Maternal Morbidity & Mortality: Together We Will Make a Difference

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Elliott K. Main, MD, Medical Director, California Maternal Quality Care Collaborative, Clinical Professor of Obstetrics and Gynecology, Stanford University School of Medicine
Robert Ferguson, MPH, Chief Policy Officer, Jewish Healthcare Foundation
The Impact on Families

(Martin N, Cillekens E, and Freitas A, 2017)
Available at https://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy
Objectives

- Identify Pennsylvania trends and themes related to maternal morbidity and mortality as reported through Pennsylvania Patient Safety Reporting System (PA-PSRS)
- Describe the strategies implemented by California to decrease maternal mortality rates and how to work toward sustainability
- Discuss the initiatives being implemented by the Pennsylvania Perinatal Quality Collaborative (PAPQC) and identify value of participation in the collaboration
General Statistics

60% of pregnancy related deaths are preventable (CDC)

*Number of pregnancy-related deaths per 100,000 live births per year

CDC, 2020; available at

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PA-PSRS Maternal Complications by Report Submission Year

- 2015: 1,325
- 2016: 1,446
- 2017: 1,753
- 2018: 1,958
- 2019: 2,449

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<table>
<thead>
<tr>
<th>F. Complication of Procedure/ Treatment/ Test</th>
<th>4. Maternal Complication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Death</td>
<td></td>
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<tr>
<td></td>
<td>b. Unplanned transfer to ICU</td>
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<td></td>
<td>c. Intrapartum fetal death</td>
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<td></td>
<td>d. Uterine rupture</td>
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<tr>
<td></td>
<td>e. Unanticipated blood transfusion</td>
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<td></td>
<td>f. DVT (Deep Vein Thrombosis)</td>
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<td>g. PE (Pulmonary Embolism)</td>
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<td>h. Seizure</td>
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<td>i. Infection</td>
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<td>j. Other (specify)</td>
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<td>a. Death</td>
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<tr>
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</tr>
<tr>
<td></td>
<td>j. <strong>Other (specify)</strong></td>
<td></td>
</tr>
</tbody>
</table>
PA-PSRS : Maternal Deaths

- **Timeframe:** 1/1/2015- 12/31/2019

- **Deaths= 22 (8 intrapartum fetal deaths)**
  - Unknown
  - Hemorrhage related
  - Amniotic fluid emboli- suspected
  - Cardiac related
Themes from PA-PSRS Reporting

- Activation of rapid response (for various reasons)
- Bleeding:
  - Identified cause: Lacerations, tear, retained placenta, uterine atony
  - Treatment: surgery/ procedure, blood/fluids, Brakri, medications
- Shoulder dystocia
- Fetal decelerations
- Cesarean delivery
- Pre-eclampsia/eclampsia
### What are Pennsylvania hospitals doing to decrease maternal morbidity and mortality?

<table>
<thead>
<tr>
<th>Process measure</th>
<th>% Fully or partially implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate access to hemorrhage prevention meds and supplies in obstetric locations</td>
<td>94%</td>
</tr>
<tr>
<td>Established and use a standard objective measure to determine post partum blood loss</td>
<td>62%</td>
</tr>
<tr>
<td>Protocol to identify and treat maternal sepsis</td>
<td>55%</td>
</tr>
<tr>
<td>Identify and manage maternal hypertension</td>
<td>83%</td>
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</tbody>
</table>

*PSA 2018 Process Measure Survey*
Utilizing the Power of State Collaboratives to Improve Maternal Outcomes

Supported by:
California Dept. of Public Health
California Health Care Foundation
Centers for Disease Control (CDC)
Merck for Mothers Project
Yellow Chair Foundation

Elliott K. Main, MD
Director of Quality Assurance and Implementation for AIM
Medical Director, CMQCC
Clinical Professor of Obstetrics and Gynecology, Stanford University School of Medicine

No conflicts or disclosures
In the last 15 years, US has seen rises in:

Maternal Mortality: Up 50-70%
Severe Maternal Morbidity: Up 100%
Cesarean Births: Up 50%
Maternal Mortality Rate,
California and United States; 1999-2013

