

Maternal Mortality: Hypertension

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Allegheny Health Network-Saint Vincent Hospital	<ul style="list-style-type: none"> Provide each antepartum/postpartum elevated BP/pre-eclamptic discharged patient with automated BP cuff DME to take, track BP's outside of the hospital. (Target go live –January 2022) NOTE: Discharge Instruction/patient education documentation should include: warning signs – “Save Your Life” magnet, discharge instruction sheet (antepartum or postpartum), how to use BP cuff and tracking of BP's, responses to education/information and available support 	<ul style="list-style-type: none"> What is the impact of patient self BP monitoring on hypertension management, reduction vs. increase in readmissions - post-delivery? 	Kay Edinger, Kim Amon, Kathy Vitale
Einstein Medical Center-Montgomery Beginning	<ul style="list-style-type: none"> Education about HTN with every staff member (RN, PCA, midwives, physician) HTN medications made available in every med station Cognitive aids posted in units (Triage, L&D, mother/baby) Provided updated information on post-partum unit to every mother (AWHONN Save your life) Educational handouts distributed in ED UPCOMING: Skills based competencies will continue in ED in the fall 	<ul style="list-style-type: none"> How are inpatient units tracking outpatient follow up? Best types of outpatient education? 	Celina Migone, MD
Evangelical Community Hospital Sustaining	<ul style="list-style-type: none"> Our Severe Hypertension Protocol for Obstetric Patients is easily located on the Tools list in our EMR. We also have a Severe Hypertension binder with the protocol, antihypertensive medication algorithms, Severe HTN/ Preeclampsia order set, and our hospital procedure for Severe HTN/ Preeclampsia. 		Jen Sullivan RN, BSN Jennifer.Sullivan@evanhospital.com

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Geisinger Ongoing	<ul style="list-style-type: none"> • Implementing checklist for HTN Crisis • Providing simulation & drills for education • Reviewing medication access • Created order set to avoid unnecessary clinical variation • Instituted home BP monitoring for patients with a diagnosis of CHTN, GHTN or Pre-Eclampsia/Eclampsia prenatally and postpartum (GHP patients only). • Comprehensive reviews of each non-compliant case to understand our gaps in care and whether or not they are justified. • Including ED in education including hospitals with no OB department (ongoing) 	<ul style="list-style-type: none"> • How do clinician leaders manage physician non-compliance with recommendations? • How do nursing leaders handle nursing non-compliance with alerting provider of the elevate readings? 	Elissa Concini emconcini@geisinger.edu
Lehigh Valley Health Network-Pocono	<ul style="list-style-type: none"> • All providers and nursing staff were educated with a Hypertension Disorders in Pregnancy module through GNOSIS • Clinical Practice Guidelines (CPG) related to perinatal hypertension reviewed with all OB providers and OB nursing staff with ED providers being educated in the near future • Daily interdisciplinary team rounding with reference to CPG's on HTN patients • Submitted a Grant proposal collaboratively with ESU to have the nursing students provide blood pressure equipment and education to hypertensive pregnant patients in their home. Patients will proactively self-monitor & report blood pressures to OB office. 	Any suggestions would be appreciated	

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<p>Moses Taylor Hospital</p> <p>Ongoing</p>	<ul style="list-style-type: none"> • Development of a Hypertensive emergencies in OB- Severe Pre-eclampsia- Critical Event Checklist. • Development of a Hypertensive emergencies in OB-Seizures/eclampsia- Critical Event Checklist. • Development of a Hypertension Emergency card that can be worn with ID badges. • Development of a Hypertensive Emergency competency which includes the appropriate way to obtain a blood pressure. Competency is completed yearly. • Education to all ED staff and ICU staff on management of hypertension in the OB population. • Departmental tabletop drills/ discussion concerning the management of patients with hypertension. • Completion of a Blood Pressure/ Hypertensive Monitor to help with the identification of severe range blood pressures and time hypertensive medications were administered. • Implementation of Perigen software to monitor and alarm with out-of-range EFM strips and maternal vital signs. • Implementation of the AWHONN Post- Birth Warning Signs as discharge instructions for going home. 	<ul style="list-style-type: none"> • How everyone is able to get other department (ICU and ED) with treating severe range pressures of 160/110? • Other possible educational avenues used for education on this topic. • What other hospitals are doing for blood pressure management of postpartum patients after discharge? 	
<p>Penn Medicine-Chester County Hospital</p>	<ul style="list-style-type: none"> • Preeclampsia Pathway • Hypertensive Management Pathway • Postpartum Hypertension Pathway • Adoption of Heart Safe Motherhood • System-wide Collaborative 	<ul style="list-style-type: none"> • How were you able to sustain improvements made with managing hypertensive disorders? 	

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<p>Penn Medicine-Lancaster General/Women and Babies</p> <p>Ongoing</p>	<ul style="list-style-type: none"> • Identified physician and unit-based champions to participate in sub-committee of care management team <ul style="list-style-type: none"> ○ Completed assessment of current state with champions and identified areas of opportunity to improve standardization and care. ○ Established a target condition to further identify stakeholders and develop an action plan • Developed provider and nursing education – Jan 2021 • Updated order sets to assist with antihypertensive medication ordering – Jan 2021 • Refined EMR best practice alerts for preeclampsia to better target treatment of severe range hypertension – June 2021 • Established a method for reporting and determining baseline data <ul style="list-style-type: none"> ○ Validated current preeclampsia pathway report provides correct information 	<ul style="list-style-type: none"> • We would like to hear success stories from other hospitals who have improved and sustained treatment of patients with severe range BP's within 60 minutes. 	<p>Janay DiBerardino, Perinatal Safety Nurse,</p> <p>Janay.DiBerardino@penmedicine.upenn.edu</p>
<p>Penn Medicine-Pennsylvania Hospital</p>	<ul style="list-style-type: none"> • Facility wide standard protocol <ul style="list-style-type: none"> ○ Checklists and escalation algorithms ○ Interdisciplinary approach including all areas where pregnant patients receive care • Standard approach to educating prenatal and postpartum women: <ul style="list-style-type: none"> ○ Evaluating options through Cipher Health or MyPennMedicine ○ Including family in education across the continuum • Severe hypertension simulations: <ul style="list-style-type: none"> ○ Incorporating hypertension drills into existing in-situ simulation program 	<ul style="list-style-type: none"> • What strategies have you used to engage community members in quality improvement? • We have fully integrated the Heart Safe Motherhood program into our care of patients with hypertension. What proactive approaches have others taken to educate women on hypertension before they are diagnosed? 	

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<p>Penn State Health- Hershey Medical Center and Children’s Hospital</p> <p>Ongoing</p>	<ul style="list-style-type: none"> • Development of written evidence-based guidelines for management of acute hypertensive emergency in pregnant and postpartum patients (completed) • ED, ICU, and WBC nursing staff education (initial and ongoing)- (completed/ongoing) • Availability of guidelines in the electronic manual(s) and posted on the unit (completed) • Development of a quick reference tool/checklist based on the written guidelines (completed) • Placement of medications in Medication Pyxis machines for quick and easy access (completed) • OB Provider education distributed and tracked via an electronic education module (completed/ongoing) • ED, Anesthesia, Trauma Provider education (in progress) • Complete case reviews for patients who were not treated within 60 minutes, per the PA PQC measure. Disseminate key findings and improvement opportunities at the monthly WBC UACT (completed/ongoing) • Conduct interdisciplinary simulations on hypertensive emergencies biannually or more frequently (completed/ongoing) • Collaboration with ED staff to improve comfort and awareness of treatment with antihypertensive medications and mag bolus/gtt. (ongoing) • New: Availability of OB HTN Emergency tackle boxes (provided through Pharmacy) (in progress) 	<ul style="list-style-type: none"> • How are you providing, and tracking education completed for providers outside of OB specialty? 	<p>Lisa Murphy, MSN RNC-OB, lmurphy2@pennstatehealth.psu.edu</p>
<p>Punxsutawney Hospital</p>	<ul style="list-style-type: none"> • Develop order sets for the ED for timely treatment of Hypertensive pregnant/postpartum patients • Education of ED staff/physicians on identifying & treating Hypertensive pregnant/postpartum patient using ACOG & AIM guidelines 	<ul style="list-style-type: none"> • Best ways they have found to educate staff-online, in person in-services, combination? 	
<p>St. Clair Hospital</p>	<ul style="list-style-type: none"> • Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists • Quantification of blood loss 	<ul style="list-style-type: none"> • Data tracking tips. • Discussion/debrief with families 	<p>Shawndel Laughner</p>

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	<ul style="list-style-type: none"> Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms) Establish a culture of huddles for high-risk patients and post-event debriefs to identify successes and opportunities Data collection started on triage patients seen for hypertension and review of those records to assess for timely treatment of Hypertension. 	<ul style="list-style-type: none"> HIS/EMR Support – tips on how other organizations-built tools to help collect data from the EMR 	
St. Luke's University Health Network- Allentown and Bethlehem	<ul style="list-style-type: none"> Implemented screening tool so all women 15-55 y.o. are screened to determine if they are currently/recently pregnant within the past 6 weeks ED RNs check off s/s on EPIC tool that will prompt the RN to facilitate more expedited follow up with an ED provider who will consider OB consult 	<ul style="list-style-type: none"> Has any other network attempted to track this kind of screening in the ED? Success? 	
Tower Health- Reading Hospital	<ul style="list-style-type: none"> HTN protocol in place by 7/1/20 (model after the California Quality Collaborative). AWHONN post birth warning signs education for staff & for all post-partum patients prior to discharge. 	<ul style="list-style-type: none"> Implementation strategies Strategies for standardization Patient and family education prenatally Feedback on our processes 	
UPMC Womens Health Service Line-Hamot Ongoing	<ul style="list-style-type: none"> Collected pre-data that validated disparity Recognized an issue with blood pressure cuffs and need to measure arm and ensure appropriate cuff Creating badge buddy for nursing staff to display nurse-driven protocol and thresholds for action Excited for recent- PAPQC innovation award for UPMC Hamot and further efforts to reduce maternal morbidity and improve time to treatment 		Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu
UPMC Womens Health Service Line- Horizon Ongoing	<ul style="list-style-type: none"> Collected pre-data that validated disparity Recognized an issue with blood pressure cuffs. And need to measure arm and ensure appropriate cuff Creating badge buddy for nursing staff to display nurse-driven protocol and thresholds for action 		Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu

