Maternal Mortality: Hypertension (PA AIM)

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Evangelical Community Hospital	• 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. • Each month, if we have a nurse or provider who does not follow the Severe HTN algorithm, I talk to the nursing staff and Dr Tyrie talks to the providers.	We continue to struggle slightly with providers following the medication dosing algorithms that are provided from ACOG. Either ordering/adjusting PO anti-hypertensives (not Procardia IR) especially for the chronic hypertensives or gestational hypertensives who are already on an established anti-hypertensive	Jen Sullivan RN, BSN Jennifer.Sullivan@evanhospital.com
Geisinger-Medical Center (GMC)	• 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.	• How do clinician leaders manage physician non-compliance with recommendations? • How do nursing leaders handle nursing non-compliance with alerting provider of the elevated readings?	Amy Schauer, BSN LoriBeth Ryder
Geisinger-Wyoming Valley (GWV)	• 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)	• Are you using any sort of notification system/alarming for severe range BPs that need attention?	Rachel Cunniffe

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Penn Medicine-Chester County Hospital	• Preeclampsia Pathway • Hypertensive Management Pathway • Postpartum Hypertension Pathway • Adoption of Heart Safe Motherhood • System-wide Collaborative	• How were you able to sustain improvements made with managing hypertensive disorders?	Katie Constantini

Penn Medicine-Lancaster General/Women and Babies	• Identified physician and unit-based champions to participate in sub-committee of care management team
	  ○ 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
	  ○ Validated current preeclampsia pathway report provides correct information
	• Monthly case reviews to determine additional opportunities for improvement
		• We would like to hear success stories from other hospitals who have improved and sustained treatment of patients with severe range BPs within 60 minutes.	Janay DiBerardino, Perinatal Safety Nurse, Janay.DiBerardino@pennmedicine.upenn.edu

Penn Medicine-Pennsylvania Hospital	• Revised and updated the hypertension policy that is used in all areas that women are treated (Women's Health, ED & Critical Care) • Severe hypertension education and drills • Perinatal disparities workgroup to implement the disparities bundle • Penn Medicine systemwide reported built to track compliance with BP measurement, treatment within 60 minutes as outlined in AIM bundle, magnesium criteria and compliance, eclamptic seizures, discharge education and follow up.	How other centers are evaluating magnesium therapy? Are other centers including all patients with one severe range BP in the denominator, persistent severe range BPs, or only patients with PEC with neurologic changes?	Melissa McKinney CRNP

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:

Penn State Health-Hershey Medical Center and Children's Hospital	• Facility-wide standard protocols for treatment, management, and education of patients
	  ○ AWHONN warning signs handout for patients; Development of a quick reference tool/checklist based on the written guidelines (completed)
	• Rapid access to treatment - Availability of OB HTN Emergency tackle boxes (provided through Pharmacy) Go Live Date: 3/1/22 (completed/ongoing)
	  ○ Placement of medications in Medication Pyxis machines for quick and easy access (completed)
	• 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)
	• 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)
		• At your facility, are pregnant and postpartum patients with hypertensive crisis managed in the EDor are these patients immediately transferred to OB upon identification?	Lisa Murphy, MSN RNC-OB, lmurphy2@pennstatehealth.psu.edu
			
			Brittany Bogar

St. Clair Hospital	• Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists • Quantification of blood loss • 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 tracking tips. • Discussion/debrief with families • Data tracking tips • Discussion/debrief with families • HIS/EMR Support – tips on how other organizations-built tools to help collect data from the EMR	Shawndel Laughner

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:

	• Next Steps:
	  ○ PA AIM Bundle participation
	  ○ Data collection started on triage patients seen for hypertension and review of those records to assess for timely treatment of Hypertension- the data is collected- need to add it to the PA-PQC data portal
	  ○ Data collection stratified by race and ethnicity		