California: ~500,000 annual births, 1/8 of all US births

Increase of >50% noted in both CA and US rates
Maternal Mortality and Severe Morbidity

Approximate distributions, compiled from multiple studies

<table>
<thead>
<tr>
<th>Cause</th>
<th>Mortality (1-2 per 10,000)</th>
<th>ICU Admit (1-2 per 1,000)</th>
<th>Severe Morbid (1-2 per 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thromboembolism</td>
<td>10-15%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Infection</td>
<td>10-15%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>10-15%</td>
<td>30%</td>
<td>45%</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>10-15%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Cardiac Disease</td>
<td>25-30%</td>
<td>20%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Obstetric Hemorrhage and Preeclampsia: Summary

- Most common **preventable** causes of maternal mortality
- Far and away the most common causes of Severe Maternal Morbidity
- High rates of provider “quality improvement opportunities”
Most common preventable causes of maternal mortality

Far and away the most common causes of Severe Maternal Morbidity

High rates of provider “quality improvement opportunities”

3 Deadly D’s: Denial, Delay, Dismissal
Hospitals know how to protect mothers. They just aren’t doing it.

Alison Young, USA TODAY
1:54 p.m. PDT July 27, 2018
Maternal Safety Bundles

What are they?
• “Checklist” of items and practices for every birthing site
• Not a national protocol!!
• Facilities will modify content based on local resources

Uniform Structure:
- Readiness
  - Every unit—prepare and educate
- Recognition & Prevention
  - Every patient—before event
- Response
  - Every Event—team approach
- Reporting/Systems Learning
  - Every unit—systems improvement

Available (with resource links) at: safehealthcareforeverywoman.org
Maternal Safety Bundles

READINESS
Every patient/family
- Provide education to promote understanding of opioid use disorder (OUD) as a chronic disease.
- Emphasize that substance use disorders (SUDs) are chronic medical conditions; treatment is available, family and peer support is necessary and recovery is possible.
- Emphasize that opioid pharmacotherapy (i.e., methadone, buprenorphine) and behavioral therapy are effective treatments for OUD.
- Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.
- Awareness of the signs and symptoms of NAS
- Interventions to decrease NAS severity (e.g., breastfeeding, smoking cessation)
- Engage appropriate partners (i.e., social workers, case managers) to assist patients and families in the development of a “plan of care” for mom and baby.

Every clinical setting/health system
- Provide staff-wide (clinical and non-clinical staff) education on SUDs.
- Emphasize that SUDs are chronic medical conditions that can be treated.
- Emphasize that stigma, bias and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
- Provide training regarding trauma-informed care.
- Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers.
- Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.
- Know state reporting guidelines regarding the use of opioid pharmacotherapy and identification of illicit substance use during pregnancy.
Hemorrhage Safety Bundle

Readiness
- Hemorrhage Cart
- Rapid access to meds
- Establish response team
- Blood bank protocols
- Unit education

Recognition and Prevention
- Assessment of hemorrhage risk for all mothers
- Measured blood loss
- Oxytocin after all births

Response
- Unit standard Hemorrhage Protocol with checklists
- Support program for patients and families

Reporting/System Learning
- Huddles and debriefs for planning and feedback
- Multidisciplinary review of serious cases
- Monitor process and outcome metrics
Developed the “Mentor Model” using physician/nurse teams that coach 6-9 hospitals within a large IHI Breakthru Style QI Collaborative

Reduction in Severe Maternal Morbidity From Obstetric Hemorrhage With a Large (99) Hospital Quality Collaborative (~300,000 patients)

<table>
<thead>
<tr>
<th>California Hospitals with CMQCC Rapid-Cycle Maternal Data Center</th>
<th>Hospitals (N)</th>
<th>Baseline SMM-HEM Rate (per 100 HEM cases)</th>
<th>Post Intervention SMM-HEM Rate (per 100 HEM cases)</th>
<th>Percent Reduction in SMM-HEM</th>
<th>Significance (p value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals in CMQCC CPMS Collaborative*</td>
<td>99</td>
<td>22.7</td>
<td>18.0</td>
<td>20.8%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>---Without Prior HEM Collaborative Experience*</td>
<td>74</td>
<td>22.7</td>
<td>19.2</td>
<td>15.4%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>---With Prior HEM Collaborative Experience*</td>
<td>25</td>
<td>22.7</td>
<td>16.2</td>
<td>28.6%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Comparison Group: Hospitals not in Collaborative and no prior CMQCC HEM Collaborative Experience</td>
<td>48</td>
<td>28.6</td>
<td>28.2</td>
<td>1.2%</td>
<td>0.7713</td>
</tr>
</tbody>
</table>

“Treat the Damn Blood Pressure!”