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UPMC Womens Health Service Line- Magee Ongoing	<ul style="list-style-type: none"> Collected pre-data that validated disparity Recognized an issue with blood pressure cuffs. And need to measure arm and ensure appropriate cuff Creating badge buddy for nursing staff to display nurse-driven protocol and thresholds for action 		Vivian Petticord Director, Women’s Health Service Line pettvm@upmc.edu
WellSpan Health Ongoing	<p>We have been working on severe HTN for quite sometime. I am listing below the new work which needs to be done which is not complete at this time. The other components of the bundle have been implemented</p> <ul style="list-style-type: none"> Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams, including the team that is continuously improving the severe hypertension—processes. —NOT STARTED Seek expertise from diverse community groups that have built trust with individuals in the community in sharing information about hypertension warning signs and response.—NOT STARTED Establish discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider Offer expansive birthing choices by collaborating and building trust with community resources that have perinatal CHWs, Doulas, and other supportive services. Analyze how institutional policies are facilitating or alleviating racial disparities, and the impact 	<ul style="list-style-type: none"> Best ways to engage diverse patients, families, and communities in conversations related to SMM and has anyone Has anyone Gathered feedback from patients using self-reported tools, such as: <ul style="list-style-type: none"> Mother’s Autonomy in Decision Making (MADM) instrument to assess the women’s autonomy and role in decision making during maternity care Mothers on Respect index (MORi) to assess the women's experiences of respect and self-determination when interacting with their maternity care. 	Adriane Burgess PhD, RNC, Director of Quality Improvement, aburgess2@wellspan.org

Moving on Maternal Depression (MOMD)

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger Medical Center Ongoing	<ul style="list-style-type: none"> • Increase prenatal screening rate • Increase postpartum screening rate • Examine all data by race/ethnicity <ul style="list-style-type: none"> ○ Address any identified disparities • Improve follow-up to at-risk screens • Improve tracking of metrics 	<ul style="list-style-type: none"> • NICU – what is the primary role of the person screening (e.g., nurse, psychologist, nursing assistant)? Is screening their full-time job? • Peds – what do we do with the positive screen immediately? What are your plans/algorithm? What supports do you have in place at Pediatric clinics? <ul style="list-style-type: none"> ○ How can Pediatricians be better trained to deal with mothers screening positive for PPD? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative kmoran3@thehealthplan.com
Jefferson Health-Abington Hospital Beginning	<ul style="list-style-type: none"> • In assessment phase- conducting assessment of current state and recruiting stakeholders • Determining measures • Working with business analytics team to enable reporting on screening and interventions in all care settings 	<ul style="list-style-type: none"> • Strategies for effective screening • Experience using patient generated data 	Susan Utterback, DNP, MSIT, RN-BC, Nursing Systems Coordinator, susan.Utterback@Jefferson.edu
Lehigh Valley Hospital-Cedar Crest Beginning	<ul style="list-style-type: none"> • Plan to replace existing phq2/9 with a different screening tool • Increase frequency of screening to 14, 24 and 36 weeks • Education for Providers • Education for Nurses 	<ul style="list-style-type: none"> • Overcoming lack of sufficient number of counselors, mental health providers • Increasing provider’s education re: other resources and counseling techniques • Overcoming fear of treating mental health disorders • Documentation help 	
*Lehigh Valley Hospital-Hazleton Beginning	<ul style="list-style-type: none"> • Plan to replace existing phq2/9 with a different screening tool • Increase frequency of screening to 14, 24 and 36 weeks • Education for Providers • Education for Nurses 	<ul style="list-style-type: none"> • Overcoming lack of sufficient number of counselors, mental health providers • Increasing provider’s education re: other resources and counseling techniques • Overcoming fear of treating mental health disorders • Documentation help 	

<p>*Lehigh Valley Hospital- Muhlenberg</p> <p>Beginning</p>	<ul style="list-style-type: none"> • Plan to replace existing phq2/9 with a different screening tool • Increase frequency of screening to 14, 24 and 36 weeks • Education for Providers • Education for Nurses 	<ul style="list-style-type: none"> • Overcoming lack of sufficient number of counselors, mental health providers • Increasing provider’s education re: other resources and counseling techniques • Overcoming fear of treating mental health disorders • Documentation help 	
<p>*Lehigh Valley Hospital- Pocono</p> <p>Beginning</p>	<ul style="list-style-type: none"> • Plan to replace existing phq2/9 with a different screening tool • Increase frequency of screening to 14, 24 and 36 weeks • Education for Providers • Education for Nurses 	<ul style="list-style-type: none"> • Overcoming lack of sufficient number of counselors, mental health providers • Increasing provider’s education re: other resources and counseling techniques • Overcoming fear of treating mental health disorders • Documentation help 	
<p>*Lehigh Valley Hospital- Schuylkill</p> <p>Beginning</p>	<ul style="list-style-type: none"> • Plan to replace existing phq2/9 with a different screening tool • Increase frequency of screening to 14, 24 and 36 weeks • Education for Providers • Education for Nurses 	<ul style="list-style-type: none"> • Overcoming lack of sufficient number of counselors, mental health providers • Increasing provider’s education re: other resources and counseling techniques • Overcoming fear of treating mental health disorders • Documentation help 	
<p>Penn Medicine- Hospital of the University of Pennsylvania</p> <p>Sustaining</p>	<ul style="list-style-type: none"> • Nursing Education surrounding significance of PPD: ongoing • Identification of Outpatient Processes post discharge: completed • Report out to unit staff and leadership: ongoing • Collaboration with Social Work: completed • Social Work Consult: metric identification in process • Identifying outpatient referral sources based on insurance and zip codes: ongoing • Identifying availability of community partnerships: in process 	<p>#1: Percent EPDS completion prior to discharge.</p> <ul style="list-style-type: none"> • Sustaining completion rates above 90%. <p>#2: Percent moderate and high risk EPDS scores receiving social work consult prior to discharge.</p> <ul style="list-style-type: none"> • Support structures from Behavioral Health 	<p>Bridget Howard</p>

	<ul style="list-style-type: none"> • Continue to educate inpatient and outpatient based on risk stratification of race/ethnicity: ongoing • Anti-Bias Training: completed by providers and staff • Partnering with outside organizations: OB/GYN Department Grand Rounds-Reproductive Justice: ongoing • Anti-Racism Work: OB/GYN Department Grand Rounds, Breastfeeding Equity Committee, OB/GYN Health Equity Work Group and Anti-Racism Book Club Committee: ongoing • Women’s Health Patient and Family Advisory Council: initiated 		
Penn State Health-Hershey Medical Center and Children’s Hospital Ongoing	<ul style="list-style-type: none"> • Edinburgh Postnatal Depression Scale (EPDS) completed after delivery prior to hospital discharge (screening completed within first day on postpartum unit). • Social work consulted for elevated scores • Early follow up for repeat screening for elevated scores or individuals with identified risk factors • Routine repeat screening at 6-week postpartum visit 	<ul style="list-style-type: none"> • Relevance of early screening in relation to follow up scoring • Improving access to mental health services for abnormal screenings 	Amy Cruz, MD, FACOG, acruz6@pennstatehealth.psu.edu
St. Clair Hospital Beginning	<ul style="list-style-type: none"> • To date we hold a Postpartum support group for women with perinatal mood changes. • Reach out to OB offices – assess the screening tool • Look at the in-hospital screening tool • Plan QI project • Addressing depression using the PHQ-2 tool in triage for all patients. <ul style="list-style-type: none"> ○ Education to come during competency in Feb-Mar 2022 on the PHQ-2 tool 	<ul style="list-style-type: none"> • Data collection tactics • Screening tools used • Postpartum follow up • Community resources used 	Shawndel Laughner
*St. Luke’s University Health Network-Allentown and Bethlehem	<ul style="list-style-type: none"> • Patient education video developed by internal medical staff (residents) • Ed. video built to be delivered to patients via MyChart Bedside on educational iPads used to distribute inpatient patient ed. 	<ul style="list-style-type: none"> • Process at other facilities to ensure no delay of discharge 	

	<ul style="list-style-type: none"> • Edinburgh Depression Screening loaded on to patient iPads to allow for self-reporting (decrease chance of bias) • Patient received notification if any of their answers would require further evaluation by care team 		
Temple University Hospital Beginning	<ul style="list-style-type: none"> • Educating nursing staff on post partum depression , provide education for patients during discharge (resources, referrals) • Screening in the third trimester on a subpopulation • Standardized resources for the Health System • Community listening sessions • Piloting transition of care clinic for with BP issues 	<ul style="list-style-type: none"> • How do we get patients to come in for prenatal and postpartum care? • How do we improves access to mental health treatment? • How do you follow a patient that screens high for maternal depression? 	Temple University Hospital
Tower Health-Reading Hospital Ongoing	<ul style="list-style-type: none"> • The Reading Hospital MOMD team has representatives from each of the OB offices including THMG and the Women’s Health Center; behavioral health including Integrated Care Clinicians and TH outpatient behavioral health; Population Health including ICCs and Care Navigators; Reading Hospital inpatient MCH units (OB Triage, Labor & Delivery, Mother-Baby, Pediatrics) and includes leadership and education roles; and pediatric offices. • Goal is to increase representation from TH pediatric offices and other community pediatric offices and community behavioral health partners. <p>Screening standard practice developed:</p> <ul style="list-style-type: none"> • At a minimum, the PHQ is administered at the initial prenatal visit, once a trimester, at every OB Triage visit, upon admission to Labor and Delivery unit, on the mother-baby unit before discharge home, at the postpartum visit, and at pediatric appts up to 9 months. <ul style="list-style-type: none"> ○ Best practice is to administer PHQ at each visit which can be done in verbal or written form. ○ The Edinburgh Postnatal Depression Scale may be used if there is a positive postpartum PHQ screen. 	<ul style="list-style-type: none"> • How to connect with ambulatory OB and pediatric offices, documentation and referral from these offices, data collection. • Marketing resources for the community at large and providers in the community specifically. • How have you been able to integrate community pediatric offices onto your team? • How have you been able to integrate community behavioral health partners onto your team? 	Kerin Kohler Women’s Health Social Worker