UPMC Womens Health Service Line-Hamot	• Collected pre-data that validated disparity. Data continues to display disparity. • Currently working with Cerner for analytic solution. • Iaware- is being explored • Rounding report being created for OB Safety Rounds which will identify elevated BPs and any medications given. • We did have a meeting with other Cerner PA PQC hospitals- and no one has an elegant solution to identify elevated BPs in a timely manner. • MOU agreements for all sites was a process		Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu
UPMC Womens Health Service Line- Horizon	• Collected pre-data that validated disparity. Data continues to display disparity. • Currently working with Cerner for analytic solution. • Iaware- is being explored • Rounding report being created for OB Safety Rounds which will identify elevated BPs and any medications given. • We did have a meeting with other Cerner PA PQC hospitals- and no one has an elegant solution to identify elevated BPs in a timely manner. • MOU agreements for all sites was a process		Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
UPMC Womens Health Service Line- Magee-Womens Hospital	• Collected pre-data that validated disparity. Data continues to display disparity. • Currently working with Cerner for analytic solution. • Iaware- is being explored • Rounding report being created for OB Safety Rounds which will identify elevated BPs and any medications given. • We did have a meeting with other Cerner PA PQC hospitals- and no one has an elegant solution to identify elevated BPs in a timely manner. • MOU agreements for all sites was a process		Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu
UPMC Northwest	• Collected pre-data that validated disparity. Data continues to display disparity. • Currently working with Cerner for analytic solution. • Iaware- is being explored • Rounding report being created for OB Safety Rounds which will identify elevated BPs and any medications given. • We did have a meeting with other Cerner PA PQC hospitals- and no one has an elegant solution to identify elevated BPs in a timely manner. • MOU agreements for all sites was a process		
UPMC Pinnacle Carlisle	• Collected pre-data that validated disparity. Data continues to display disparity. • Currently working with Cerner for analytic solution. • Iaware- is being explored • Rounding report being created for OB Safety Rounds which will identify elevated BPs and any medications given. • We did have a meeting with other Cerner PA PQC hospitals- and no one has an elegant solution to identify elevated BPs in a timely manner. • MOU agreements for all sites was a process		

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
UPMC Pinnacle Lititz	• Collected pre-data that validated disparity. Data continues to display disparity. • Currently working with Cerner for analytic solution. • Iaware- is being explored • Rounding report being created for OB Safety Rounds which will identify elevated BPs and any medications given. • We did have a meeting with other Cerner PA PQC hospitals- and no one has an elegant solution to identify elevated BPs in a timely manner. • MOU agreements for all sites was a process		

Moving on Maternal Depression (MOMD)

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger-Medical Center (GMC)	• Increase prenatal screening rate • Increase postpartum screening rate • Examine all data by race/ethnicity ○ Address any identified disparities • Improve follow-up to at-risk screens • Improve tracking of metrics • Assist pediatric clinic follow up support • Initiate postpartum depression support group	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
Einstein Medical Center-Montgomery	• The team plans to conduct patient surveys, focus groups, and analyze EPDS scores of Inpatient and Outpatient OB GYN patients of the EMCM Hospital system. We will review data and determine gaps in care. Initial plan may be to increase awareness of staff through education on screenings for Perinatal Mood Disorder. Then, based on data, increase the screenings	• Addressing administrative hurdles and maintaining enthusiasm for project. Recruitment of members to project.	Daryl Stoner, MD
Jefferson Health-Abington Hospital	• Implementation of patient-generated depression screening using EPDS within electronic health record (EHR) for all individuals assessed in L&D triage or directly admitted to L&D • Conducting assessment of current state and recruiting stakeholders	• Best practices for documenting and capturing data on response to screening • Experience using patient generated data	Susan Utterback, DNP, MSIT, RN-BC Director Women's Services susan.Utterback@Jefferson.edu