Controlling blood pressure is the key intervention to prevent deaths due to stroke in women with preeclampsia.

Over the last decade, the UK has focused QI efforts on aggressive treatment of both systolic and diastolic blood pressure and has demonstrated a reduction in deaths.
Severe Maternal Hypertension Treated Within 60 Minutes

Goal: 80% of women treated <60 min

Increased 41% to 82%
Change per Month, aOR = 1.11, 95% CI 1.10-1.12
P < 0.001
New Standards for Perinatal Safety

• Issued August 21, 2019

PC.06.03.01
Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia.

Element(s) of Performance for PC.06.03.01

1. Develop written evidence-based procedures for measuring and remeasuring blood pressure. These procedures include criteria that identify patients with severely elevated blood pressure.

2. Develop written evidence-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes the following:
   - The use of an evidence-based set of emergency response medications that are stocked and immediately available on the obstetric unit
   - The use of seizure prophylaxis
   - Guidance on when to consult additional experts and consider transfer to a higher level of care
   - Guidance on when to use continuous fetal monitoring
   - Guidance on when to consider emergent delivery
   - Criteria for when a team debrief is required
   Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, emergency department, anesthesiology, nursing, laboratory, and pharmacy.

3. Provide role-specific education to all staff and providers who treat pregnant/postpartum patients about the hospital’s evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.
   Note: The emergency department is often where patients with symptoms or signs of severe hypertension present for care after delivery. For this reason, education should be provided to staff and providers in emergency departments regardless of the hospital’s ability to provide labor and delivery services.

4. Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Severe hypertension/preeclampsia drills include a team debrief.

AIM Structure Measures: Hypertension

- Hypertension/Preeclampsia Policy/Protocol that covers measurement of BP, treatment of severe HTN, administration of Magnesium and treatment of Mag overdose
- Drills at least annually
- Multidisciplinary case reviews
- Debriefs after case with complications
- Staff Education
Maternal Mortality Rate
California and United States; 1999-2013

California: ~500,000 annual births, 1/8 of all US births

Maternal Deaths per 100,000 Live Births

- California Rate
- United States Rate

Year

Maternal Mortality Review Committee
Maternal Mortality Rate
California and United States; 1999-2013

California: ~500,000 annual births, 1/8 of all US births

Maternal Deaths per 100,000 Live Births

- California Rate
- United States Rate

Year

CMQCC
Toolkits and Collaboratives
CA Mortality Review Committee
Maternal Mortality by Race/Ethnicity

How did we do in California?

United States

California

Black:White Ratio

3.8x

4.4x

3.8x

Black:White Ratio

2.8x

All Races

All Races
Why do Black Women do so much worse?

Usual explanation by doctors and nurses is that black women have more obesity, more hypertension, more diabetes, and more social disadvantages…
What If We Looked At B:W Disparity In SMM Only Among College Graduates?

And adjusted for age, BMI and other clinical and demographic risk factors…
What If We Looked At B:W Disparity In SMM Only Among College Graduates?

And adjusted for age, BMI and other clinical and demographic risk factors...

Black-White disparity in SMM is highest among college graduates (2.2x higher than whites)
What If We Looked At B:W Disparity In SMM Only Among College Graduates?

And adjusted for age, BMI and other clinical and demographic risk factors…

Black-White disparity in SMM is highest among college graduates (2.2x higher than whites)

Looking At Absolute Rates:

• SMM rate in Black women with college degrees: 2.4%
• SMM rate in White women without high school diplomas: 1.6%

California linked data: 2010-2015 Q3
How does a state Perinatal Quality Collaborative (PQC) Improve Care and Outcomes?