<p>UPMC Womens Health Service Line-Magee-Womens Hospital</p> <p>Beginning</p>	<ul style="list-style-type: none"> • * HEALTH EQUITY NOW met 9/2, 11/16 and 12/2/21 • * Implemented PHQ9 across all birthing hospitals in July • * 9/2 Created calendar for monthly events to recognize • 11/16: Advocacy Day @ UPMC. • Hosted DHS & JHF to showcase work on the project which included standardized screening. Focus groups with AA women and listening. Pts want advocate. Led to creation of Doula Program. 2 doulas spoke. • MWRI Summit: Afternoon of advocacy. Dr Livingston participated in panel discussion. Many great community leaders and key speakers spoke of diversity and injustices in society today. 	<ul style="list-style-type: none"> • Interested to know other ways to connect with community that are beneficial • How to build trust with community? 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>
<p>WellSpan Health</p> <p>Ongoing/Sustaining</p>	<p>We are essentially following all of the MOMD steps.</p> <ul style="list-style-type: none"> • Ensuring system wide follow up for women with increased scores-increasing access to resources system wide- Have postpartum case manager who will call all women who score high at discharge. She is Also available for referral in the prenatal and postpartum setting • Embedding alerts and improved documentation into the EHR-BPA to fire with high EPDS scores-- • Required documentation on discharge summary of any patient with an increased EPDS score. • Increasing patient education in Babyscripts on mental health—including Spanish materials • Working on developing process to screen for PPD in NICU--COMPLETED • Screening in the PEDS/Family practice visit—BPA created • Creating a data dashboard to track system wide screening and follow up—COMPLETED • Working with Behavioral Health service line to create pathways from perinatal care to therapy screening and follow up (completed) 	<ul style="list-style-type: none"> • How to start community conversations to address this topic? • Targeted interventions to address perinatal depression in BIPOC 	<p>Adriane Burgess PhD, RNC Director, Quality Improvement aburgess2@wellspan.org</p>

Immediate Postpartum Long-Acting Reversible Contraception (IP LARC)

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger Medical Center (GMC) Sustaining	<ul style="list-style-type: none"> • (Re)educate providers and nurses on IUD insertion immediately postpartum. • Clarify billing, coding, and reimbursement processes. • Clarify patient eligibility for reimbursement outside of the DRG. • Improve device access on L&D (storage). • Assess patient desire for IP LARC. • Monitor and address expulsion rates (as applicable). 	<ul style="list-style-type: none"> • Are you using verbal or written consent for IPLARC placement? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative kmoran3@thehealthplan.com
Geisinger Wyoming Valley (GWV) Ongoing	<ul style="list-style-type: none"> • (Re)educate providers and nurses on IUD insertion immediately postpartum. • Clarify billing, coding, and reimbursement processes. • Clarify patient eligibility for reimbursement outside of the DRG. • Improve device access on L&D (storage). • Assess patient desire for IP LARC. • Monitor and address expulsion rates (as applicable). 	<ul style="list-style-type: none"> • Are you using verbal or written consent for IPLARC placement? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative kmoran3@thehealthplan.com
Geisinger Lewistown Hospital (GLH) Beginning	<ul style="list-style-type: none"> • (Re)educate providers and nurses on IUD insertion immediately postpartum. • Clarify billing, coding, and reimbursement processes. • Clarify patient eligibility for reimbursement outside of the DRG. • Improve device access on L&D (storage). • Assess patient desire for IP LARC. • Monitor and address expulsion rates (as applicable). 	<ul style="list-style-type: none"> • Are you using verbal or written consent for IPLARC placement? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative kmoran3@thehealthplan.com

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Main Line Health, Lankenau Medical Center Ongoing	<ul style="list-style-type: none"> • “Desires IPLARC” has been implemented as a field in the EMR • Education for providers, residents, and staff about offering and documenting LARC desire and LARC placement – supply, role, etc. • Prenatal patients are educated about pros/cons of IPLARC, and determination of interest is obtained <ul style="list-style-type: none"> ○ Prenatal counseling ○ Video on display in clinic ○ Patient education materials and information sheets being distributed 	<ul style="list-style-type: none"> • Expanding services to commercial insurance patients. • What are the options for counseling and billing if they do desire LARC? • Is there an opportunity to encourage insurance providers to consider including LARC in their coverage? • Expanding services to other hospitals and educating private practices on counseling • What is the most effective way for spreading the word? Seminars, training sessions, newsletters, etc. 	Sam Meske, MS, MBA Business Manager meskes@mlhs.org
St. Clair Hospital Beginning	<ul style="list-style-type: none"> • To date we formed a team: <i>team updates due to turnaround</i> <ul style="list-style-type: none"> ○ Key physician lead ○ Social Work/Case Management ○ Clinical Integration Specialist ○ Director W&C Services ○ Director Inpatient Pharmacy • Develop the supporting structure, processes, team roles, and skills to offer contraceptive counseling and access, including IPLARC • OB department will identify in the office those in need of IPLARC • Insertion added to charge OB charge master • Work with pharmacy to obtain product <ul style="list-style-type: none"> ○ Pharmacy has an ETA of the 2nd week in January to revisit IPLAC purchasing – we are adding Liletta and Nexplanon – <ul style="list-style-type: none"> - Depo Provera currently available. ○ Pushed back because of J&J vaccine implementation and distribution 	<ul style="list-style-type: none"> • How you were able to implement the structures and processes to routinely counsel, offer, and provide IPLARC? • Did you meet any resistance on offering IPLAC in the hospital setting? • Did you find a large need/desire from patients for IPLARC? 	Shawndel Laughner

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St. Luke's University Hospital-Anderson campus Sustaining	<ul style="list-style-type: none"> Use EMR to identify patients who desire and receive IPLARC 	<ul style="list-style-type: none"> Methods for tracking which patients desire IPLARC to more accurately follow PA PQC metrics How to overcome insurance barriers to make IPLARC available for all patients 	Danielle Johnson, DO Danielle.johnson@sluhn.org
St. Luke's University Hospital-Allentown campus Sustaining	<ul style="list-style-type: none"> Use EMR to identify patients who desire and receive IPLARC 	<ul style="list-style-type: none"> Methods for tracking which patients desire IPLARC to more accurately follow PA PQC metrics How to overcome insurance barriers to make IPLARC available for all patients 	Danielle Johnson, DO Danielle.johnson@sluhn.org

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<p>UPMC Womens Health Service Line-Altoona</p> <p>Beginning</p>	<ul style="list-style-type: none"> • Ensure IT systems are modified to document acquisition, stocking, ordering, placement, counseling, consent, billing and reimbursement for IPLARC. • Ensure all patients receive contraceptive information prenatally- including the option to receive IPLARC. • Modify L&D, OB OR, postpartum workflows to identify and have devices available for pts desiring LARC. Store LARC devices for easy access in a timely manner. <ul style="list-style-type: none"> ○ Educate clinicians, community partners and nurses on informed consent and shared decision making. • Involve pharmacy for obtaining the device & distribution to ensure timely placement. • Assure billing codes are in place and that staff in all necessary departments are educated on correct billing procedures- device and procedure costs. • Participate in hands-on training of IPLARC insertion. • Shared UPMC consent processes for IPLARC to customize for each hospital. • Educate providers, nurses, lactation consultants, social workers about clinical recommendations related to IPLARC placement and breastfeeding. • Assure all patients receive comprehensive contraceptive counseling prior to discharge. 	<ul style="list-style-type: none"> • This is a difficult project to implement. The training is still remote for providers and not in-person related to on-going pandemic. • Billing and reimbursement for cost of device and insertion remains challenging 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>

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<p>UPMC Womens Health Service Line-Hamot</p> <p>Beginning</p>	<ul style="list-style-type: none"> • Ensure IT systems are modified to document acquisition, stocking, ordering, placement, counseling, consent, billing and reimbursement for IPLARC. • Ensure all patients receive contraceptive information prenatally- including the option to receive IPLARC. • Modify L&D, OB OR, postpartum workflows to identify and have devices available for pts desiring LARC. Store LARC devices for easy access in a timely manner. <ul style="list-style-type: none"> ○ Educate clinicians, community partners and nurses on informed consent and shared decision making. • Involve pharmacy for obtaining the device & distribution to ensure timely placement. • Assure billing codes are in place and that staff in all necessary departments are educated on correct billing procedures- device and procedure costs. • Participate in hands-on training of IPLARC insertion. • Shared UPMC consent processes for IPLARC to customize for each hospital. • Educate providers, nurses, lactation consultants, social workers about clinical recommendations related to IPLARC placement and breastfeeding. • Assure all patients receive comprehensive contraceptive counseling prior to discharge. 	<ul style="list-style-type: none"> • This is a difficult project to implement. The training is still remote for providers and not in-person related to on-going pandemic. • Billing and reimbursement for cost of device and insertion remains challenging 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>
<p>UPMC Womens Health Service Line-Harrisburg</p> <p>Beginning</p>	<ul style="list-style-type: none"> • Ensure IT systems are modified to document acquisition, stocking, ordering, placement, counseling, consent, billing and reimbursement for IPLARC. • Ensure all patients receive contraceptive information prenatally- including the option to receive IPLARC. • Modify L&D, OB OR, postpartum workflows to identify and have devices available for pts desiring LARC. Store LARC devices for easy access in a timely manner. 	<ul style="list-style-type: none"> • This is a difficult project to implement. The training is still remote for providers and not in-person related to on-going pandemic. • Billing and reimbursement for cost of device and insertion remains challenging as well as identifying who has SUD 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	<ul style="list-style-type: none"> ○ Educate clinicians, community partners and nurses on informed consent and shared decision making. ● Involve pharmacy for obtaining the device & distribution to ensure timely placement. ● Assure billing codes are in place and that staff in all necessary departments are educated on correct billing procedures- device and procedure costs. ● Participate in hands-on training of IPLARC insertion. ● Shared UPMC consent processes for IPLARC to customize for each hospital. ● Educate providers, nurses, lactation consultants, social workers about clinical recommendations related to IPLARC placement and breastfeeding. ● Assure all patients receive comprehensive contraceptive counseling prior to discharge. 		

