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COVID REALITIES: PIVOTING TO VIRTUAL QI TRAINING IN INDIA

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10.1136/bmj-2021-IHL.12

Abstract Description A program to scale-up improvements in maternal and newborn health in India confronted the challenges of providing quality improvement training to leaders and front-line clinicians and staff in 38 district hospitals in the state of Bihar, India. Virtual training programs, while not entirely new to the participants, was something that had not been done before on this scale. Results showed exciting improvements in quality improvement understanding and

skills, as well as confidence to use and apply new-found knowledge.

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A LEARNING SYSTEM FOR SAFER RE-OPENING OF K-12 SCHOOLS DURING THE COVID-19 PANDEMIC

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10.1136/bmj-2021-IHL.13

Background School closures due to the coronavirus disease 2019 (COVID-19) pandemic are harmful to children's education. Uncertainty in infectiousness and challenges of managing

Abstract 13 Figure 1 P Chart (funnel chart):% of Los Angeles Unified elementary students electing in-person learning by city within the school district catchment area when schools re-opened, stratified by community vaccination rate

Abstract 13 Figure 2 P Chart:% of Grade 6-8 students electing in-person learning in 215 middle schools

asymptomatic infection slowed school re-opening in many areas of the US. The pandemic required fast, evolving, iterative response from public health and K-12 schools.

Objective Use data displays designed for improvement, coupled with expertise in learning from variation, to offer insights in a fast-paced policy environment. Provide learning support alongside data.

Methods A multidisciplinary team with expertise in epidemiology, family medicine, public health, and biostatistics formed to provide support in learning methods to the second largest US

K-12 school system. The team generated time series and funnel statistical process control charts, using the drill-down pathway to provide insight at multiple levels of the school system. The team identified essential capabilities in data and scientific translation to support real-time, fast-paced operational decision-making.

Results Outcomes include positive COVID-19 tests identified through surveillance (figure 5), school-based secondary infection, school enrollment (figures 1 and 2), quarantine associated with being a close contact of a COVID-19 positive

Abstract 13 Figure 3 C Chart and cumulative percentage: Uptake of vaccine by age group & neighborhood

Abstract 13 Figure 4 C Chart (annotated) # of residents age 16-17 receiving their first COVID-19 vaccine dose, in selected neighborhoods

Abstract 13 Figure 5 Hybrid C Chart and I Chart: COVID-19 case counts

student or staff member, and vaccination drawing from community-level data linked with school region (figures 3 and 4). Data displays showed variation in actionable formats.

Conclusions Common data displays in COVID-19 lack elements required to learn from variation, including denominators, disaggregation (granularity), and operationally relevant stratification (such as subregion and school configuration). Providing these displays offered actionable data to the school district that they employed in areas such as vaccination outreach and testing protocols. There is an ongoing need for scientific input and support of actionable data displays, for use by public health as well as school districts. Future work will include incorporating these displays into operations and generating them from developing databases.

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ADDRESSING SOCIAL HEALTH AND EARLY CHILDHOOD WELLNESS: NATIONAL RESILIENCE LEARNING COLLABORATIVE

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10.1136/bmjopen-2021-011141

Background Unmet social needs in early childhood create risk of lifelong physical/mental health challenges. Pediatricians can intervene by routinely assessing child development including child and family social emotional wellbeing. Many providers report barriers to interventions that meet families' social needs and lack reimbursement.

Abstract 14 Figure 1 AAP Addressing Social Health and Early Childhood Wellness (ASHEW) key driver diagram