- Not just by convening a group of interested stakeholders
- Not just by establishing a system of outreach education

Success for AIM:
- Focus on Building State Capacity to Drive Systems & Culture Change
- Focus on building bridges with Public Health and Communities

Courtesy: Dr. Ann Borders, Medical Director, Illinois Perinatal Quality Collaborative
‘I am one of the 50,000’

Every year, 50,000 women in the U.S. suffer injuries or severe complications related to childbirth. Many are lucky to survive. They want you to hear their stories.

USA TODAY Investigations

― Rachel Yencha, Ohio
Thanks to the CMQCC Staff

Visit: CMQCC.org
August 11, 2020
PSA Maternal Morbidity Mortality Webinar
Robert Ferguson, MPH, Chief Policy Officer, Jewish Healthcare Foundation
PQCs are networks of teams working to identify processes that need to be improved and quickly adopt best practices to achieve collective aims.
The PA PQC was Built on Statewide Efforts

- Premie Network and AAP
- West Chester University Pilot Study with the Vermont Oxford Network (VON)
- PA PQC Task Force
  - Facilitated by March of Dimes
- PA PQC Advisory and Work Groups
PA PQC Work Groups Created the Driver Diagrams and Quality Measures in Early 2019

PA PQC Advisory Group
State agencies, providers, health system associations, provider associations, health plans, community-based organizations, researchers, foundations, quality improvement collaboratives, and advocates

Maternal Mortality Driver Diagram Work Group
Loren Robinson, MD, MSHP
Hyagriv Simhan, MD, MS

Neonatal Abstinence Syndrome (NAS) Driver Diagram Work Group
Kimberly Costello, DO

Opioid Use Disorder (OUD) Driver Diagram Work Group
Elizabeth Krans, MD, MSc

Quality Improvement Methods Work Group
Michael Posencheg, MD

Maternal Mortality Quality Metrics
Jason Baxter, MD
Stacy Beck, MD

NAS Quality Metrics Work Group
Scott Lorch, MD

OUD Quality Metrics Work Group
Marian Jarlenski, PhD, MPH

Policy Work Group
Aasta Mehta, MD, MPP

Access the Driver Diagrams and Measures here: https://www.whamglobal.org/data-collection
Jewish Healthcare Foundation

The Jewish Healthcare Foundation facilitates the PA PQC
The NEPapPQC is Part of the PA PQC
The PA PQC is designed to help birth sites and NICUs drive improvement and adopt standards of care towards three aims.
PA PQC Aims

✓ Reduce maternal mortality and morbidity as an action arm of the Maternal Mortality Review Committee (MMRC)

✓ Improve Identification of and Care for Pregnant and Postpartum Women with Opioid Use Disorders (OUD)

✓ Improve Identification of and Care for Opioid-Exposed Newborns (OEN)

PA PQC Funded by:
The PA PQC Includes

65 birth sites and NICUs

87% of live births in PA

14 health plans
What it Means to be a PA PQC Site

- Form a Team
- Participate in Learning Sessions
- Launch Quality Improvement (QI) Cycles
- Access QI Coaching and Resources
- Report Aggregate Data and Quarterly Surveys

https://www.whamglobal.org/data-collection
Step 1: Form a Team & Meet Monthly

https://www.whamglobal.org/get-involved

**Team Roles**

- PA PQC Champions
  - Maternal Health Provider Champion
  - Neonatal Health Provider Champion
  - Admin. Champion
  - Data Champion
- Multi-Disciplinary Quality Improvement Teams
- Community-Based Partners

*Your team is not alone...the health plans also formed a team.*

**Team Activities**

- Prioritize an improvement opportunity for your QI project (e.g., review your team’s PA PQC baseline survey)
- Create a QI project plan, with a 30-60-90 day plan and data collection plan
- Coordinate the rollout of the QI project plan and PDSA cycles
- Review data submitted to the PA PQC Data Portal and Surveys to inform PDSA cycles
# PA PQC Learning Sessions

Materials available here: [https://www.whamglobal.org/member-content/materials-from-sessions](https://www.whamglobal.org/member-content/materials-from-sessions)

