PA PQC Data Collection Webinar

May 13, 2019
10:00 a.m. to 11:00 a.m.
Agenda

1. 10:00 a.m. to 10:15 a.m. – **Overview of the Data Definitions for the PA PQC Quality Measures** – Robert Ferguson, MPH, Director of Government Grants and Policy, Jewish Healthcare Foundation (JHF)

2. 10:15 a.m. to 10:25 a.m. – **Data Collection Strategies for OUD Diagnosis Rates and Postpartum Care for Women with OUD** – Karena M. Moran, PhD, Project Manager, Northeastern PA PQC (NEPaPQC)

3. 10:25 a.m. to 10:35 a.m. – **Data Collection Strategies for Severe Maternal Morbidity, Percent of Pregnant Women Screened for SUD, and Average Hospital Length of Stay for Newborns with NAS** – Saanie Sulley MD, PhD, MBA, Data Analyst, Alliance for Innovation on Maternal Health (AIM)

4. 10:35 a.m. to 10:45 a.m. – **Data Collection Strategies for MAT Initiation, Average Hospital Length of Stay for Newborns with NAS, and Treatment of Severe Hypertension within One Hour** – Patricia A. Lee King, PhD, MSW, State Project Director, Quality Lead, Illinois Perinatal Quality Collaborative (ILPQC)

5. 10:45 a.m. to 11:00 a.m. – **Questions and Answers**
Objectives

1. Describe the data specifications for the required and optional, prioritized PA PQC measures

2. Describe data collection strategies from the NEPaPQC, AIM, and ILPQC for these measures
Open the Chat Panel and send questions to “Host”
Overview of the Data Definitions for the PA PQC Quality Measures

ROBERT FERGUSON, MPH
DIRECTOR OF GOVERNMENT GRANTS AND POLICY
JEWISH HEALTHCARE FOUNDATION
Process to Create the PA PQC Measures

- Nov. 16 PA PQC Advisory Input
- Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles and Metrics
- IL PQC and Ohio PQC
- National Network of PQC (NNPQC) Conference
- Vermont Oxford Network (VON) NAS Universal Training Program and Toolkit
- Maternal Mortality Review Reports from Nine States and Philadelphia

8 Work Groups (PA Expertise)

- PA PQC Quality Improvement Framework
- PA PQC Driver Diagrams and Quality Metrics for Maternal Mortality, NAS, and OUD
PA PQC Measurement Specifications