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
<p>UPMC Womens Health Service Line- Horizon</p> <p>Sustaining</p>	<ul style="list-style-type: none"> • Ensure IT systems are modified to document acquisition, stocking, ordering, placement, counseling, consent, billing and reimbursement for IPLARC. • Ensure all patients receive contraceptive information prenatally- including the option to receive IPLARC. • Modify L&D, OB OR, postpartum workflows to identify and have devices available for pts desiring LARC. Store LARC devices for easy access in a timely manner. <ul style="list-style-type: none"> ○ Educate clinicians, community partners and nurses on informed consent and shared decision making. • Involve pharmacy for obtaining the device & distribution to ensure timely placement. • Assure billing codes are in place and that staff in all necessary departments are educated on correct billing procedures- device and procedure costs. • Participate in hands-on training of IPLARC insertion. • Shared UPMC consent processes for IPLARC to customize for each hospital. • Educate providers, nurses, lactation consultants, social workers about clinical recommendations related to IPLARC placement and breastfeeding. • Assure all patients receive comprehensive contraceptive counseling prior to discharge. 	<ul style="list-style-type: none"> • This is a difficult project to implement. The training is still remote for providers and not in-person related to on-going pandemic. • Billing and reimbursement for cost of device and insertion remains challenging as well as identifying who has SUD 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>
<p>UPMC Womens Health Service Line- Williamsport</p> <p>Beginning</p>	<ul style="list-style-type: none"> • Ensure IT systems are modified to document acquisition, stocking, ordering, placement, counseling, consent, billing and reimbursement for IPLARC. • Ensure all patients receive contraceptive information prenatally- including the option to receive IPLARC. • Modify L&D, OB OR, postpartum workflows to identify and have devices available for pts desiring LARC. Store LARC devices for easy access in a timely manner. 	<ul style="list-style-type: none"> • This is a difficult project to implement. The training is still remote for providers and not in-person related to on-going pandemic. • Billing and reimbursement for cost of device and insertion remains challenging 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	<ul style="list-style-type: none"> ○ Educate clinicians, community partners and nurses on informed consent and shared decision making. ● Involve pharmacy for obtaining the device & distribution to ensure timely placement. ● Assure billing codes are in place and that staff in all necessary departments are educated on correct billing procedures- device and procedure costs. ● Participate in hands-on training of IPLARC insertion. ● Shared UPMC consent processes for IPLARC to customize for each hospital. ● Educate providers, nurses, lactation consultants, social workers about clinical recommendations related to IPLARC placement and breastfeeding. ● Assure all patients receive comprehensive contraceptive counseling prior to discharge. 		
<p>WellSpan Health</p> <p>Completing</p>	<ul style="list-style-type: none"> ● Working with pharmacy to ensure IPLARC is available at each facility. ● Meetings occurring at each 3 entities (Gettysburg (Nexplanon in place) and Ephrata (approved by DOH and Nexplanon in place as of end of Nov), Chambersburg (submitted and awaiting DOH approval—then IUD and Nexplanon will be in place) to move forward initiative ● Working on provider guidelines – ● draft near completion—aim to put out for review and approval Jan 2022 	<ul style="list-style-type: none"> ● How to handle lack of insurance coverage outside of Medicaid payors? 	<p>Adriane Burgess PhD, RNC Director, Quality Improvement aburgess2@wellspan.org</p>

Maternal OUD

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Allegheny Health Network-Forbes Hospital	<ul style="list-style-type: none"> • Have OB offices send list of patients who have positive screen. • Social work able to initiate plan before patient even arrives for delivery. • Social work to reach out to other facilities to see how they are working through this. 	<ul style="list-style-type: none"> • Make sure women are being appropriately screened and have resources in place prior to discharge. 	
Allegheny Health Network-Jefferson Hospital	<ul style="list-style-type: none"> • We provided staff-wide education on SUD/OUD as well as use of the 5P screening tool. • We began screening all pregnant people for OUD/SUD in the outpatient setting. • We refer appropriate patients to our Perinatal Hope Program and/or a social worker to more fully identify their needs and make a plan for the remainder of their pregnancy care. • We educated our inpatient staff and started using the 5P screen inpatient on any patient without a previous outpatient screen. 	<ul style="list-style-type: none"> • Their facility's urine drug testing and sending of cord stats in relation to implementation of a 5P screen. 	
Allegheny Health Network-Saint Vincent Hospital	<ul style="list-style-type: none"> • Staff Education • Provider documentation education completed; Laminated tip sheets located at provider PC's • Incorporate information on Growing Hope/Perinatal Hope program and community support available for addicted moms-to-be • Utilization of NAS informational booklet – implemented, access in provider offices and community locations. • Distribution of community agency support listing – still in process • Re-education of ED staff for referral process* (January 2022 target) 	<ul style="list-style-type: none"> • Are chart audits completed randomly to ensure coding accuracy? • How are incorrect codings identified and how is provider documentation reviewed to reflect accurate patient picture/level of acuity? 	Lani Erdman, Kay Edinger, Kim Amon, Erika Pluta, Kathy Vitale
Conemaugh Memorial Medical Center	<ul style="list-style-type: none"> • Solidifying reporting process used to capture women screened for SUD and OUD. • Identification of standardized and universal screening tool. • Implementation of screening tool across all practices. 	<ul style="list-style-type: none"> • Successes and challenges encountered from other obstetric practices in implementing universal screening tool. 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Einstein Medical Center Philadelphia	<ul style="list-style-type: none"> • No workflow in current state <ul style="list-style-type: none"> ○ Solution- work with current MAT program pilot to determine how to perform out-patient screening for OUD • Need standardized screening tool <ul style="list-style-type: none"> ○ Solution- choose tool from ones presented at PA PQC and work with MAT program pilot leaders to coordinate efforts • Change in workflow for providers and MA staff <ul style="list-style-type: none"> ○ Solution- develop educational plan for provider and MA staff • Lack of provider resources for SBIRT <ul style="list-style-type: none"> ○ Solution- develop multi-disciplinary team to determine utilization of resources 		
Evangelical Community Hospital Ongoing	<ul style="list-style-type: none"> • Positive screening initiates a plan of care by an obstetrical provider and consult with Care Management as needed. 	<ul style="list-style-type: none"> • Does anyone have a clinical pathway for SUD that we could review? 	Jen Sullivan RN, BSN Jennifer.Sullivan@evanhospital.com
Geisinger Bloomsburg Sustaining	<ul style="list-style-type: none"> • Implementing universal SUD screening in L&D and Outpatient • Implementing a clinical pathway for at-risk screens • Re-educating on existing protocol for when to obtain a urine drug test • Streamlining workflow and information sharing with data entry in EMR 	<ul style="list-style-type: none"> • Process for when patient refuses to complete screening tool. <ul style="list-style-type: none"> ○ Or mother refuses to give urine sample? • How to implement and track universal screening and adherence to algorithm in outpatient prenatal clinics? <ul style="list-style-type: none"> ○ How often do you screen prenatally? • What is your process for medical marijuana? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative kmoran3@thehealthplan.com

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger Community Medical Center Ongoing	<ul style="list-style-type: none"> Implementing universal SUD screening in L&D and Outpatient Implementing a clinical pathway for at-risk screens Re-educating on existing protocol for when to obtain a urine drug test Streamlining workflow and information sharing with data entry in EMR 	<ul style="list-style-type: none"> Process for when patient refuses to complete screening tool. <ul style="list-style-type: none"> Or mother refuses to give urine sample? How to implement and track universal screening and adherence to algorithm in outpatient prenatal clinics? <ul style="list-style-type: none"> How often do you screen prenatally? What is your process for medical marijuana? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative k Moran3@thehealthplan.com
Geisinger Lewistown Sustaining	<ul style="list-style-type: none"> Implementing universal SUD screening in L&D and Outpatient Implementing a clinical pathway for at-risk positive screens Re-educating on existing protocol for when to obtain a urine drug test Streamlining workflow and information sharing with data entry in EMR 	<ul style="list-style-type: none"> Process for when patient refuses to complete screening tool. <ul style="list-style-type: none"> Or mother refuses to give urine sample? How to implement and track universal screening and adherence to algorithm in outpatient prenatal clinics? <ul style="list-style-type: none"> How often do you screen prenatally? What is your process for medical marijuana? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative k Moran3@thehealthplan.com
Geisinger Medical Center Beginning	<ul style="list-style-type: none"> Implementing universal SUD screening in L&D and Outpatient Implementing a clinical pathway for at-risk positive screens Re-educating on existing protocol for when to obtain a urine drug test Streamlining workflow and information sharing with data entry in EMR 	<ul style="list-style-type: none"> Process for when patient refuses to complete screening tool. <ul style="list-style-type: none"> Or mother refuses to give urine sample? How to implement and track universal screening and adherence to algorithm in outpatient prenatal clinics? <ul style="list-style-type: none"> How often do you screen prenatally? What is your process for medical marijuana? 	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative k Moran3@thehealthplan.com