<table>
<thead>
<tr>
<th>Date</th>
<th># Attendees</th>
<th># Session Evaluations Completed</th>
<th>Satisfaction (average)</th>
<th>Good use of time?</th>
<th>Help you identify strategies towards goals?</th>
<th>Learning Objective Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/11</td>
<td>Over 200</td>
<td>169</td>
<td>4.29</td>
<td>99%</td>
<td>99%</td>
<td>4.13-4.29</td>
</tr>
<tr>
<td>6/28</td>
<td>Over 170</td>
<td>85</td>
<td>4.17</td>
<td>97.6%</td>
<td>91.8%</td>
<td>4.0-4.34</td>
</tr>
<tr>
<td>9/24</td>
<td>Over 180</td>
<td>73</td>
<td>4.36</td>
<td>100%</td>
<td>99%</td>
<td>4.11-4.5</td>
</tr>
<tr>
<td>12/11</td>
<td>Over 180</td>
<td>85</td>
<td>4.14</td>
<td>98%</td>
<td>98%</td>
<td>3.8-4.1</td>
</tr>
<tr>
<td>3/18</td>
<td>Over 200</td>
<td>94</td>
<td>4.14</td>
<td>98%</td>
<td>99%</td>
<td>3.98-4.34</td>
</tr>
<tr>
<td>6/11</td>
<td>Over 220</td>
<td>104</td>
<td>4.18</td>
<td>100%</td>
<td>N/A</td>
<td>4.17-4.32</td>
</tr>
</tbody>
</table>
The Learning Sessions Spark PDSA Cycles

Current State

PDSA

PDSA

PDSA

Each improvement moves the process closer to the ideal

IDEAL

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The PA PQC Coaches Guide Your Team on Quality Improvement and Implementation Science

Karena Moran, PhD  
Research and Quality Project Manager

Jennifer Condel, SCT(ASCP)MT  
Manager, Lean Healthcare Strategy and Implementation

Pauline Taylor, CQIA  
Program Specialist

Elizabeth Balskus, MA  
Quality Improvement Facilitator

Carol Frazer, MEd, LPC  
Practice Transformation Specialist
PA PQC sites launched 105 QI projects

- 35 sites working on SUD QI projects
- 3 sites working on Immediate Postpartum LARC projects
- 28 sites working on NAS QI Projects
- 39 sites working on Maternal Mortality QI Projects
OUD Preliminary Survey Results

*Baseline compared to Jan-March*

Process in place to provide ongoing SUD sensitivity training requirements for staff and providers

14% vs. 34%

Used a validated, self-report screening tool for substance use in pregnancy

34% vs. 69%
NAS Preliminary Survey Results

Used standardized pharmacologic protocols for NAS
67% vs. 76%

Used standardized non-pharmacologic protocols for NAS
67% vs. 71%
PA PQC Data Submission

✓ 27 sites submitted data on NAS-related measures
✓ 13 sites submitted data on OUD-related measures
✓ 24 sites submitted data on MM-related measures
PA PQC Quality Improvement Award Sites

Geisinger Lewistown Hospital – SUD Screening

UPMC Hamot, Horizon, Northwest – Spreading Eat, Sleep, Console

Penn State Health Hershey Medical Center and Children’s Hospital – SUD Screening and SBIRT

Temple University Hospital – SUD Screening and Follow-up and Rooming In

WellSpan York Hospital – NAS Non-pharmacologic bundle
PA PQC Quality Improvement Award Sites

Thomas Jefferson Abington – SUD Screening
Einstein Philadelphia – NAS Standardized Care
Wayne Memorial – SUD Screening
WellSpan Chambersburg – NAS Eat, Sleep, Console (ESC)
AHN WestPenn Hospital – NAS Non-pharmacologic bundle
AHN Saint Vincent Hospital – NAS Inter-Rater Reliability Scoring
Geisinger Bloomsburg Hospital – SUD Screening
Geisinger Holy Spirit – SUD Screening
UPMC Magee-Womens Hospital – NAS Non-pharmacological and ESC tool
Immediate Postpartum LARC Pilot