	• Establishing workflow for patient generated screening in triage/on admission to L&D • Working with business analytics team to enable reporting on screening and interventions in all care settings • DNP student led project to implement patient generated screening in EHR in triage and on admission to L&D		
Penn Medicine – Hospital of the University of Pennsylvania	• Improving Perinatal Depression screening and follow-up services • Reducing racial and ethnic disparities	• Outpatient services	Bridget Howard
Penn State Health- Hershey Medical Center and Children's Hospital	• Report consistently PAPQC data and stratify by race and ethnicity • Improve access to specific psych by having a dedicated psychiatrist available for maternal mental health • Schedule inter-departmental grand rounds • Increase comfort and knowledge of OBGYN residents' diagnosis and treatment of perinatal depression • Screen with EPDS 4-6 weeks PP AND 1, 2, 4, and 6 month newborn visits • Implement universal hospital PPD screening using EPDS for all patients within 24 hours of delivery	• What tools and/or protocols have you put into place to support providers and ensure quality and safe care for patients when a positive depression screen is completed/received during a newborn appointment?	Brittany Bogar
St. Clair Hospital	• To date we hold a Postpartum support group for women with perinatal mood changes. • Reach out to OB offices – assess the screening tool • Plan QI project ○ Implement the Edinburgh Screening tool for hospital outpatients and inpatients	• Data collection tactics • Screening tools used • Postpartum follow up • Community resources used	Shawndel Laughner

Tower Health-Reading Hospital	• The Reading Hospital MOMD team has representatives from each of the OB offices including THMG and the Women's Health Center.
	  ○ The team has representatives of behavioral health including Integrated Care Clinicians
	  ○ The team has representatives from all of the Reading Hospital inpatient MCH units (OB Triage, Labor & Delivery, Mother-Baby, Pediatrics) and includes leadership and education roles.
	  ○ The team has representatives from pediatric offices.
		• 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?*
			Kerin Kohler

	○ Goal is to increase representation from TH pediatric offices and other community pediatric offices. ○ Goal is to increase representation from TH Outpatient Behavioral Health and Reading Hospital Emergency Department ○ Goal is to increase representation from community behavioral health partners. • *Reading Hospital THMG offices use the PHQ 2/9 and the adolescent PHQ-A screening tools which are incorporated into the EHR. Edinburg Postnatal Depression Screening tool is available in the EHR. A Social Determinants of Health (SDOH) screen is also conducted for patients who are Medicaid and Medicare recipients. Patient race/ethnicity is captured in the EHR.* • *Screening standard practice developed:* ○ 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 6 months. ○ 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 in addition to the completion of the PHQ 2/9. • <u>Understanding the Current State: Description or Diagram of the Current Process</u> ○ Although PQC requires follow up for all patients with a documented positive depression screen following delivery or the postpartum period, Reading Hospital has chosen to require follow up for all patients with a documented positive depression screen during pregnancy. ○ PHQ scores: ○ 5-9, provide a list of preventive resources ○ 10+ referred to ICC. ○ 20+ referred to ICC. ICC will refer to RHOBHS (insurance dependent) or other community based BH provider. RHOBH providers can see which is insurance based within 1-2 weeks. ○ *Discussing how documentation needs to exist in the EHR so that all parties are aware of the follow up.* • <u>Identifying Improvement Opportunities</u>	• *How have you been able to integrate community behavioral health partners onto your team?*	

	○ Create comprehensive list of Psych and counseling services for patients with perinatal mood disorders. Include urgent, emergent and non-urgent resources. Include whether they take Medicaid. ○ Create education materials/training for providers and OB office staff ○ Learning Hub activities on MOMD and MI ○ List of services and supports available for offices to give to patients. ○ Strengthen MH services within the system to support pregnant and postpartum women with MMD. ○ OB consult with psychiatrist for medication management. ○ Offer educational program through PSI to internal organization staff/providers in addition to community members.		
UPMC Womens Health Service Line- Magee-Womens Hospital	• #BlackMaternalHealthWeek- April 11-17 • UPMC Health Equity NOW committee chose "***Reducing maternal health disparities by aligning patient, family, community, and health system resources to support safer childbirth in our UPMC birthing hospitals"*** as our theme for the week. • **Warm Walk:** UPMC Magee, Lititz, Harrisburg, Williamsport, Hamot; Doulas, midwives, social workers, and other appropriate staff to interact with patients and collect a brief needs assessment for mental health. The results will help drive how UPMC better meets the mental health needs of our patients, especially BIPOC and LGBTQ. • **Grand Rounds Tuesday, April 12**, 7:15 a.m.: *Implicit Racial Bias in Prenatal Visit Patient-Clinician Communication, Prenatal Screening, and Interventions*, **Abisola Olaniyan, PhD, MBBS, MPH** UPMC Magee-Womens Hospital • **<u>UPMC Healthbeat blog posts and FB articles</u>** ○ The Importance of Addressing Black Maternal Health ○ We must remedy disparities in US maternal health [column] ○ Supporting Breastfeeding for Black Women ○ UPMC Life Changers: Dr. Sharee Livingston ○ Mental Health Challenges Black Mothers Face ○ Why Does Black Maternal Health Matter • UPMC provides support during Black Maternal Health Week ○ Health Disparities Q&A with Sharee Livingston, DO		Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu

	○ Media stories During Black Maternal Health Week! ○ WPXI-TV: Black moms from across region attend meeting to discuss fears of maternal health disparities (***Birthing While Black event***) ○ WTAE-TV: UPMC provides support during Black Maternal Health Week **By Chandi Chapman** ○ **CityCast** Pittsburgh: PA's Maternity Care Work Needs…A Lot of Work **(Dr. Livingston)** ○ FOX 43: Local health experts highlight health inequities among black pregnant women ahead of Black Maternal Health Week (**Dr. Livingston**) ○ WNEP-TV: Doctor in Lycoming County discusses Black Maternal Health Week (**Dr Alligood**) ○ WESA-FM Black pregnant patients encouraged to speak up, even if it's uncomfortable (***Birthing While Black event***) • WHTM-TV Physicians, state lawmakers address maternal health disparities in women of color • WHP(Local21news): Studies point to Black maternal mortality inequity, advocates call for change **(Dr. Livingston)** • **Letter in support** to Rep. Cephas's bill for Medicaid payment of Doula Services to the House Health Committee • **Video's on Magee's Facebook page** Facebook.com/UPMCMagee including: ○ **4/11/22Chatón T. Turner, Esq**., suggests that when patients go into the hospital for childbirth, they look out to see if anything is amiss, speak up if they see something that needs to be addressed, and escalate the situation to leadership if for some reason those who are caring for you are not responding adequately. (419 views) ○ **4/13/22 Dr. Amaris Yandel** talks about how providers can build patient trust through active listening and validation. (96 views) ○ **4/15/22 Dr. Chavone Momon-Nelson** discusses improving postpartum care. Important time for women to continue receiving care. This includes the fourth trimester (the 12 weeks after giving birth) as well as the entire year following childbirth. (130 views) • **And Finally: Tuesday, April 19,** noon-1p.m**.** *Birthing While Black- Improving Maternal Health Outcomes in*		

	Women of Color. Kingsley Center, 6435 Frankstown Ave., Pittsburgh, PA 15206		
WellSpan-Ephrata Community Hospital	• Patient is screened with PHQ-2 and PHQ-9 if appropriate, at every OB intake appointment. Each patient with high score or history of depression is referred to the perinatal depression program. • Perinatal Depression Program Nurse calls patient. Additional resources, such as behavioral health can be expedited for appropriate patients from this referral. • Every patient is screened with EPDS during inpatient hospital stay. Perinatal Depression program Nurse calls each patient with elevated screening and assists with additional resource/referrals, as necessary. • Every patient is screened at postpartum OB visit with EPDS and referred to Perinatal Depression program, if needed. • 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 education in Babyscripts on mental health	• Are other hospitals experiencing increases in perinatal or postpartum depression due to COVID? • Creative opportunities to improve access to mental health services for our patients	Aimee Fleischman