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger Wyoming Valley Ongoing	<ul style="list-style-type: none"> Implementing universal SUD screening in L&D and Outpatient Implementing a clinical pathway for positive screens Re-educating on protocol for when to obtain a urine drug test Streamlining workflow and information sharing with data entry in EMR 	<ul style="list-style-type: none"> Process for when patient refuses to complete screening tool. <ul style="list-style-type: none"> Or mother refuses to give urine sample? How to implement and track universal screening and adherence to algorithm in outpatient prenatal clinics? <ul style="list-style-type: none"> How often do you screen prenatally? What is your process for medical marijuana? 	<p>Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative</p> <p>k Moran3@thehealthplan.com</p>
Guthrie Packer Hospital	<ul style="list-style-type: none"> Finding a validated screening tool- chose 4P's tool Educating staff and training on chosen tool Implement screening of all pregnant women at least once during prenatal care (to start) 	<ul style="list-style-type: none"> Suggestions on how to gather data from Epic efficiently Any trouble shooting or suggestions on how to use/implement the screening tool (4P's)? 	
Holy Redeemer Health Beginning	<ul style="list-style-type: none"> Follow up and collection of all paper screens to compare for accuracy with Athena report –defines how many patients we are capturing –still inconsistent. Work in progress. Need to identify how many new OB's each office has to obtain percentage of mom's screened. Re-training one office how to attach screen to tool in Athena for tracking –this is how we want to capture Hiring a navigator for our SUD Program 	<ul style="list-style-type: none"> How referrals are followed up on? Does the office follow up, if so what is the process, challenges, outcomes? 	<p>Julie Greenfield , Director of Nursing, OB-GYN Acute and Ambulatory Alliance</p> <p>jgreenfield@holyredeemer.com</p>
Jefferson Health- Abington Hospital Sustaining	<ul style="list-style-type: none"> Implementation of Universal Screening with 5Ps tool at first prenatal visit and all triage and inpatient admissions to L & D Working with data team to enable reporting on ambulatory screening and follow-up/treatment data after Epic transition. This data will help to measure impact of screening and drive improvement efforts. 	<p>Engaging care givers and overcoming stigma</p>	<p>Susan Utterback, DNP, MSIT, RN-BC, Nursing Systems Coordinator,</p> <p>susan.Utterback@Jefferson.edu</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Lehigh Valley Health Network-Pocono	<ul style="list-style-type: none"> • Educate all Prenatal Care Providers on the 4P's scripting • Educating on the referral process to the LSW • Provide educational materials to pregnant women with OUD 		
Main Line Health Sustaining	<ul style="list-style-type: none"> • Social Work Evaluation of Outpatient Resources Across 4 Hospitals & 4 Geographic Counties: Goal to Optimize & Standardize • Develop Clinical and Psychosocial Pathways for OUD/SUD & NAS • Coordinate early consultation with Neonatology to optimize therapies & care plan 	<ul style="list-style-type: none"> • Best Practices for OUD/NAS Pathways • Outpatient Resource Referrals • Overcoming Epic Documentation Challenges (Problem List) 	Main Line Health OUD/SUD Interdisciplinary Team
Moses Taylor Hospital Ongoing	<ul style="list-style-type: none"> • Initiated the use of the 5 P screening tool in both Labor and Delivery at MTH and Prenatal offices. • Standardized LOS for newborns born to mothers born to with OUD. • Utilize the Pediatric Department to encourage bonding during increased newborn LOS. 	<ul style="list-style-type: none"> • Other tools hospitals have developed to help with patient educations. 	
Penn Medicine-Chester County Hospital	<ul style="list-style-type: none"> • Completed process mapping, gap analysis, Affinity Diagram, & brainstorming • Established working groups: <ul style="list-style-type: none"> ○ Development of staff and patient education program ○ Implementation of Eat, Sleep, Console ○ Establishment of 5P's in inpatient and outpatient settings 	<ul style="list-style-type: none"> • How to partner with residential programs to help mothers spend time with their infants when admitted for NAS. 	
Penn Medicine-Hospital of the University of Pennsylvania	<ul style="list-style-type: none"> • Create standardized workflow for SUD/OUD screening and education • Screen all pregnant patients for SUD/OUD using a validated screening tool • Map local SUD/OUD treatment options that provide MAT and women-centered care including local resources that support recovery 	<ul style="list-style-type: none"> • Do you have any recurring education/resources for staff (OB/nursing/lactation) to increase comfort in managing patients on admission/postpartum? 	Adi Hirshberg, MD

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Penn State Health-Hershey Medical Center & Children's Hospital	<ul style="list-style-type: none"> • Gain consensus & approval on a validated screening tool to screen all pregnant women for substance use- Done • Draft a paper patient-friendly form to screen patients at the time of the first prenatal appointment- Done • Develop workflow to identify: who will respond to patients who screened positive; who will refer patients to treatment; and to whom can we refer our patients- Done • Draft Substance Use Treatment Referral Reference List- Done • Provide unbiased non-judgmental, trauma-informed care: <ul style="list-style-type: none"> ○ Complete baseline attitudes measurement staff survey- Done ○ Provide education/intervention- Done ○ Complete reassessment through the attitudes measurement staff survey • Complete staff education regarding: <ul style="list-style-type: none"> ○ The 5Ps tool and screening rationale- Done ○ The 5Ps screening process and SBIRT- Done • Spread to other practice sites within the health system- In progress 	<ul style="list-style-type: none"> • How do you collect and track data on prenatal outpatient screenings and MAT initiation and continuity? • How do you track patients with a positive OUD diagnosis? (is it in your EMR? Do you run reports based on diagnosis codes?) • What education was most beneficial for your providers? (specific SBIRT training?) 	
Penn State Health- Holy Spirit Medical Center Ongoing	<ul style="list-style-type: none"> • Implementing universal SUD screening: L&D, Outpatient • Implementing a clinical pathway for positive screens • Re-educating on protocol for when to obtain a urine drug test 	<ul style="list-style-type: none"> • Process for when patient refuses to complete screening tool. <ul style="list-style-type: none"> ○ Or mother refuses to give urine sample? • How to implement and track universal screening and adherence to algorithm in outpatient prenatal clinics? 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
St. Clair Hospital Sustaining	<ul style="list-style-type: none"> We began using the 5Ps tool for outpatient prenatal visits and inpatient admissions to our hospital in June 2019. We coordinated with the affiliated OB offices for them to utilize this tool for screening their pregnant patients in the office setting, starting with the 1st prenatal visit and then again in the 2nd and 3rd trimester. We provided the OB offices with referral forms to be faxed to our Level 2 Nursery Coordinator for follow-up care. When our nursery coordinator receives a referral, she reaches out to the family to discuss the care they can expect when they arrive for their delivery. We educated inpatient nursing staff on 5Ps screening tool and implemented it to be utilized on all patients admitted. 	<ul style="list-style-type: none"> Growing the role of our newly created perinatal social worker position. 	Shawndel Laughner
Tower Health-Reading Hospital	Clinical pathway for pregnant women with OUD <ul style="list-style-type: none"> Screening for SUD/testing at initial OB Hospital observation for MAT induction, methadone and buprenorphine offered Connection with methadone program in county. Suboxone maintenance program at Women’s Health Center for pregnant women with OUD. Soft Landings- support program for pregnant and postpartum women with opioid and stimulant use issues. Case management, therapy, support & educational groups. Prenatal development of a Plan of Safe Care. Prenatal education about neonatal opioid withdrawal. Connection to Early Intervention. QI project to look at results of screening tools and urine tests; Screening questions asked at initial prenatal visit. 		Kerin Kohler; Liz Huyett

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
UPMC Womens Health Service Line	<p>Access:</p> <ul style="list-style-type: none"> ○ Maternal medical support to prevent withdrawal during pregnancy ○ On call service for all UPMC hospitals 24/7 ○ Provide regular prenatal and other medical appointments ○ 4 Outreach Community Centers ○ Same day on next day within 24-hour appointments <p>Prevention:</p> <ul style="list-style-type: none"> ○ Community education ○ Obstetrical provider education ○ Minimize fetal exposure to Opioid substances ○ Early engage mother as a leader in her recovery ○ Narcan “to go” <p>Response:</p> <ul style="list-style-type: none"> ○ Pregnancy Recovery Center (Prenatal & Postpartum) ○ UPMC Healthplan engagement <ul style="list-style-type: none"> ▪ Support programs for patients, families, staff ○ Multidisciplinary team OB, MFM, SW, Nurses, Mental Health therapists ○ Methadone Conversion to buprenorphine from inpatient to outpatient. ○ Outpatient buprenorphine medication treatment ○ Warm hand overs ○ ED Physician and APP trained in buprenorphine treatment ● Reporting: Centers of Excellence <ul style="list-style-type: none"> ○ State, Allegheny County, UPMC Healthplan ○ Report as appropriate to various committees 	<ul style="list-style-type: none"> ● Thoughts on the regulatory hurdles for medication assisted treatment can we as a group impact? ● Post-Partum pain management 	
Wayne Memorial Hospital Ongoing	<ul style="list-style-type: none"> ● Monitor screening rate monthly and report out at OB and PI committees. ● Monitor the follow up and referrals to MAT ● Monitor patients that started MAT 	<ul style="list-style-type: none"> ● Following up Post partum on MAT patients 	Janice Pettinato pettinatoj@wmh.org Mary Beth Dastalfo dastalfom@wmh.org
Washington Health System	<ul style="list-style-type: none"> ● Readiness rulers to supplied to OB/GYN offices ● Simplification of SBIRT protocol 	<ul style="list-style-type: none"> ● Implementing MAT/MOUD in primary care settings while complying with Privacy & Security 	Lisa Pareso, Manager Rural Health Model at WHS, lpareso@whs.org

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Beginning	<ul style="list-style-type: none"> Review completion of screening questionnaire workflow Connect to two local FQHCs and community stakeholders 	issues in the electronic medical record.	