UPMC Horizon | St Luke's Anderson Campus | Geisinger Medical Center

1. Formed IPLARC Teams
2. Organizing PA PQC Policy Group on IPLARC
3. Holdings trainings with ACOG
4. Rolling out structures, processes, and skills to offer IPLARC
PA PQC Data Portal - OUD

PQC: Opioid Use Disorder - Monthly

- a) Women screened for SUD with a validated screen at any time during the pregnancy (numerator)
- b) Women with an OUD diagnosis at any time during pregnancy (numerator)
- c) Women with a delivery in the month (denominator)
- d) Women 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 (numerator)
- e) Women with a delivery and OUD diagnosis in the month (denominator)
- f) Cumulative number of women who received a postpartum visit on or between 1 and 84 days after delivery (numerator)
- g) Cumulative number with a delivery at least 84 days ago who are diagnosed with OUD (denominator)

* Enter NA for not applicable, incomplete, or missing data
PA PQC Data Portal - NAS

Tableau Dashboard

Hospital: Demo Hospital
Date: May 2020
Domain:

PQC: Neonatal Abstinence Syndrome Additional Measures - Monthly

a) Number of who are treated with a nonpharmacologic bundle (numerator)
b) Number receiving pharmacologic therapy (numerator)
c) Number referred to follow-up services at discharge (numerator)
d) Number of NAS cases (denominator)

PQC: Neonatal Abstinence Syndrome Additional Measures - Monthly
PQC: Maternal Mortality SMM - Quarterly (1Q=Mar, 2Q=June, 3Q=Sept, 4Q=Dec)
PQC: Maternal Mortality: SMM - Annually (Enter data in last month of that year, e.g. Dec)
PQC: Maternal Mortality: Non-Transfusion SMM - Quarterly (1Q=Mar, 2Q=June, 3Q=Sept, 4Q=Dec)
PQC: Maternal Mortality: non-transfusion SMM - Annually (Enter data in last month of that year, e.g. Dec)
PQC: Maternal Mortality Additional Measures - Monthly
PQC: Opioid Use Disorder - Monthly
PQC: Opioid Use Disorder Additional Measures - Monthly
PQC: Neonatal Abstinence Syndrome - Quarterly (1Q=Mar, 2Q=June, 3Q=Sept, 4Q=Dec)
PQC: Neonatal Abstinence Syndrome Additional Measures - Monthly
PQC: IPLARC - Monthly

* Enter NA for not applicable, incomplete, or missing data

Click for data portal technical issues/questions
Click to E-Mail about PAPQC Data Definitions

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PQC: Neonatal Abstinence Syndrome - Quarterly (1Q=Mar, 2Q=June, 3Q=Sept, 4Q=Dec)

Measure
a) Median number of hospital days from birth through discharge to home among newborns greater than 34 gestational weeks with NAS

Entry

* Enter NA for not applicable, incomplete, or missing data
### Data Dictionary for OUD measures

#### Tableau Dashboard

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Date</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demo Hospital</td>
<td>May 2020</td>
<td>PQC. IPLARC - Monthly</td>
</tr>
</tbody>
</table>

#### PQC: IPLARC - Monthly

**Measure**

- a) Number of LARC devices placed prior to discharge (numerator)
- b) Number of postpartum women (women aged 15-44 years who had a live birth) who desired IPLARC placement (denominator)
- c) Number of LARC devices placed prior to discharge for those with OUD (numerator)
- d) Number of postpartum women (women aged 15-44 years who had a live birth) with OUD who desired IPLARC placement (denominator)

**Entry**

- [ ]
- [ ]
- [ ]
- [ ]

* Enter NA for not applicable, incomplete, or missing data

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Click for data portal technical issues/questions
Click to E-Mail about PA PQC Data Definitions
OUD SUD Screening Percentage