Download the Specifications at https://www.whamglobal.org/papqc/PA-PQC-data
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<th>Metric</th>
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<tbody>
<tr>
<td>Severe Maternal Morbidity</td>
<td>Number of cases with any severe maternal morbidity (SMM) code</td>
<td>All mothers during their birth admission, excluding ectopics and miscarriages</td>
<td>Hospital Discharge Data File (ICD-9/ICD-10)</td>
<td>Report aggregate numbers and also by race, ethnicity (NH white, NH black, Hispanic, NH other), and insurance status (private, Medicaid, or uninsured) Report quarterly, starting in January 2019</td>
<td>AIM Severe Maternal Morbidity Codes List <a href="https://safehealthcareforeverywoman.org/aim-data/">https://safehealthcareforeverywoman.org/aim-data/</a></td>
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<td>Severe Maternal Morbidity (excluding cases with only a transfusion code)</td>
<td>Number of cases with any non-transfusion SMM code</td>
<td>All mothers during their birth admission, excluding ectopics and miscarriages</td>
<td>Hospital Discharge Data File (ICD-9/ICD-10)</td>
<td>Report aggregate numbers and also by race and ethnicity (H white, NH black, Hispanic, NH other), and insurance status (private, Medicaid, or uninsured) Report quarterly, starting in January 2019</td>
<td>AIM Severe Maternal Morbidity Codes List <a href="https://safehealthcareforeverywoman.org/aim-data/">https://safehealthcareforeverywoman.org/aim-data/</a></td>
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<td>Treatment of Severe HTN within 1 hour</td>
<td>Cases who were treated within 1 hour with IV Labetalol, IV Hydralazine, or PO Nifedipine</td>
<td>Women with persistent (twice within 15 minutes) new-onset Severe HTN (Systolic: ≥ 160 or Diastolic: ≥ 110)</td>
<td>Hospital logbooks, EHR, and pharmacy records</td>
<td>Report monthly starting in January 2019 Denominator excludes women with an exacerbation of chronic HTN It is best to use at least two systems for identification of denominator cases.</td>
<td>AIM Severe Hypertension P4</td>
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<td>Timely Fourth Trimester Contact</td>
<td>Number of patients receiving postpartum care contact within first three weeks from discharge</td>
<td>All patients who gave birth 3 weeks prior to the end of the month and no later than 3 weeks prior to the month</td>
<td>EHR and Claims Data</td>
<td>Report on a monthly basis, starting in May 2019 “Postpartum care” can be counted as physician office visits, home health visits, nursing care, or telemedicine</td>
<td>Based on ACOG Fourth Trimester [<a href="https://www.acog.org/Womens-Health/Optimizing-Postpartum-Care?isMobileSet=false">https://www.acog.org/Womens-Health/Optimizing-Postpartum-Care?isMobileSet=false</a>]</td>
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<td>Median hospital length of stay for newborns with NAS</td>
<td>Median number of hospital days from birth of newborns with NAS through discharge to home among newborns ≥ 35 gestational weeks with NAS</td>
<td>Report quarterly, starting in January 2019</td>
<td>Informed by AIM Opioid Metrics Spreadsheet (04)</td>
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<td>Birth Hospital Data Form or State Data with NAS ICD 10 code and total hospital LOS</td>
<td>Newborns are those admitted at 0 days old, transferred up to 1 week old, or readmitted from home/ER/clinic up to 1 week old (i.e., admitted at less than 7 days old)</td>
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<td>Newborns diagnosed with NAS are defined by:</td>
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<td>• ICD 10 Code P96.1 (Neonatal Withdrawal Symptoms from Maternal Use of Drugs of Addiction), or</td>
<td>Informed by ILPQC protocol for handling transfers</td>
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<td>• OEN with clinical signs of opioid withdrawal (e.g., Finnegan score ≥ 8 three consecutive times)</td>
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<td>Includes all days hospitalized whether transferred outside of a NICU or transferred to another institution</td>
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<td>Median calculations assume some sites will have outliers that will skew the normal distribution of data. The median is the value separating the higher half from the lower half of a data sample this ordered from low to high numbers. (In response to outliers, conduct a root cause analysis to understand the causes of the outliers.)</td>
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Median Hospital LOS for NAS

Protocol for how to handle transfers:

For infants transferred between hospitals, this data is reported by the hospital that provided the majority of care during the acute period of risk. Typically, for mother this is during delivery and for infants this is approximately day 3 to day 10 of life. We are defining that hospital as the BIRTH hospital if the infant remains there for at least 5 days of life, and the RECEIVING hospital if the infant is transferred at day of life 5 or less. For all mother/infants, the data should only be reported ONCE. Examples are listed below.

Scenarios:

- Infant born at hospital A, remains at hospital A until discharge (Hospital reports data)
- Infant born at hospital A, transferred to hospital B on day of life 20 for convalescent care, remains at hospital B until discharge (Hospital A reports data)
- Infant born at hospital A, transferred to hospital B on day of life 2 for acute care, remains at hospital B until discharge (Hospital B reports data)
- Infant born at hospital A, transferred to hospital B on day of life 2 for acute care, transferred back to hospital A on day of life 20 for convalescent care, remains at hospital A until discharge (Hospital B reports data)