Neonatal Abstinence Syndrome (NAS)

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Allegheny Health Network-Jefferson Hospital	<ul style="list-style-type: none"> We provided staff-wide education on Eat, Sleep, Console – along with algorithm to follow when evaluating newborns Transitioning to new tool helps promote parent/newborn bonding by newborn remaining in room Using non-pharmacological treatment measures to care for infant Educating parents on how to best comfort newborns during their anticipated five day stay to monitor for symptoms of withdrawal 	<ul style="list-style-type: none"> Have other facilities seen a large reduction in pharmacological treatment of newborns with the implementation of Eat, Sleep, Console? How have staff and pediatricians adapted to the change? 	Ashley Preksta

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Allegheny Health Network-Saint Vincent Hospital	<ul style="list-style-type: none"> • Met with key stakeholders (neonatologists, pediatrician, pharmacy, NICU nurse manager, MCH educator, two NICU nurses) re: modified Finnegan assessment, pharmaceutical intervention, nurse education/process in place to achieve a more standardized approach in NAS scoring babies in the NICU • Presented Eat, Sleep, Console (ESC) initiative to (9) Family Practice Residents plus medical students on 11/5/2020. Presented by: Dr. Susheel, NICU NM, and NICU nurse • Mother-baby staff assigned to watch YouTube video titled: "Reconsidering the Standard Approach to Neonatal Abstinence Syndrome" by Dr. Matthew Grossman on 11/2/2020 • Two Mother-baby nurses (as part of their Master's capstone project) spearheading (ESC) initiative on Mother-baby. Started on 11/16/2020. One of the nurses will focus on the mothers and their NAS babies, the other nurse will focus on the other mothers and their babies to prepare them to better manage the Baby's Second Night and reinforce the '5 S's' by Dr. Harvey Karp. • Identified (6) super users on Mother-baby to resource mother-baby nurses re: ESC scoring • NICU NM working with IT re: EPIC build for ESC documentation COMPLETED • Developed a tracking sheet titled "NAS Admission Log" for babies admitted to NICU. Data points include: patient label, baby from Mother-Baby or outside transfer, Strict No Publicity, date and time of NICU admission, discharge date, pharmaceutical intervention. • ESC implemented on 5 N. Provider met with nurse managers, re: ESC, outcome was both ESC and Modified Finnegan scoring would be completed on babies on 5N. 		Lani Erdman, Kim Amon, Anita Alloway, Molly Soltis

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Allegheny Health Network- West Penn Hospital	<ul style="list-style-type: none"> ● Reviewing and enforcing our process of inter-user reliability with Finnegan ● Implementation of Eat-Sleep-Console strategy for management of NAS ● Improve communication and provide education to referring PCP's ● Obtain certification as NAS Center of Excellence 	<ul style="list-style-type: none"> ● Pitfalls, mistakes, things that work, unexpected obstacles 	
Doylestown Hospital Ongoing	<ul style="list-style-type: none"> ● Provide family education about NAS and ESC and what to expect in prenatal period through discharge. ● Reinforce the Neonatal Consult template and pamphlet to help families understand their hospital stay from beginning to end. ● Create a questionnaire for mother to complete prior to consult and at time of discharge to monitor effectiveness of educational process. ● Follow up phone calls 1 month after discharge 	<ul style="list-style-type: none"> ● Other measures that can be monitored after discharge with the follow up phone calls. ● After May's PA PQC QI Collaborative-consider collecting data on % breastfeeding, breastfeeding/formula, or formula. Consider adding if mom had post-partum follow-up 	Michelle Joseph BSN, Pediatric Clinical Lead, mijoseph@dh.org
Einstein Medical Center- Montgomery Ongoing	<ul style="list-style-type: none"> ● Sustain: <ul style="list-style-type: none"> ○ Multidisciplinary meetings targeted for every two months ○ Continued distribution of information antenatally (pamphlets), and updated results at OB provider meetings ○ Non-pharmacologic supportive measures ○ Breastfeeding "Traffic Light" ● Improve: <ul style="list-style-type: none"> ○ Unified approach to testing infants in concert with OB to develop standardized screening and testing of mothers ○ Transportation and Food Vouchers for parents to stay with infants (has been varied as COVID restrictions and guidelines have changed) ○ Post discharge follow-up and evaluation of Plan of Safe Care ○ Community Out-reach through clinics and support groups ○ ESC education and pathway revisions ● Start: <ul style="list-style-type: none"> ○ Infant massage training 	<ul style="list-style-type: none"> ● Changes/obstacles/solutions due to COVID visitation restrictions and changing hospital policies? ● How many infants being scored with ESC tool have needed a second line medication? ● Anyone able to report a readmission for NAS in the 2 weeks following discharge when using ESC tool? ● Has anyone seen an infant exposed to daily long-acting benzodiazepine in the absence of any opioid or opioid like substance? If so, how was that infant evaluated? ● What gestational age is used as a cutoff? (35 vs 36wk) ● Does anyone switch between scoring tools? 	Celina Migone, MD