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<tbody>
<tr>
<td>Women screening for SUD with a validated screen at any time during the pregnancy</td>
<td>855</td>
<td>451</td>
<td>408</td>
<td>630</td>
<td>1,606</td>
<td>1,511</td>
<td>1,761</td>
<td>1,766</td>
<td>1,645</td>
<td>1,667</td>
<td>912</td>
<td>1,570</td>
<td>937</td>
<td>806</td>
<td>462</td>
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<tr>
<td>Women with a delivery in the month</td>
<td>0</td>
<td>627</td>
<td>600</td>
<td>869</td>
<td>844</td>
<td>783</td>
<td>994</td>
<td>505</td>
<td>595</td>
<td>501</td>
<td>462</td>
<td>441</td>
<td>855</td>
<td>451</td>
<td>408</td>
<td>630</td>
<td>1,606</td>
<td>1,511</td>
<td>1,761</td>
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</table>
Upcoming Learning Sessions

https://www.whamglobal.org/member-content/register-for-sessions

Upcoming Learning Collaboratives

Register For September 3rd PA PQC Learning Collaborative

Register For December 16th PA PQC Learning Collaborative
Upcoming QI Collaboratives

https://www.whamglobal.org/member-content/register-for-sessions

Upcoming QI Collaborative Virtual Meetings

Register for July 8 11:00am to 12:00pm

Register for August 12 11:00am to 12:00pm

Register for October 14 11:00am to 12:00pm
Additional Training Opportunities

https://www.whamglobal.org/member-content/additional-trainings

ASAM Buprenorphine Waiver Trainings for Women’s Health Providers

1. August 26 from 8:00 a.m. to 12:30 p.m.
2. September 30 from 8:00 a.m. to 12:30 p.m.

AccessMatters’ Implicit Bias Trainings

1. Thursday, August 13 from 9:00 a.m. to 12:00 p.m.
2. Wednesday, August 26 from 1:00 p.m. to 4:00 p.m.
3. Monday, September 15 from 9:00 a.m. to 12:00 p.m.

Motivational Interviewing Strategies
PA PQC Policy Group

Past Accomplishments

• Recommended quality measures for value-based payment models that informed the design of maternity bundled payment models in 2021 (see the policy section at https://www.whamglobal.org/resources)

Current Work

• Policy recommendations for rural maternity care
• Increase commercial coverage for IPLARC and problem-solve any operational challenges with coverage among HealthChoices MCOs
Future Directions for the PA PQC

- Launching an initiative to improve maternal depression screening and follow-up and reduce racial disparities
  - Launch Task Force to create a Change Package
  - Facilitate community listening and planning meetings to develop action plans in communities with low rates of depression screening/follow-up and high rates of racial disparities
  - Recruit and support PA PQC sites to adopt the Change Package
Future Directions for the PA PQC

- Applying to become an AIM State, with the hemorrhage OR severe hypertension AND disparities bundles
Future Directions for the PA PQC

- **Maintaining a focus on OUD/NAS Key Interventions:**
  - Screening all pregnant women for SUD/OUD using validated screening tools
  - Establishing clinical pathways for women with OUD, and engaging them in MAT treatment
  - Providing access to immediate postpartum contraceptive options, including LARC
  - Providing home visitation post-discharge for mothers and infants exposed to opioids in partnership with health plans and counties
  - Creating a safe environment for the infant by connecting the mom/baby dyad to wrap around supports
  - Caring for the mom/baby dyad for 15 months through well-child visits
What questions do you have?
Evaluation/Certificate of Continuing Education

- If you are the registrant of today’s webinar, upon exiting the webinar, an evaluation will be displayed in a new internet browser window for participants to participate in an evaluation and obtain their certificate of continuing education.

- For those who did not register but are participating as a group, please participate in the evaluation by copying and pasting the below link into a new internet browser window:

  https://www.surveymonkey.com/r/MaternalMorbidityAndMortalityTogetherWeWillMakeaDifference08112020

- In order to receive a certificate of continuing education each individual requesting credit must complete an evaluation including contact information. After completing the evaluation, a link will be provided to download and print a certificate of continuing education. Evaluations must be completed by 1 p.m. on August 14, 2020.

- If you experience any issues accessing the evaluation and/or certificate of continuing education, please feel free to direct any inquiries to Shelly Mixell at shmixell@pa.gov.
References


References


Thank You!

@PennsylvaniaPatientSafetyAuthority  @PAPatientSafety  Pennsylvania Patient Safety Authority  Pennsylvania Patient Safety Authority