The hospital reporting the data should attempt to contact transferring or receiving hospitals for information needed. If an infant was transferred for acute care at day of life 5 or less, the receiving hospital should get information on the perinatal and birth history from the birth hospital. If the infant is transferred after day 10 for convalescent care, the transferring hospital should get information from the receiving hospital on eventual disposition and length of stay.
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<tr>
<td>Percentage of pregnant women screened for SUD with a validated screen</td>
<td>Number of women screened for SUD with a validated screen at any time during the pregnancy</td>
<td>Number of women with a prenatal visit in the month</td>
<td>EHR Data</td>
<td>Report on a monthly basis, starting in May 2019</td>
<td>AIM Opioid Optional P3 (adapted)</td>
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<td>It is ideal to have multiple conversations/check ins, but at least one SUD screening per person would count for the numerator. SUD screens during prenatal and hospital/delivery visits count.</td>
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<td>It is suggested to screen for SUD around 28 weeks prenatal and to screen at multiple touch points</td>
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<td>SUD Domains Include: Alcohol, tobacco, opioids, and other drugs</td>
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<td><strong>Validated SUD screening tools:</strong> 4Ps Plus, Integrated 5Ps, NIDA Quick Screen, Substance Use Risk Profile Pregnancy (SURP-P) Scale, ASSIST, TICS</td>
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<td>Percentage of pregnant women diagnosed with OUD at any time of pregnancy</td>
<td>Number of women with an OUD diagnosis during pregnancy</td>
<td>Number of women with a prenatal visit in the month</td>
<td>EHR Data</td>
<td>Report on a monthly basis, starting in January 2019</td>
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<td>Clinical Criteria for “Women Diagnosed with OUD”:</td>
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<td>• positive self-report screen or positive opioid toxicology screen during pregnancy and assessed to have OUD, or</td>
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<td>• Patient endorses or reports misuse of opioids / opioid use disorder, or</td>
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<td>• using non-prescribed opioids during pregnancy, or</td>
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<td>• using prescribed opioids chronically for longer than a month in the third trimester, or</td>
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<td>• newborn has an unanticipated positive neonatal cord, urine, or meconium screen for opioids or if the newborn has symptoms associated with opioid exposure including NAS</td>
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<td>ICD-10 codes for OUD: F11 diagnosis codes (O99.320 and Z79.891 may also be used). (The OUD diagnosis should be counted in the numerator if it is active between pregnancy start date and the end of the data reporting month.)</td>
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<td>For all of the PA PQC measures, an individual should only be counted once in the numerator and denominator.</td>
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| Percentage of pregnant and postpartum women diagnosed with OUD who initiate MAT (required) | Number who filled a prescription for or were administered or ordered an MAT medication (buprenorphine or methadone) for OUD at any time during or after the pregnancy | Number of women with a delivery and OUD diagnosis in the month            | EHR Data & Claims Data (based on Rx)                  | Report on a monthly basis, starting in January 2019  
See above for clinical criteria for “Women Diagnosed with OUD” and ICD-10 codes for OUD                                                                 | Informed by NQF 3400 (Use of Pharmacotherapy for OUD)  
http://www.qualityforum.org/QPS/ |
| Percentage of pregnant and postpartum women with OUD and 90-day continuity of MAT pharmacotherapy for OUD (required) | Cumulative number who have at least 90 days of continuous pharmacotherapy with a medication prescribed for OUD (buprenorphine or methadone) without a gap of more than seven days | Cumulative number of women with a delivery in the past year OUD diagnosis, and at least one claim for an MAT medication (buprenorphine or methadone) at least 90 days ago | EHR Data & Claims Data (based on Rx)                  | Report cumulatively on a monthly basis, starting in May 2019  
Example: For the denominator reported for the month of May 2019, pull all deliveries in the past year (e.g., June 1, 2018 to May 31, 2019) for women who (1) had an OUD diagnosis, and (2) had at least one MAT claim at least 90 days prior to the end of May 2019.  
See above for clinical criteria for “Women Diagnosed with OUD” and ICD-10 codes for OUD                                                                 | |
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<tr>
<td>Percentage of pregnant and postpartum women with OUD and 180-day continuity of MAT pharmacotherapy for OUD</td>
<td>Cumulative number who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD (buprenorphine or methadone) without a gap of more than seven days</td>
<td>Cumulative number of women with a delivery in the past year, OUD diagnosis, and at least one claim for an MAT medication (buprenorphine or methadone) at least 180 days ago</td>
<td>EHR Data &amp; Claims Data (based on Rx)</td>
<td>Report cumulatively on a monthly basis, starting in May 2019. Example: For the denominator reported for the month of May 2019, pull all deliveries in the past year (e.g., June 1, 2018 to May 31, 2019) for women who (1) had an OUD diagnosis, and (2) had at least one MAT claim at least 180 days prior to the end of May 2019. See above for clinical criteria for “Women Diagnosed with OUD” and ICD-10 codes for OUD</td>
<td><a href="http://www.qualityforum.org/QPS/">http://www.qualityforum.org/QPS/</a></td>
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<tr>
<td>Percentage of women diagnosed with OUD receiving postpartum visit (required)</td>
<td>Cumulative number who received a postpartum visit with a provider on or between 21 and 56 days after delivery</td>
<td>Cumulative number of women with a delivery at least 56 days ago who are diagnosed with OUD</td>
<td>Claims Data / EHR Data with Outpatient Post-Partum Information</td>
<td>Report cumulatively on a monthly basis, starting in March 2019. Example: For the denominator reported for the month of May 2019, pull data for deliveries between January 1, 2019 and April 5, 2019 (this is 56 days before May 31, 2019). Then, for the denominator reported for the month of June 2019, pull data for deliveries between January 1, 2019 and May 5, 2019 (56 days before June 30, 2019). A provider may include an MD/DO, CRNP, Physician Assistant, or Midwife. See above for clinical criteria for “Women Diagnosed with OUD” and ICD-10 codes for OUD</td>
<td>Adapted from Medicaid Measures <a href="https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html">https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html</a></td>
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Data Collection Strategies for OUD Diagnosis Rates and Postpartum Care for Women with OUD