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Einstein Medical Center-Philadelphia	<p>ESC (pilot in January 2021)</p> <ul style="list-style-type: none"> • Open baby type NICU <ul style="list-style-type: none"> ○ Solution – transition Care-by-Parent room to be able to be used for ESC dyad • No current protocol in place for ESC at EMCP <ul style="list-style-type: none"> ○ Solution – Development of policy & procedure by EMCP PA PQC team • No educational materials for staff re: ESC <ul style="list-style-type: none"> ○ Solution – Development of HealthStream educational module by EMCP PA PQC team in conjunction with Nursing Education and Professional Development Dept. <p>Prenatal Consults (implementation in December 2020)</p> <ul style="list-style-type: none"> • Data collection of total opioid use mothers <ul style="list-style-type: none"> ○ Solution – place ticket for report from AeCIS • Lack of educational materials in outpt OB offices <ul style="list-style-type: none"> ○ Solution – finish informational pamphlet for mothers • Ensure on-going inter-rater reliability for use of the MOM NAS Score in the NICU by implementing a process for above by December 1, 2020 • Standardize use of MOM NAS Scoring system at EMCP by introduction and validation of system to Term Nursery by December 31, 2020 <p>Use of MOM NAS Score on MBU (Implementation Sept.-Dec. 31, 2020)</p> <ul style="list-style-type: none"> • Staff perception of difficulty of using MOM NAS Score <ul style="list-style-type: none"> ○ Solution – <ul style="list-style-type: none"> ▪ Education ▪ Score NICU infants prior to rollout on MBU 	<ul style="list-style-type: none"> • Who has been able to initiative the Eat/Sleep/Console methodology in an open NICU floor plan and how? • Who has modified the Eat/Sleep/Console methodology to accommodate an open NICU floor plan and how? 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger Bloomsburg Hospital Sustaining	<ul style="list-style-type: none"> Reviewed maternal risk factors Sought guidance from PQC members Evaluated equipment needs Implemented staff education Implemented Eat Sleep Console for NAS monitoring Created process to identify eligible patients Involved physicians, nurses & pharmacists in MFM, prenatal care & pediatric care Involved Certified Recovery Specialists and care managers Developed EMR documentation Developed education for prenatal patients Survey of patient experience in process 	<ul style="list-style-type: none"> Do you have collaborative relationships with external MAT programs and how did you create this relationship? How does it work (e.g., data sharing, communication, etc.)? Suggestions on additional metrics to track (maternal or infant)? Are you collecting feedback from patients about the ESC program/process? 	Elissa Concini emconcini@geisinger.edu Karena Moran kmoran3@thehealthplan.com
Geisinger Lewistown Hospital Beginning	<ul style="list-style-type: none"> Reviewed maternal risk factors Sought guidance from PQC members Evaluated equipment needs Implemented staff education Implemented Eat Sleep Console for NAS monitoring Created process to identify eligible patients Involved physicians, nurses & pharmacists in MFM, prenatal care & pediatric care Involved Certified Recovery Specialists and care managers Developed EMR documentation Developed education for prenatal patients Survey of patient experience in process 	<ul style="list-style-type: none"> Do you have collaborative relationships with external MAT programs and how did you create this relationship? How does it work (e.g., data sharing, communication, etc.)? Suggestions on additional metrics to track (maternal or infant)? Are you collecting feedback from patients about the ESC program/process? 	Elissa Concini emconcini@geisinger.edu Karena Moran kmoran3@thehealthplan.com
Jefferson Health – Abington Hospital	<ul style="list-style-type: none"> Implementation of Eat, Sleep, Console tool for NAS assessment 	<ul style="list-style-type: none"> How to evaluate interrater reliability 	
Moses Taylor Hospital Ongoing	<ul style="list-style-type: none"> Developed a standardized opioid protocol for weaning newborns with NAS. Development of an educational tool to help parents understand NAS admission. 	<ul style="list-style-type: none"> How to use Vermont Oxford for staff education. 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
<p>Mount Nittany Health System- Mount Nittany Medical Center</p> <p>Ongoing/ Completing 2/3 QI Cycles</p>	<ul style="list-style-type: none"> • Consideration of prenatal visit with pediatric hospitalist to review welcome brochure with NAS mothers. • Staff completion of VON modules- “Center of Excellence” achievement. • Creating a non-pharmacologic intervention standardized protocol. 	<ul style="list-style-type: none"> • What ways can we help engaged mothers get ORT while infant is still admitted? ---our pharmacy will not supply after mother is discharged/while nesting with infant, clinics closed weekends/holidays (an unexpected delivery on a Friday leaves them without options) • Are you banning breastfeeding if mother’s admission drug screen is positive? 	<p>Rachel E. Zimmerman, D.O.</p> <p>rezpsu@gmail.com</p> <p>*Also available through Tigertext; participating in most Hershey Medical Center Project ECHO conferences this year (seeing many Pa-PQC affiliations there)</p>
<p>Penn Medicine- Hospital of the University of Pennsylvania</p> <p>Ongoing</p>	<ul style="list-style-type: none"> • Centered around mother-infant dyad collaborating with newborn nursery to reduce Mom/Baby separation • Facilitating participation in escalation huddles to maximize non-pharmacologic interventions <ul style="list-style-type: none"> ○ Transfer from S8 to ICN ○ Escalation in treatment in the ICN ○ *Both with discussion of non-pharm measures attempted prior to escalation • Staff & Family education • Data collection and discharge phone calls to collect data and patient feedback • Prenatal Consults • Nonpharmacologic bundle • Volunteer program- on hold (COVID) • Feeding policies created: breastfeeding eligibility policy, routine fortification 	<ul style="list-style-type: none"> • Strategies for getting parents to spend more time at the bedside • Feedback on implementation of ESC <ul style="list-style-type: none"> ○ Strategies for increasing comfort level of the staff. • Strategies to engage with hospital administration/regulatory around rooming in patient rooms after birth parents are discharged but infants remain in the hospital for observation. • Plans of safe care: Specifically, the impact ESC has on plans of safe care. How are you deeming infants as “affected by substance use” for plans of safe care. • Question for other Philadelphia County Hospitals: What improvement efforts have you done for increasing/connecting prenatal care & involvement? 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
<p>Penn Medicine-Lancaster General/Women and Babies</p> <p>Ongoing</p>	<ul style="list-style-type: none"> ● Identified physician and unit-based champions to participate in Eat, Sleep, Console (ESC) implementation team <ul style="list-style-type: none"> ○ Completed assessment of current state with champions and identified areas of opportunity to improve standardization and care of NAS infants. ○ Established a target condition to identify stakeholders and develop an action plan ○ Investigated EMR tools for OUD screening, ESC assessment and order set changes ○ Implemented ESC program for well newborn population - Feb 2021 ○ Further expand ESC for NICU population – Current state and target condition completed. Currently working through action plan. Planned go-live Dec 2021. ● Established a method for reporting and determining baseline data <ul style="list-style-type: none"> ○ Validated current NAS report provides correct information ○ % Pharmacologic treatment rates ○ % 30-day readmission rates for NAS infants 	<ul style="list-style-type: none"> ● If the infant requires a rescue dose of Morphine, is the infant transferred to the NICU for care, or is there another process for a single dose treatment? 	<p>Janay DiBerardino, Perinatal Safety Nurse, Janay.DiBerardino@penmedicine.upenn.edu</p>
<p>Penn Medicine-Pennsylvania Hospital, Newborn Medicine</p>	<p>Prenatal consultation:</p> <ul style="list-style-type: none"> ● Creation of an EMR template for a prenatal consult for pregnant women with OUD ● Consistent use of NAS pamphlet with consult ● Educating OB staff about need for prenatal consultation when able <p>NAS care:</p> <ul style="list-style-type: none"> ● PAH-specific NAS protocol (vs using CHOPs) ● Guidelines on obtaining UDS for mothers and infants now live <p>EI referral:</p> <ul style="list-style-type: none"> ● Standardized EI referral (via EMR) by assigning neonatal NP who tracks/reports all OENs 	<ul style="list-style-type: none"> ● How to successfully implement Eat Sleep Console without private rooms? 	<p>Melissa McKinney, MSN, CRNP; Dustin Flannery, DO, MSCE</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
<p>Penn State Health- Hershey Medical Center & Children's Hospital</p> <p>In progress</p>	<ul style="list-style-type: none"> • Universal collection of meconium at delivery or transfer within 24-48 hrs. • Cerner (EHR) order and task created • Store refrigerated specimen for 7 days • Collection and storage of umbilical cord tissue for preterm infants <35 weeks- In Progress 	<ul style="list-style-type: none"> • Does your hospital use a standardized screening protocol to determine which babies will require toxicology testing? <ul style="list-style-type: none"> ○ What is your screening criteria? • If your toxicology results return after a healthy infant has been discharged from the birthing center, what is the process for follow-up? • Has your institution considered universal testing of all infants? 	<p>Mary Lewis, MSN RNC-NIC</p>
<p>St. Luke's University Health Network</p>	<ul style="list-style-type: none"> • Working with IT to create an EPIC report to accurately identify any babies with NAS & who are affected by OUD • PA PQC core team: working on completing the required NAS education to build competence & consistency within our NAS scoring throughout the network 	<ul style="list-style-type: none"> • Has anyone else created an EPIC report to reflect the data needed for the day audits? 	
<p>Temple University Hospital</p>	<ul style="list-style-type: none"> • Education to Moms pre/post delivery • Getting OUD screening into EPIC • Teaching for Eat, Sleep, Console approach available on HealthStream • Created Nesting Room protocol 	<ul style="list-style-type: none"> • Finding available space for Moms • Gaining insight/support from Social Work 	<p>Temple University Hospital</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Thomas Jefferson University Hospital- Center City (Intensive Care Nursery /Well Baby Nursery)	<p>Improve Parental and Staff Education</p> <ul style="list-style-type: none"> • ICN nurses to treatment program for education sessions • Educational materials and provider education at OB clinic • Breast feeding education during methadone/buprenorphine stabilization hospitalization • Standardized prenatal neonatology consult <p>Improve Breast Pump Access</p> <ul style="list-style-type: none"> • Coordinating with WIC • Standardized process with post-partum and case management <p>Improve Treatment Program Involvement in supporting breast feeding</p> <ul style="list-style-type: none"> • Working with new management to • improve maternal access from inpatient treatment to hospital • Create pumping and milk storage space • Support leaving sessions to pump <p>Improve breast feeding support while in hospital</p> <ul style="list-style-type: none"> • Improving lactation consultant access • Support skin-to-skin in NICU • Encourage early breast feeding in DR, upon post-partum arrival 	<ul style="list-style-type: none"> • How often to sample a percentage for run chart? On average we're discharge 1-2 OENs that are eligible to receive breast milk each month. • Do not have the ability to have moms' room in past their post-partum stay currently. <ul style="list-style-type: none"> ○ Any non-pharmacologic tips in this situation – we have cuddlers and already follow most of the tips on the website's suggested measures ○ Any other hospitals been successful petitioning administration to carve out rooms/units in the hospital for moms to stay and/or board with their babies? ○ Even if we get rooms for moms, many of our moms are in treatment programs and can't stay for long. Any thoughts? • How are you handling the decision of whether to allow breast milk in moms testing positive for marijuana or admitting to its use. Currently, most of the Philadelphia hospitals are restricting breast feeding in this scenario. 	
Tower Health-Reading Hospital	<ul style="list-style-type: none"> • Implement "Eat Sleep Console" program on Specialty care unit. (Moms will room-in with newborns.) Transfer family to pediatrics when mother is discharged. • Staff education, music therapy, cuddlers, OT, patient/family education, community education 		

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
UPMC Womens Health Service Line	<p>Access:</p> <ul style="list-style-type: none"> • Maternal medical support to prevent withdrawal during pregnancy • Provide regular prenatal and other medical appointments <p>Prevention:</p> <ul style="list-style-type: none"> • Minimize fetal exposure to illicit substances • Engage mother as a leader in her recovery <p>Response:</p> <ul style="list-style-type: none"> ○ Parent Partnership Unit (PPU) <ul style="list-style-type: none"> ▪ Eat, Sleep, Console (ESC) implemented and continuing to spread across system ▪ Implemented ESC and developed a PPU model at Altoona ▪ Developing a service line SUD Committee with membership consisting of representatives from each hospital for Plans of Safe Care. ▪ Created a NOWs Brochure for Prenatal offices and hospitals to provide patients with education about the condition in effort that parents are prepared to stay and provide that non-pharm care to the infant. ▪ Magee is expanding the PPU to 6, Level II NICU beds so that babies that require medication can stay with the mothers so that the non-pharm care can be provided without interruption by the mother. • Reporting: <ul style="list-style-type: none"> ○ Pa DOH of all NAS occurrences ○ Internal leadership and appropriate committees e.g., NICU 	<ul style="list-style-type: none"> • How you can best implement Eat, Sleep, Console when baby requires medication therapy? Though we are working on a plan for babies to receive treatment while in the PPU with the addition of Level II NICU beds. 	
UPMC Womens Health Service Line- Altoona Ongoing	<p>Parental Presence/Caregiver/Cuddler Presence</p> <p><u>Reinforce or Increase:</u></p> <ul style="list-style-type: none"> • Rooming-in • Parental presence • Skin to skin • Holding 	<ul style="list-style-type: none"> • Still remain very interested in protocols that provide intermittent medication treatment for symptoms versus protocols that dose on a routine basis. 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	<ul style="list-style-type: none"> • Swaddling • Optimal feeding • Quiet environment • Limit visitors • Education classes <i>on hold due to pandemic.</i> • Parents prepared to stay and administer the non-pharm care- though we recently created a nice brochure for prenatal offices to provide patients so that they can be prepared to stay and care for baby. • Shared ordering information on NOWS brochure with all prenatal offices and hospital sites at various local site meetings 		
<p>UPMC Womens Health Service Line- Cole</p> <p>Ongoing</p>	<p>Parental Presence/Caregiver/Cuddler Presence</p> <p><u>Reinforce or Increase:</u></p> <ul style="list-style-type: none"> • Rooming-in • Parental presence • Skin to skin • Holding • Swaddling • Optimal feeding • Quiet environment • Limit visitors 	<ul style="list-style-type: none"> • Still remain very interested in protocols that provide intermittent medication treatment for symptoms versus protocols that dose on a routine basis. 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>
<p>UPMC Womens Health Service Line- Hamot</p> <p>Ongoing</p>	<p>Parental Presence/Caregiver/Cuddler Presence</p> <p><u>Reinforce or Increase:</u></p> <ul style="list-style-type: none"> • Rooming-in • Parental presence • Skin to skin • Holding • Swaddling • Optimal feeding • Quiet environment • Limit visitors 	<ul style="list-style-type: none"> • Still remain very interested in protocols that provide intermittent medication treatment for symptoms versus protocols that dose on a routine basis. 	<p>Vivian Petticord Director, Women’s Health Service Line</p> <p>pettvm@upmc.edu</p>
<p>UPMC Womens Health Service Line- Horizon</p>	<p>Parental Presence/Caregiver/Cuddler Presence</p> <p><u>Reinforce or Increase:</u></p>	<ul style="list-style-type: none"> • Still remain very interested in protocols that provide intermittent medication 	<p>Vivian Petticord Director, Women’s Health Service Line</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
<p>Ongoing</p>	<ul style="list-style-type: none"> • Rooming-in • Parental presence • Skin to skin • Holding • Swaddling • Optimal feeding • Quiet environment • Limit visitors 	<p>treatment for symptoms versus protocols that dose on a routine basis.</p>	<p>pettvm@upmc.edu</p>
<p>UPMC Womens Health Service Line- Magee</p> <p>Ongoing</p>	<p>Parental Presence/Caregiver/Cuddler Presence</p> <p><u>Reinforce or Increase:</u></p> <ul style="list-style-type: none"> • Rooming-in • Parental presence • Skin to skin • Holding • Swaddling • Optimal feeding • Quiet environment • Limit visitors <ul style="list-style-type: none"> • Opened the NTU (Neonatal Transitional Unit) July 12. This is a 6-bed unit where the parents can stay with their infant who may require an extended stay for treatment of bili light therapy for jaundice, antibiotics for treatment of chorio. Two rooms are designated as Parent Partnership Unit. The benefit to this new unit is that previously when babies required treatment with morphine, they required transfer to the NICU and the parents could not stay and continue to provide that non-pharm care. • We also received a small grant to offer milk bank breast milk to infants in the PPU whose mothers are breastfeeding and may require supplementation as a means to support the mother's choice to breastfeed. • In recognition of Safe Sleep & SIDs Awareness (new UPMC swaddles!)- understanding mothers with SUD are high risk population: Facebook Premiere Nov 23rd. 	<ul style="list-style-type: none"> • Still remain very interested in protocols that provide intermittent medication treatment for symptoms versus protocols that dose on a routine basis. 	<p>Vivian Petticord Director, Women's Health Service Line</p> <p>pettvm@upmc.edu</p>

