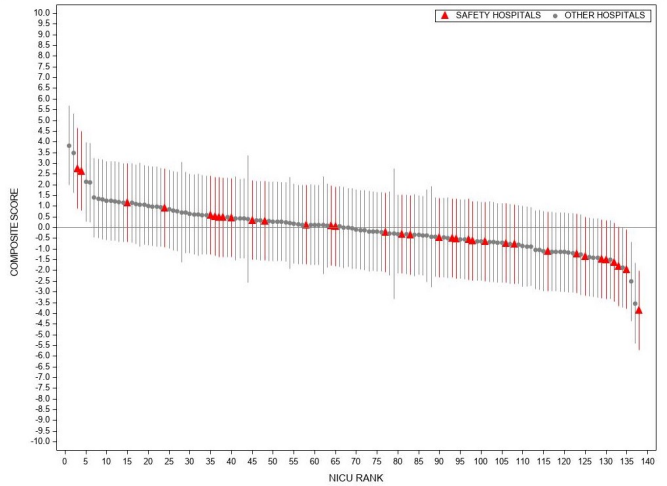


Safety Net NICUs
Stronger Together

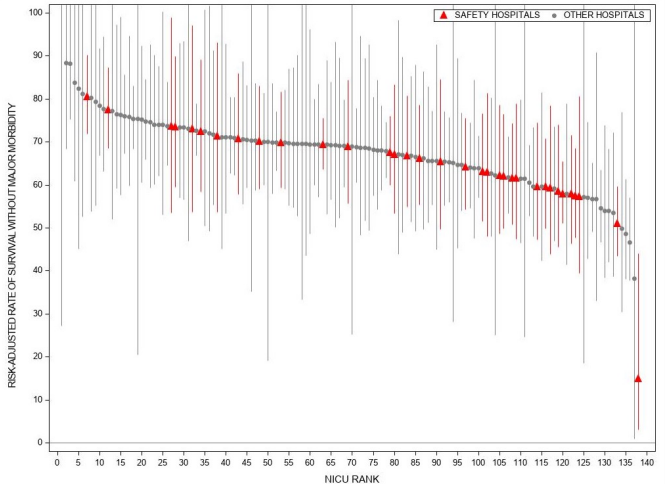
2024 CPQCC QI Collaborative

NIH Grant Goals

1. Create a community of learning among safety net NICUs
   - Unique needs based on
     - Resource challenges
     - Socioeconomic challenges of population
   - Develop platform for ongoing interaction
   - Develop resources for group sharing
     - Toolkits
     - mentorship
2. Build QI capacity
   - Breastmilk feeding collaborative
     - Outcome is any human milk feeding at dc
3. Understand wide performance differences
   - Culture survey
   - Key stakeholder interviews
   - Site visits (low key)
   - Vignettes



Baby-MONITOR Score



Survival Without Major Morbidity

Liu J, Profit J, et al. *J Pediatr.* 2022 Apr;243:99-106

What you get

1. No participation cost CPQCC led QI Collaborative
2. Expert panel to guide implementation of potentially better practices
3. Access to CPQCC parent advisors to help guide implementation
4. Formal QI learning support through CPQCC
5. Mentorship from high performing NICUs
6. Learning about and accessing clinical and community resources.
7. Creating opportunities to partner with OB and community settings
8. Expert assessment and feedback on your NICU's care culture (teamwork, safety, well-being)
9. Building community connections and friendships with your peers!!

REGISTER NOW!!

Timeline

1. Register interest via QR code at any time
2. Faculty panel formation (9/23)
3. Collaborative prework (1/24 – 4/24)
4. Collaborative start (6/24), 3 face to face learning sessions
5. Culture survey (7/24 and 8/24)
6. Collaborative active phase end (6/25)
7. Sustainability period (12/25)

REGISTER NOW!!