WellSpan-Gettysburg Hospital	• Patient is screened with PHQ-2 and PHQ-9 if appropriate, at every OB intake appointment. Each patient with high score or history of depression is referred to the perinatal depression program. • Perinatal Depression Program Nurse calls patient. Additional resources, such as behavioral health can be expedited for appropriate patients from this referral. • Every patient is screened with EPDS during inpatient hospital stay. Perinatal Depression program Nurse calls each patient with elevated screening and assists with additional resource/referrals, as necessary. • Every patient is screened at postpartum OB visit with EPDS and referred to Perinatal Depression program, if needed. • 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 education in Babyscripts on mental health	• Are other hospitals experiencing increases in perinatal or postpartum depression due to COVID? • Creative opportunities to improve access to mental health services for our patients	Aimee Fleischman
WellSpan- Good Samaritan Hospital	• Patient is screened with PHQ-2 and PHQ-9 if appropriate, at every OB intake appointment. Each patient with high score or history of depression is referred to the perinatal depression program. • Perinatal Depression Program Nurse calls patient. Additional resources, such as behavioral health can be expedited for appropriate patients from this referral. • Every patient is screened with EPDS during inpatient hospital stay. Perinatal Depression program Nurse calls each patient with elevated screening and assists with additional resource/referrals, as necessary. • Every patient is screened at postpartum OB visit with EPDS and referred to Perinatal Depression program, if needed. • 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 education in Babyscripts on mental health	• Are other hospitals experiencing increases in perinatal or postpartum depression due to COVID? • Creative opportunities to improve access to mental health services for our patients	Aimee Fleischman

WellSpan-Summit Health Chambersburg Hospital	• Patient is screened with PHQ-2 and PHQ-9 if appropriate, at every OB intake appointment. Each patient with high score or history of depression is referred to the perinatal depression program. • Perinatal Depression Program Nurse calls patient. Additional resources, such as behavioral health can be expedited for appropriate patients from this referral. • Every patient is screened with EPDS during inpatient hospital stay. Perinatal Depression program Nurse calls each patient with elevated screening and assists with additional resource/referrals, as necessary. • Every patient is screened at postpartum OB visit with EPDS and referred to Perinatal Depression program, if needed. • 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 education in Babyscripts on mental health	• Are other hospitals experiencing increases in perinatal or postpartum depression due to COVID? • Creative opportunities to improve access to mental health services for our patients	Aimee Fleischman
WellSpan-York Hospital	• Patient is screened with PHQ-2 and PHQ-9 if appropriate, at every OB intake appointment. Each patient with high score or history of depression is referred to the perinatal depression program. • Perinatal Depression Program Nurse calls patient. Additional resources, such as behavioral health can be expedited for appropriate patients from this referral. • Every patient is screened with EPDS during inpatient hospital stay. Perinatal Depression program Nurse calls each patient with elevated screening and assists with additional resource/referrals, as necessary. • Every patient is screened at postpartum OB visit with EPDS and referred to Perinatal Depression program, if needed. • 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 education in Babyscripts on mental health	• Are other hospitals experiencing increases in perinatal or postpartum depression due to COVID? • Creative opportunities to improve access to mental health services for our patients	Aimee Fleischman

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-Bloomsburg Hospital	• Implementing offering of IPLARC • Kick off workgroup meetings have occurred and to continue until implementation. • Provider and staff education planning is in process. • Storage location of devices has been decided upon in collaboration with Pharmacy.		Sara Whyne Debra Knittle

Geisinger – Community Medical Center (CMC)	• Develop the supporting structure, processes, team roles, and skills to other contraceptive counseling including IPLARC.
	  ○ Once the sites' infrastructure to offer LARC is in place, the PA PQC LARC initiative will increase placement of IPLARC among eligible individuals desiring LARC
	  ○ Planning meetings are in place. Preparing staff education. IPLARC has not been implemented at this time.
		• What has been a successful method for teaching staff about the program?	Alex Davis

Geisinger Medical Center (GMC)	• (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).	• Do you limit your IPLARC placement to patients with certain insurances?	LoriBeth Ryder
Geisinger Wyoming Valley (GWV)	• (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).	• How have sites worked through provider barriers related to comfort-levels in placing IPLARC, specifically IUDs?	Rachel Cunniffe

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:

Main Line Health-Lankenau Medical Center	• "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
	  ○ Prenatal counseling
	  ○ Video on display in clinic
	  ○ Patient education materials and information sheets being distributed
	• Patient education video for immediate postpartum LARC:
	◦ This video will be played in the waiting room - awaiting tech support to display
	◦ Marketing will put this on the MLHS YouTube site so patients can also view it there and share it with others.
	◦ Marketing is developing additional educational/promotional materials for us that we will have in our Care Center.
		• What are the most effective:
		◦ Counseling strategies?
		◦ Strategies for physician and patient engagement in program?
		◦ Educational materials?
		◦ Workflow for monthly reporting?
		◦ Documenting and collecting information on why LARC was desired but not placed?	