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
UPMC Womens Health Service Line- Northwest Ongoing	Parental Presence/Caregiver/Cuddler Presence <u>Reinforce or Increase:</u> <ul style="list-style-type: none"> • Rooming-in • Parental presence • Skin to skin • Holding • Swaddling • Optimal feeding • Quiet environment • Limit visitors 	<ul style="list-style-type: none"> • Still remain very interested in protocols that provide intermittent medication treatment for symptoms versus protocols that dose on a routine basis. 	Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu
Wayne Memorial Hospital Beginning	<ul style="list-style-type: none"> • We are starting to move forward with NAS. We have all 5 core users fully trained in VON and have a total of 13 out of 20 OB staff. 		Janice Pettinato pettinatoj@wmh.org Mary Beth Dastalfo dastalfom@wmh.org
Wellspan- York Hospital Sustaining	<ul style="list-style-type: none"> • Held two "Lunch and Learn" activities to pediatrics including physicians, nursing, and ancillary staff to identify barriers to consistent ESC documentation or opportunities for improvement (Pre-education implementation-100% of infants admitted to pediatrics had one instance of missed huddle opportunity or lack of documentation. N= 12) • Used findings and discussion topics for re-education of healthcare team, including the definition of positive ESC, importance of documenting positive ESC screen, and contacting provider to discuss next steps in "huddle" through staff meeting summary presentation and huddle talking points. • Providers stressed the importance of parental involvement in the huddle • Identified caregiver accessibility for huddles • After review of results, realized that education needs to be provided to nursing staff and providers in NICU and Newborn Nursery/ Maternity. 	<ul style="list-style-type: none"> • How do you successfully incorporate parental involvement in every team huddle? • Does nursing contact the provider for repeated yes on ESC and re-huddle each time? • How do you address inconsistencies between providers and nurses over positive ESC potentially not related to NAS? 	Elizabeth Imboden MD

Maternal Mortality: Hemorrhage

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Einstein Medical Center-Philadelphia	<p>Change in workflow for providers and nursing staff</p> <ul style="list-style-type: none"> • Solution – educational plan developed for provider and nursing staff (January 2021) <p>PPH Scoring in AeCIS</p> <ul style="list-style-type: none"> • Solution – Cerner working with CMQCC to standardize scoring for risk tool based on AWHONN project (Jan. 2021) 		
Jefferson Health- Thomas Jefferson University Hospital	<ul style="list-style-type: none"> • Upgrade to EMR allows PPH calculation tool to flow directly into Delivery Summary • Collect data to determine predictability of PPH score • Hemorrhage supplies added to delivery cart for remote deliveries (ICU) • Assign K2 antepartum hemorrhage module 	<ul style="list-style-type: none"> • How do other health systems align policy and procedures within their specific hospitals, especially in EMR? 	
Penn Medicine-Chester County Hospital	<ul style="list-style-type: none"> • Code OB Emergency Response Developed • Hemorrhage Carts on Labor & Delivery and Mother/Baby • OB Emergency Cards • Interdisciplinary Simulations 	<ul style="list-style-type: none"> • What strategies are being used to prevent postpartum hemorrhage from occurring? 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
<p>Penn Medicine-Lancaster General/Women and Babies</p> <p>Ongoing</p>	<ul style="list-style-type: none"> ● Train champions to facilitate QBL process <ul style="list-style-type: none"> ○ Feedback and process recommendations for clinical workflow ○ Communication/Education with teams ● Implemented EMR tool for PPH risk assessment (12/2/19) ● Inventory tools/equipment required for QBL process <ul style="list-style-type: none"> ○ Additional scale obtained for L&D ● Implemented QBL with EMR calculator for high-risk patients (2/12/20) <ul style="list-style-type: none"> ○ Expanded QBL process to all vaginal delivery patients (7/27/20) ○ Expand QBL process to include cesarean deliveries (1/21) ○ Current QBL process reviewed, and a new and improved process was trialed by our L&D team. (4/5/21) ○ Developed physician orders to include standard response interventions based on QBL values. (Summer 2021) ● Order set changes approved by OBGYN Care Management team ● Established a method for reporting and determining baseline data <ul style="list-style-type: none"> ○ OB Vaginal & Cesarean PPH reports built in EMR ○ Blood utilization and uterotonic usage reports ○ QBL report 	<ul style="list-style-type: none"> ● Have you developed standard interventions for care based on QBL values? If so, are you using a stage-based approach? (Ex. Stage 1 for QBL >500 mL for vaginal delivery) ● Have you successfully implemented ongoing cumulative QBL during cesarean deliveries, rather than a calculation of QBL at the end of cesarean case? 	<p>Janay DiBerardino, Perinatal Safety Nurse, Janay.DiBerardino@penmedicine.upenn.edu</p>
<p>Penn Medicine-Pennsylvania Hospital</p>	<ul style="list-style-type: none"> ● We implemented a comprehensive Code Crimson policy that includes 3 levels of hemorrhage with specific assessments, actions, and checklists for each. ● We made significant improvements to our QBL calculator and created a dashboard to measure our progress. ● We educated all nurses and providers working in L&D or Mother Baby and had drills prior to implementation. A debrief occurs after each event. 	<ul style="list-style-type: none"> ● Have you identified any risk factors that surprised you? 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Penn State Health- Hershey Medical Center & Children's Hospital	<ul style="list-style-type: none"> • Assessment by provider using an evidence- based tool. • Risk Assessment score placed in EMR and on electronic Chalkboard. • Postpartum Hemorrhage kit with emergency medications present at every delivery. • Postpartum Hemorrhage Cart containing guidelines for actions & emergency supplies immediately available. • Simulation exercises are ongoing. 	<ul style="list-style-type: none"> • How are other organizations providing education to their patients on the signs and symptoms of postpartum hemorrhage during hospitalization? 	
Temple University Hospital	<ul style="list-style-type: none"> • Risk assessment for every patient • Implement the hemorrhage protocol (everything will be consistent) • Hemorrhage cart (virtual) • Running Drills • Cultural diversity training • Pain Management protocol 	<ul style="list-style-type: none"> • Gathering data • Inconsistencies in assessment and treatment • High Risk population 	Temple University Hospital
Tower Health- Reading Hospital	<ul style="list-style-type: none"> • Create standard for prenatal identification of high-risk patients, quantitative blood loss, and early interventions • All nurses, providers attend yearly sim. QBL roll-out scheduled for 3/7/20; Sims – yearly • Policy / protocol in place and communicated by 7/1/20 	<ul style="list-style-type: none"> • Implementation strategies • Strategies for standardization • Patient and family education prenatally • Feedback on our processes 	

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
UPMC Womens Health Service Line	<p>Readiness:</p> <ul style="list-style-type: none"> Includes: hemorrhage cart supplies, checklist, algorithms, hemorrhage medication kit, response team, advanced gynecologic surgery, massive transfusion protocols, unit guidelines, unit-based drills with post-drill debriefs, and staff/provider education <p>Recognition and Prevention:</p> <ul style="list-style-type: none"> Standardized assessment tool <ul style="list-style-type: none"> Admission, other appropriate times Measurement from EBL to QBL & defined quantity <p>Response:</p> <ul style="list-style-type: none"> Conducted tracer document for compliance to new Perinatal Joint Commission Standards Created system wide policy for assessing and managing PPH. Updated hemorrhage checklist. Service Line Education Committee is creating hemorrhage module for staff education Feb and March rolled out new medical device for hemorrhage <ul style="list-style-type: none"> Rolling this out to other 14 birthday hospitals April 14 Creating hemorrhage education for patients <p>Reporting:</p> <ul style="list-style-type: none"> Event reporting to Risk/Quality Department Multidisciplinary review for opportunities in systems and processes <ul style="list-style-type: none"> Internal hospital systematic reviews are conducted per occurrence Monitor outcomes and metrics via Obstetrical Dashboard all hospitals have direct access Report as appropriate to various committees 	<ul style="list-style-type: none"> Providing education on PPH. Would like to see what education other hospitals are providing patients beyond AWHONNs Post Birth Warning Signs. 	

Maternal Mortality: Timely Fourth Trimester Contact

Site Name:	Key Interventions:	Our team would most like to learn from our peers:
Jefferson Health-Abington Hospital	<ul style="list-style-type: none"> Standardized guidelines for PP follow-up (current focus on HTN and PPD) Interprofessional postpartum rounding on inpatient Mother-baby units Developing standardized guidelines for postpartum follow-up 	<ul style="list-style-type: none"> Innovative models for postpartum follow-up Coding and billing r/t 4th trimester care