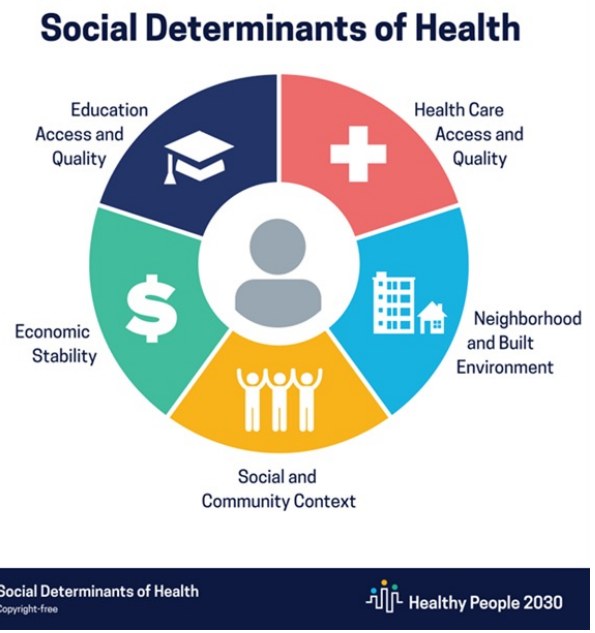
What we ask

1. Let us know if you are interested and sign up early!!
2. Form a multidisciplinary team for the QIC (ideally including a parent)
3. Complete pre-collaborative exercises and evaluations to allow us to optimize intervention design.
4. Participate in QIC, commit to collecting data, and team to complete didactic learnings along the way
5. Participate in Learning Sessions, report outs, and engage with your peers
6. Complete culture survey with high response rate (>60%; with leadership and ingenuity this is not hard)
7. Identify a few key stakeholders in your NICU for us to interview
8. Open your NICU to us for a low-key site visit (no expenses to you) for one on one insight & custom tailored approaches to addressing change.
9. Access your CPQCC report data and ask us about them

REGISTER NOW!!

2024 CPQCC QI Project:

Health Related Social Needs Collaborative



GOAL: Implementing Social Determinants of Health (SDOH): Screening & Referrals

Approximately one quarter of U.S. families with preterm infants have unmet basic needs, such as housing or job insecurity (Parker, 2020)

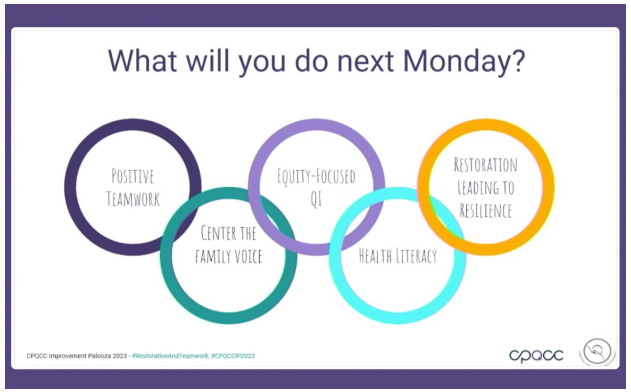
- 26% of families experienced food insecurity,
- 33% experienced housing insecurity, and
- 28% experienced energy insecurity

Only a quarter of neonatal intensive care units have a standardized screening/referral process for SDOH.

Parker MG, Ettinger de Cuba S, Rateau LJ, Sandel M, Frank DA, Cutts DB, Heeren TC, Lê-Scherban F, Black MM, Ochoa ER, Garg A. Household Unmet Basic Needs in the First 1000 Days and Preterm Birth Status. Journal of Perinatology. 42, 389-396 (2022).

Improvement Palooza

RESTORATION & TEAMWORK



IP2023 March 2, 2023

www.cpqcc.org/IP2023

CPQCC Welcome Table (info, resources, swag). Community Boards (gratitude & grief). Pet Therapy Dogs during lunch. Team Spirit Photos. Team Restoration with dancing, restorative reads, and raffle prizes.

IP2023

RESTORATION & TEAMWORK

290 Participants

- 117 in person attendees
- 173 virtual attendees

10 Countries

- 95% from USA
- 1.8% Sweden
- <1% Finland, Netherlands, Austria, Australia, Germany, Norway, UK, Puerto Rico

9 States

- 57% from CA
- 14% Virginia
- 7% Washington
- 4% Oregon
- <3% Texas, Nevada, Idaho, Florida, and Iowa

CPQCC
Family Advisory Council

IP2023 Conversation Circles

Ground everything we do in equity, inclusion, and restoration

Overview

- Frame each webinar around **Restoration, Revelation, and Relationships**: Self, Team, and Community
- Cover **equity, inclusion, and restoration** in each webinar
- Each speaker starts with a focus and kudos to their team with a **team photo**
- Align with topics from IP21-23 **(anti-racism, family centered care)**

Themes

- **June 2023: Wellness and restoration of self.** Focus on the individual.
- **September 2023: Team dynamics.** What are ways to raise each other up?
- **January 2024: Engagement with families.** How do we interact with patients and family members when we are stressed? How does this play out with team dynamics?