St. Clair Hospital	• To date we formed a team: *team updates due to turnaround*
	  ○ 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
	  ○ Pharmacy working on charge structure IPLARC purchasing – we are adding Liletta and Nexplanon
	  - Depo Provera currently available.
	  ○ HIS working on ordering the devices in
		• 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

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
St. Luke's University Hospital-Anderson Campus	• Use EMR to identify patients who desire and receive IPLARC • Use EMR to make ordering and documenting provision of IPLARC more streamlined for physicians	• 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	• Use EMR to identify patients who desire and receive IPLARC • Use EMR to make ordering and documenting provision of IPLARC more streamlined for physicians	• 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
UPMC Womens Health Service Line-Altoona	• 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. ○ 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.	• 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	Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
UPMC Womens Health Service Line-Hamot	• 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. ○ 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.	• 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	Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu
UPMC Womens Health Service Line-Harrisburg	• 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.	• 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	Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	○ 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:
UPMC Womens Health Service Line- Horizon	• 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. ○ 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.	• 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	Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu
UPMC Womens Health Service Line- Williamsport	• 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.	• 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	Vivian Petticord Director, Women's Health Service Line pettvm@upmc.edu

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	○ 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.		
WellSpan-Ephrata Community Hospital	• System wide nursing policy approved on IPLARC • EPIC Orders built and approved • Procedure education provided for nursing and providers.	• How do we ensure insurances cover the cost of Nexplanon in private pay patients?	Aimee Fleischman
WellSpan-Gettysburg Hospital	• System wide nursing policy approved on IPLARC • EPIC Orders built and approved • Procedure education provided for nursing and providers.	• How do we ensure insurances cover the cost of Nexplanon in private pay patients?	Aimee Fleischman
WellSpan-Good Samaritan Hospital	• System wide nursing policy approved on IPLARC • EPIC Orders built and approved • Procedure education provided for nursing and providers.	• How do we ensure insurances cover the cost of Nexplanon in private pay patients?	Aimee Fleischman
WellSpan-Summit Health Chambersburg Hospital	• System wide nursing policy approved on IPLARC • EPIC Orders built and approved • Procedure education provided for nursing and providers.	• How do we ensure insurances cover the cost of Nexplanon in private pay patients?	Aimee Fleischman
WellSpan-York Hospital	• System wide nursing policy approved on IPLARC • EPIC Orders built and approved • Procedure education provided for nursing and providers.	• How do we ensure insurances cover the cost of Nexplanon in private pay patients?	Aimee Fleischman

Maternal OUD and Maternal Substance Use

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Allegheny Health Network- Forbes Hospital	• Increase education among patients related to substance use • Increase universal screening and follow up for substance abuse among pregnant and postpartum individuals	• Implementation and follow up process	Tiffany Mayer, Nurse Manager Tiffany.Mayer@ahn.org
Allegheny Health Network- Jefferson Hospital	• 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 at the first prenatal visit, at 28 weeks, and again at post-partum visit. • 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. • There is now a devoted outpatient social worker that sees any patient that screens position prenatally, and a notification is sent to L&D management team when the patient is close to delivery.	• Are providers not ordering cord stats when nursing feels one should be ordered? • What screening tools are other locations using? • Should questions directly related to opiate use be asked if they screen positive in the initial 5 questions?	Ashley Preksta RN, BSN
Allegheny Health Network- Saint Vincent Hospital	• 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* (September 2022 target)	• Are chart audits completed randomly to ensure coding accuracy? • How is incorrect coding identified and how is provider documentation reviewed to reflect accurate patient picture/level of acuity?	Lani Erdman Kim Amon Erika Pluta Jill O'Connor