KARENA M. MORAN, PHD
PROJECT MANAGER
NORTHEASTERN PA PQC (NEPAPQC)
PA PQC Data Collection Webinar

May 13, 2019

Karena M. Moran, PhD
Project Manager, NEPaPQC
Overview

• What you need to know to pull data
• Small vs. large delivery site (or resource availability)

• Example Metrics:
  • OUD diagnosis during pregnancy
  • Postpartum appointment attendance

*Note:*
• Epic EHR system
Numerator
(of those within the denominator)

OUD Diagnosis:
• Pregnancy start date
• F11 and other ICD-10 codes
• Positive self-report (social history or validated screen)
• Positive urine toxicology screen for opioids
• Rx opioid use for more than one month during 3rd trimester
• Positive newborn toxicology screen for opioids, or
• Newborn symptoms of opioid withdrawal

Postpartum Appointment Attendance:
• Delivery date + 21-56 days
• Visit name
• Must be seen by a provider
Denominator

• **OUD Diagnosis metric:**
  • Number of women with prenatal visit in the month
    • January = January 1, 2019 to January 31, 2019
    • February = February 1, 2019 to February 28, 2019

• **Postpartum Appointment Attendance metric:**
  • Cumulative number of women diagnosed with OUD with a delivery at least 56 days ago
    • Postpartum appt. March 1-31, 2019 = January 1, 2019 to February 3, 2019
    • Postpartum appt. April 1-30, 2019 = January 1, 2019 to March 5, 2019
Small Delivery Rate – Manual Review

- **Hospital A**: 43 deliveries in January, 29 deliveries in February, 29 deliveries in March, 38 deliveries in April

- Create a checklist of items and directions about where to find them

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<tr>
<td>1</td>
<td>Mother MRN</td>
<td>Screened for SUD w/ validated tool</td>
<td>F11 Dx</td>
<td>Self-reported opioid use</td>
<td>Pos urine tox for opioids</td>
<td>Rx &gt;1month in 3rd trimester</td>
<td>Newborn MRN</td>
<td>Pos newborn tox for opioids</td>
<td>Newborn symptoms of opioid exposure</td>
<td>OUD Dx (yes/no)</td>
<td>Initiate MAT</td>
<td>90 MAT continuity</td>
<td>180 MAT continuity</td>
<td>PP appoint, attended</td>
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**NEPaPQC**

Northeastern Pennsylvania Perinatal Quality Collaborative
Example Epic EMR chart review:
OUD diagnosis active on problem list

- History of substance abuse
- Pregnancy complicated by subutex maintenance, antepartum (HCC)
- Bipolar disease during pregnancy in second trimester (HCC)
- BIPOLAR AFFEC, MANIC-MOD
- Insomnia
- Tobacco use in pregnancy
- History of cesarean section complicating pregnancy
- Anxiety during pregnancy in first trimester, antepartum
- Supervision of other high risk pregnancy, antepartum
- History of preterm labor, current pregnancy
- Encounter for monitoring Subutex maintenance therapy
- Supervision of high-risk pregnancy
- Opioid use disorder, severe, dependence (HCC)
- History of postpartum hemorrhage, currently pregnant
- Short interval between pregnancies complicating pregnancy, antepartum
- History of preterm labor
- History of preterm delivery, currently pregnant