Connections

- What is our focus area (e.g., leadership roles)?
- What are our perspectives, tangible ways to recognize when people don't feel they belong or receive messages that aren't inclusive?
- Help people recognize blind spots; not in a judgmental way but in a revealing way
- Restoration and revelation speak to how we are trying to move things forward toward less stress, more inclusion, and fully restored

*** SAVE THE DATE – March 1, 2024 *** Coronado, CA

Hybrid CPQCC Improvement Palooza 2024

IP2024 Framework

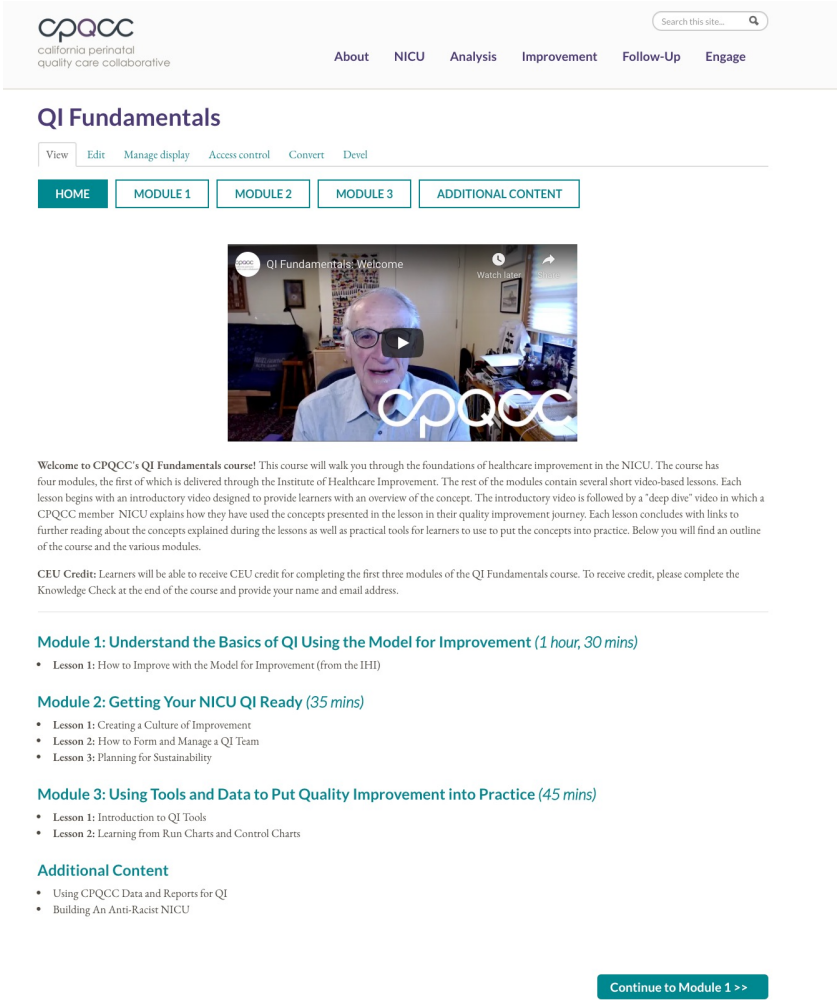
1. Main themes: addressing unmet social needs in the NICU, mental health, equity, & advocacy
2. Morning and afternoon headliners:
   Family voice, nursing voice, physician voice
3. Advocacy workshops
4. Spotlight fellows/young faculty work: Neonatal Justice Collaborative (NJC)
5. Highlight work by CPQCC's Family Advisory Council (formed in early 2022)
6. Workshops: QI and implementation science & actionable tools

*Ground **everything** we do in equity, inclusion, and restoration*

Educational Course:

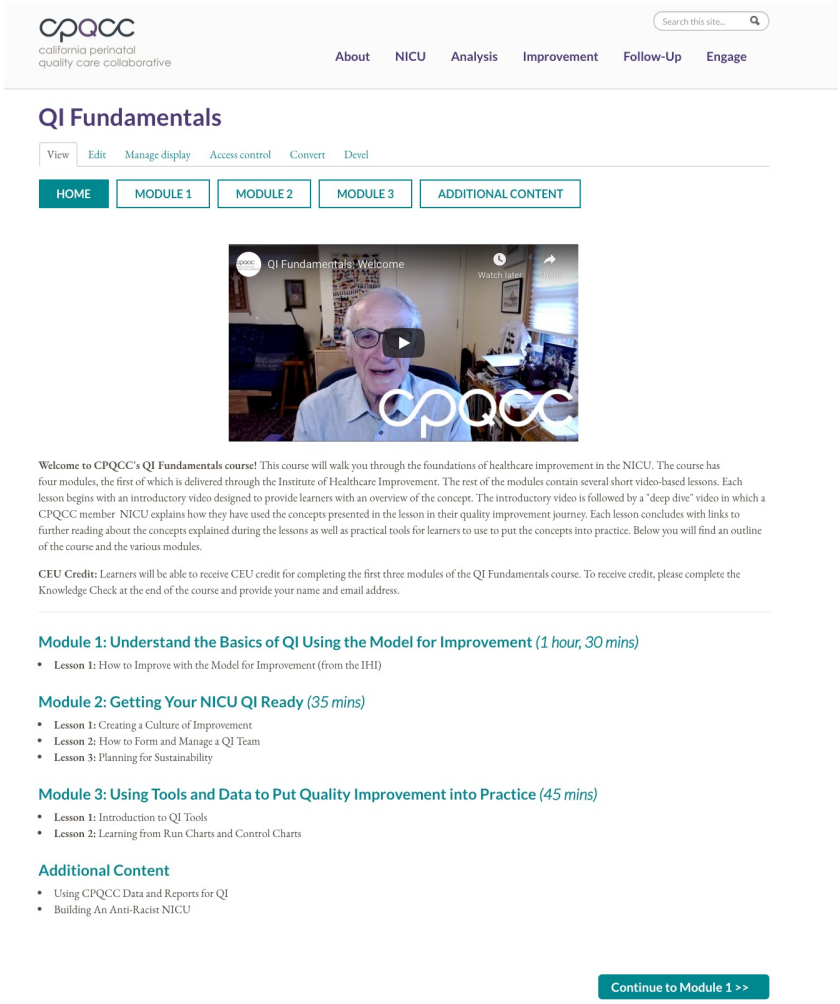
QI Fundamentals

CPQCC QI Fundamentals



- Video-based quality improvement course that walks learners through the foundations of healthcare improvement in the NICU.
- Three main modules: **Understand the Basics of QI Using the Model for Improvement, Getting Your NICU QI Ready, Using Tools and Data to Put Quality Improvement into Practice** plus one module of additional content on anti-racism and understanding CPQCC data and reports
- Each module begins with an introductory video that provides an overview of a concept, followed by a "deep dive" video in which a CPQCC member NICU explains how they have put that concept into practice
- Each lesson concludes with links to further reading and practical tools to put concepts into practice
- CEU credit available for completing the course

CPQCC QI Fundamentals



- Currently available to sites participating in a CPQCC QI collaborative
- 80 learners have received CME credit to date (must score > 70% on the knowledge check)
- Course is updated in new learning management system (*Coassemble*) and will be relaunched and available to all CPQCC members (free of charge) later this year

CONNECT WITH CPQCC

Please Join Us!

- Join a Subcommittee
- Share your QI project

Look at your data

What's Next?

Family Advisory Council!

CPQCC Family Advisory Council

Funded by a grant from the Lucile Packard Foundation for Children's Health Palo Alto, California

FAC Goals

Short Term:

- Build community with each other
- Inform CPQCC how our activities and priorities might be more family centered including QI projects, toolkits, committees, webinars, and data collection.
- Develop & curate materials for FAC toolkit for NICUs

Long Term:

- Increase the number of CA NICUs with a Family Council
- Allow NICUs to consult with CPQCC FAC
- Create system-level change across California

What do FAC members hope to accomplish?

- Improved mental health for parents, especially PPA/PPD/PTSD
- Improved discharge readiness
- Care for families with non-English language of preference
- Improved health equity
- Making NICU care more consistent across providers (some nurses said to do one thing, others said another; some hospitals allowed one thing, others didn't, etc)
- Better communication with parents
- Caring for family unit

A civil society will no longer accept disproportionate suffering.

Yancy, C. JAMA 2020

Closing

Recording and Webinar Evaluation

!!ATTENTION!!

At the end of this webinar please click the evaluation link provided to submit your evaluation for this data trainings.

Note: CEU's will be accumulated and distributed after all data training sessions have been completed (for live sessions only)

The webinar recording and slides will also be posted at:
https://www.cpqcc.org/engage/annual-data-training-webinars-2023

Upcoming Data Trainings

October 11th – What's New with NICU Data

THANK YOU!