Medications
- buprenorphine HCl (SUBUTEX) 8 MG Sublingual tablet
  - 1 1/2 tablets under tongue in the am and 1 tablet in the pm.
- acetaminophen (TYLENOL) 325 MG Tablet
  - Take 3 Tabs by mouth every 8 hours.
Large Delivery Rate – Data Broker

- Hospital B: 185 deliveries in January, 138 deliveries in February, 164 deliveries in March, 160 deliveries in April

- Dates
  - Full data pull dates
  - Earliest to latest metric (e.g., June 1, 2018 to May 31, 2019)
  - Individual dates for metrics and/or patients

- Codes and Names
  - Diagnosis codes, medication codes, procedure codes
  - Visit name and provider types
  - Where to find in chart if not discrete data field
Extra Slides
Example EMR chart review: Self-reported opioid use

denies all 9/13/18, marijuana in teens only, socially.; opiates- last use Oct 2017. Subutex effective since 10/2017
Example EMR chart review: Urine toxicology (continued on next slide)

Filter encounters to search for tox screen orders
• Search whatever type of tox screen is routinely used at your site.
Example EMR chart review: Urine toxicology continued...

Patient in MAT confirming Bup & Norbup levels

Patient tested at admission to L&D
Example EMR chart review:
Postpartum Appointment Attendance

Delivery Date: 06/01/2018

PP Appt Date: 10/22/2018

Greater than 56 days after delivery.
Data Collection Strategies for Severe Maternal Morbidity, Percent of Pregnant Women Screened for SUD, and Average Hospital Length of Stay for Newborns with NAS

SAANIE SULLEY MD, PHD, MBA
DATA ANALYST, ALLIANCE FOR INNOVATION ON MATERNAL HEALTH (AIM)
AIM Data Collection

Saanie Sulley, MD. MBA., PhD
Alliance for Innovation on Maternal Health
AIM Measure Philosophy (1)

• Right Balance: Low Burden but enough to guide QI Efforts
  • Few hospitals have the capacity to do chart reviews except for the most important metrics (e.g. Rapid treatment for Severe HTN)
  • Quarterly process measures frequency is enough

• Outcome Measures: always a challenge
  • Death is too rare and too delayed to collect accurately and timely (but we will capture state MMR committee data later)
  • Morbidity—use admin data whenever possible
  • Looking for population impact!!
  • Hospital-level data essential, but can be a legal/regulatory challenge for some health departments
  • Race-level data on key measures
• Emphasis on structure measures that represent permanent institutional change
  • e.g. order sets in EMR
• Measures need to be standardized across collaboratives, but with customized minor additions as needed locally
• Open to adjusting outcome measure specifications to reflect changes in administrative data processes (e.g. transfusions using revenue codes)
AIM Outcome Measures

• Severe Maternal Morbidity
• Severe Maternal Morbidity without Transfusions

• Severe Maternal Morbidity among Women with Hemorrhage
• Severe Maternal Morbidity among Women with Severe Hypertension

What About By Race?
Focus on Severe Maternal Morbidity by Race

- SMM was developed as a composite measure by the CDC representing ICD diagnosis and procedure codes in 25 “buckets”, indicative of major complications during delivery (e.g. pulmonary edema, renal failure, hysterectomy, blood transfusion). Transfusions have grown to represent 50% of cases.
- SMM is approx. 100X more common than Maternal Mortality with U.S. rates ~1.8% (based on a national samples).
- CDC has reported a 100% rise in SMM from 1998 to 2010, again with the greatest rise in hemorrhage complications.
- CDC and others have reported significant B:W disparities in SMM on the order of 2X (national sample).
AIM Opioid Metrics

- Percentage of pregnant women screened for SUD with a validated screen
  - Recommendation is to use a validated screening tool and to screen and evaluate ALL pregnant women

**Denominator:** Number of women in prenatal care

**Numerator:** Among the denominator, number of women screened for OUD during the pregnancy or 6 weeks postpartum

PNC site data *Voluntary*

**Process**

*Ideal is multiple conversation/check in, but one screening would count.*

*Reinforcing commitment to improved identification and referral by PNC providers.*

AIM Bundle: Recognition & Prevention
AIM Opioid Metrics

- Average hospital length of stay for newborns with NAS
  - Most states are doing both maternal and infant arms of their QI projects.

**Denominator:** Number of newborns ≥35 weeks gestation diagnosed with NAS

**Numerator:** Among the denominator, total number of hospital days
Questions
ssulley@acog.org
AIM Data FAQ
https://safehealthcareforeverywoman.org/aim-data/
Data Collection Strategies for MAT Initiation, Average Hospital Length of Stay for Newborns with NAS, and Treatment of Severe Hypertension within One Hour

PATRICIA A. LEE KING, PHD, MSW
STATE PROJECT DIRECTOR, QUALITY LEAD, ILLINOIS PERINATAL QUALITY COLLABORATIVE (ILPQC)
ILPQC Statewide QI Initiatives:
Data Collection Strategies for AIMs and Measures
Overview

• ILPQC
• Measure and report development
• Mothers and Newborns affected by Opioids
  – Women with OUD on Medication Assisted Treatment (MAT) Prenatally or by Delivery Discharge
  – Length of Stay for Opioid-Exposed Newborns (OENs) (≥35 Weeks) with NAS Symptoms (Median Days)
• Severe Maternal Hypertension
  – Maternal Hypertension: Time to Treatment
Illinois Perinatal Quality Collaborative (ILPQC)

- 119 Illinois hospitals participating in 1 or more initiative
  - 99% of IL births covered by ILPQC
  - 100% of IL NICU beds covered by ILPQC
- Support participating hospitals’ implementation of evidenced-based practices since 2013 using
  - Collaborative learning
  - Rapid response data
  - Quality improvement support
- Strong ILPQC advisory group participation representing
  - OB Advisory Group – 30 hospitals
  - Neonatal Advisory Group – 20 hospitals

>99% of IL births
ILPQC Development of Aims, Measures, and Data Collection

- **ILPQC Central and Initiative Clinical Leads**
  - Review other state PQCs’ resources
  - Draft based on lessons learned and IL needs

- **ILPQC OB/Neonatal Advisory Workgroup**
  - Provide input and guidance on tools and strategies

- **ILPQC Initiative Wave 1 Hospital Teams**
  - Test the data form
  - Provide feedback to ILPQC on data collection feasibility, usefulness of measures

- **ILPQC Central and Initiative Clinical Leads**
  - Develop Reports
  - Review with Advisory Workgroups
  - Implement with Wave 1 & Wave 2 Teams
ILPQC Hospital Team Data System Utilization Cycle

Collect data
- Hospital teams collect data on structure, process, and outcome measures

Input data into ILPQC Data System
- Teams input data into ILPQC Data System

Review reports during monthly meetings
- Teams review reports to compare data across time and across hospitals

Decide next steps for QI
- Team uses data to drive hospital QI

Team uses QI Toolkits to implement evidence-based systems changes to drive culture change

ILPQC Hospital Team Data System Utilization Cycle

Hospital teams collect data on structure, process, and outcome measures

Teams input data into ILPQC Data System

Teams review reports to compare data across time and across hospitals

Team uses data to drive hospital QI

Team uses QI Toolkits to implement evidence-based systems changes to drive culture change
Mothers and Newborns affected by Opioids- OB Initiative

<table>
<thead>
<tr>
<th>Aim: ≥70% women with OUD receiving MAT; ≥80% connected to Behavioral Health Counseling/Recovery Services prenatally or by delivery discharge</th>
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<tbody>
<tr>
<td><strong>Benchmarks:</strong></td>
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<tr>
<td>• ≥80% all pregnant women screened with a universal validated screener during prenatal period among all deliveries</td>
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<td>• ≥80% all pregnant women screened with a universal validated screener during L&amp;D admission among all deliveries</td>
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<tr>
<td>• ≥70% women with OUD with an OUD clinical care checklist completed prenatally or during delivery admission</td>
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<tr>
<td>• ≥70% women with OUD receiving: Narcan, Hep C, contraception, behavioral health/ social work consult prenatally or during delivery admission</td>
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<tr>
<td>• ≥70% women with OUD receiving pediatric / neonatal consult on NAS and role in newborn care prenatally or during delivery admission</td>
</tr>
<tr>
<td>• ≥80% women with OUD receiving OUD/NAS education prenatally or during delivery admission</td>
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101 hospital teams - May 2018 kick off through present
82 Hospitals have ever submitted data for over 1,000 women with OUD
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<tr>
<td>Develop QI Initiative (AIMS, Measures, Data Form) &amp; Identify Clinical Leads</td>
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<td>Recruit and Launch Wave 1: with OB &amp; Neonatal Teams (test data process) (33 Wave 1 Teams)</td>
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<td>Launch Wave 2 with all hospital teams (101 OB Teams, 88 Neo Teams)</td>
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<td>Baseline (Oct-Dec 201) &amp; Prospective Data Collection</td>
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<td>Rapid-Response Reports Development</td>
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<td>Rapid Response Reports Available for Teams</td>
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Teams collect data as indicated on ILPQC Data Form

16. Outcome Measure: Was the mother receiving Medication Assisted Treatment (MAT) prenatally or by delivery discharge? (Updated 1/2019)

- Yes
- No
- Patient declined MAT
- MAT not available (box to address issue)
- MAT not indicated (box to indicate why)
- MAT counseling not provided
- Unknown
- Unknown

17. If yes, when did the mother receive MAT?
- MAT started prenatally, before delivery admission
- MAT started during delivery admission
- Unknown

Teams enter data in ILPQC Data System

Teams review rapid-response report

Report: Women with OUD receiving MAT prenatally or by delivery discharge

Women with OUD on Medication Assisted Treatment (MAT) Prenatally or by Delivery Discharge
Mothers and Newborns affected by Opioids- Neo Initiative

Aims:

• Decrease pharmacologic treatment in opioid-exposed newborns with NAS to 20%
• Increase safe and optimized discharge plans in opioid-exposed newborns to 95%
• Increase breastfeeding rates in opioid-exposed newborns at discharge to 70%

Measures:

• Percent of opioid-exposed newborns receiving a toxicology screen (urine/cord/meconium)
• Percent of opioid-exposed newborns requiring pharmacologic therapy for NAS
• Number of days of pharmacologic treatment for NAS
• Percent of mothers and newborns rooming together during infant hospitalization
• Percent of opioid-exposed newborns receiving maternal breast milk at neonatal discharge
• Percent of opioid-exposed newborns discharged with plan of safe care in place
• Average length of stay for opioid-exposed newborns
Length of Stay for Opioid-Exposed Newborns (OENs) (≥35 Weeks) with NAS Symptoms (Median Days)

Teams collect data as indicated on ILPQC Data Form

<table>
<thead>
<tr>
<th>Data of Delivery (MM/DD/YYYY)</th>
<th>Data of Delivery ____ / ____ / ______</th>
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</thead>
<tbody>
<tr>
<td>Gestational age at birth 0-44</td>
<td>Gestational age, weeks: ______</td>
</tr>
<tr>
<td>Gestational age at birth 0-6</td>
<td>Gestational age, days: ______</td>
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<tr>
<td>What day of life was infant final discharge to home? Day of birth is considered day of life ZERO. This could be from your hospital or receiving hospital. If unable to determine, enter 999.</td>
<td>Day of Life: ______</td>
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</table>

Did infant have evidence of Neonatal Abstinence Syndrome (NAS)?

- Yes
- No

**ILPQC NAS Definition:**
“Neonatal Abstinence Syndrome refers to the collection of signs and symptoms that occur when a newborn is prenatally exposed to prescribed, diverted, or illicit opiates experiences opioid withdrawal. This syndrome is primarily characterized by irritability, tremors, feeding problems, vomiting, diarrhea, sweating, and in some cases, seizures.”

Teams enter data in ILPQC Data System

Teams review rapid-response reports

Report: Median LOS among OENs (≥35 weeks) with evidence of NAS Symptoms
Aim: Reduce the rate of severe morbidities in women with severe preeclampsia, eclampsia, or preeclampsia superimposed on pre-existing hypertension by 20% by December 2017

Approach:
1. Reduce time to treatment
2. Improve postpartum patient education
3. Improve postpartum patient follow up
4. Improve provider & RN debrief

- 110 hospital teams - May 2016 kick off to December 2017
- 106 Hospitals submitted data for over 17,000 women who experienced severe maternal HTN across the initiative
- Sustainability started January 2018, 86 teams submitted sustainability data
Maternal Hypertension: Time to Treatment

Teams collect data as indicated on ILPQC Paper Data Form

How long after the BP reached systolic $\geq 160$ and/or diastolic $\geq 110$ and persistent for 15 minutes was first BP medication given? ☐ <30 minutes ☐ 30-59 minutes ☐ $\geq 60$ minutes ☐ No action taken/ Missed opportunity

Teams enter data in ILPQC Data System

Teams review rapid-response reports

Report: Women with severe range blood pressures receiving medication within 60 min
Tracking QI Processes: Time to Treatment vs SMM Data

Time to Treatment Data (Severe HTN REDCap Data)

- Available monthly for hospital teams via medical record abstraction
- Facilitates process changes via rapid-cycle improvement
- ILPQC can identify and reach out to teams not achieving goals to provide timely QI support

SMM Data (Illinois DPH Hospital Discharge Data)

- Provides population-level outcomes data
- 1-2 year lag in availability of state-level data precludes rapid-cycle reporting and QI support for hospitals
- Provides an opportunity for end-of-initiative analysis on effects to SMM
APPENDIX: MNO-OB/NEO MONTHLY MOTHERS WITH OUD AND OPIOID-EXPOSED NEWBORNS DATA FORM
Who to collect data on

• *Monthly Data: Patient-Level
  – All women with OUD / opioid exposed newborns process & outcome measures

• **All women with Opioid-Use Disorder delivering at your hospital including:**
  • Positive self-report screen assessed to have OUD;
  • Positive opioid toxicology test during pregnancy or reporting opioid use disorder;
  • Using any non-prescribed opioids during pregnancy;
  • Using prescribed opioids chronically longer than a month in the third trimester.
  • In addition, include mothers if newborn (viable pregnancy ≥24 weeks, 0 days) has an unanticipated positive neonatal cord, urine, or meconium screen for opioids.
MNO-OB Baseline Data Collection
Strategies for Monthly Patient-Level Form

• Strategies for identifying OUD screening/self-report for baseline data:
  – Chart review
  – Neonatal logs
  – Key word searches in EMR
  – Diagnostic code (ICD-10) (Ex: Search for IDC-10 code O99.32 on problem list, or neonatal log of opioid exposed babies or babies with NAS)

• Some teams may have only a small # across 3 months:
  – 3 months (Oct-Dec 2017 baseline data)
  – If less than 5 moms, go one month earlier up to 6 months until 5 moms are identified (Sept, August, July 2017)
Identifying Women for Monthly Data

- Chart review
- Key word searches in EMR
- Pharmacy log
- Problem list - social work consult, psychiatric liaison/consult
- Track via bedside checklist
- Search diagnostic codes (ICD-10) Opioid Related Disorders:
  - F11.xx Opioid related disorders --or more precisely:
    - F1120: Opioid dependence, uncomplicated
    - F1123: Opioid dependence with withdrawal
    - F1124: Opioid dependence with opioid-induced mood disorder
    - F11288: Opioid dependence with other opioid induced disorder
    - F1129: Opioid dependence with unspecified opioid induced disorder
    - F1190: Opioid use, unspecified, uncomplicated
    - F11921: Opioid use, unspecified, with intoxication delirium
    - F1194: Opioid use, unspecified with opioid-induced mood disorder
    - F1199: Opioid use, unspecified with unspecified opioid-induced disorder
  - Also to consider: Z79.891 Long term (current) use of opiate analgesia
Linking Mother & Newborn Data

- Strategies to collect data from mom/baby pairs
- All moms with OUD documented - collect data each month for all moms delivered that month
- Opioid exposed newborns - collect data for all babies (OEN) discharged each month
- Keep log of Moms with OUD they enter and share with Neo team to confirm mom/baby pairs have data entered to complete mom/baby record
Identifying Mothers through Newborns

• Identify if data is available in EMR or chart review
• Data tracked via bedside checklist
• HRSA ICD-10 Opioid Related Disorders (changes coming in Oct 2018):
  • NAS: P96.1 Neonatal withdrawal symptoms from maternal use of drugs of addiction
  • "Newborn affected by Maternal use of opiates"
    • Current: P04.49 Newborn affected by maternal use of other drugs of addiction
    • New in Oct 2018: P04.14 Newborn affected by maternal use of opiates
Questions

Open the **Chat Panel** and send questions to “Host”