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Allegheny Health Network- West Penn Hospital	• Continue to screen patients with 5 Ps on admission to labor and delivery • Establish clear protocols based on clinical criteria for when drug tests are indicated and obtain informed patient consent for toxicology prior to testing • Establish policies and protocols to provide Naloxone to anyone who may witness an overdose	• Ways to improve discharge follow-up and resources for patients	Kristen Maguire
Allegheny Health Network- Wexford Hospital	• Quarterly education with Dr. Tracey Vogel on trauma-informed care. • Wexford has formed a multidisciplinary team that meets on the 4th Tuesday of every month. First meeting scheduled for March 29th • All charts are audited by staff RNs on admission to ensure 5 P's screening was done *at least* once during pregnancy. If patient has not been screen, staff RN will give patient 5P's screening tool on paper to fill out privately and then input in HER.	• How other sites have educated staff on stigma and breaking biases surrounding mothers with substance use disorder. Guest speakers? Role playing?	Alycia Kerstetter, MSN, RNC-OB

Einstein Medical Center- Philadelphia	• No workflow in current state
	  ○ Solution – work with current MAT program LCSW to determine how to implement standardized screening on all women presenting for prenatal care
	• Change in workflow for providers and MA staff
	  ○ Solution – develop educational plan for provider and MA staff		

Evangelical Community Hospital	• Our Quality team reviews all charts monthly by hand for the 5Pcompletion.We report our compliance monthly at our OB committee meetings	Our upcoming challenge will be transitioning to the NIDA screening, from the 5P, due to our future transition to EPIC in December. We will have to re-educate our nursing staff and providers on a new screening form, ideally, before we go live with EPIC. Looking for any advice on how best to transition to the NIDA from 5P	Jen Sullivan RN, BSN Jennifer.Sullivan@evanhospital.com

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger-Bloomsburg Hospital	• 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	• Process for when patient refuses to complete screening tool? • Or mother refuses to give urine sample? • How to implement and track universal screening and adherence to algorithm in outpatient prenatal clinics? • How often do you screen prenatally? • What is your process for medical marijuana? •	Sara Whyne Debra Knittle
Geisinger-Community Medical Center (CMC)	• Education for staff regarding the NIDA form. Encouragement and praise for increasing and sustaining compliance with collecting patient forms	• What is the most engaging way you have provided education to staff on substance abuse disorder in pregnancy?	Karena Moran Research and Quality Project Manager Northeastern PA Perinatal Quality Collaborative kmoran3@thehealthplan.com Alex Davis
Geisinger-Lewistown Hospital (GLH)	• Implementing universal SUD screening in L&D and Outpatient • Implementing a clinical pathway for at-risk screens • Streamlining workflow and information sharing with data entry in EMR	• How do you address conflicted information? ○ Patient statement on SUD vs. OB History • How do you track universal screening and adherence to the algorithm in outpatient prenatal clinic?	Abby Newman Jen Sunderland
Geisinger Medical Center (GMC)	• 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	• Process for when a patient refuses to complete the screening tool? • How to ensure compliance of nursing staff completing the electronic medical record documentation of the screening tool? • What is your process for medical marijuana?	Amy Schauer, BSN

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Geisinger-Wyoming Valley (GWV)	• Re-educating on existing protocol for when to obtain a urine drug test • Placing NIDA as one of the 2022 Competencies • Review as standing item in each months Staff Meeting.		Rachel Cunniffe
Holy Redeemer Health	• Re-design and re-education of updated 5P screening tool for all OB pts, including streamlined scoring. • Initiate use of 5P screening tool for postpartum pts. • Development of job description for Substance Use OB Navigator, including position posting and active recruitment. • Creation of MOUD algorithm for pregnant patients. • Development of Narcan ordering/dispensing at discharge for patients identified at risk for SUD. • Ongoing staff and patient education.	• Any tips for streamlining data collection. Any additional resources for patient referrals/support being used.	Julie Greenfield, Director of Nursing, OB-GYN Acute and Ambulatory Alliance jgreenfield@holyredeemer.com Christina Marczak
Main Line Health-Bryn Mawr Hospital	• Social Work Evaluation of Outpatient Resources Across 4 Hospitals and 4 Geographic Counties: Goal to Optimize & Standardize • Develop Clinical and Psychosocial Pathways for OUD/SUD and NAS • Coordinate early consultation with Neonatology to optimize therapies and care plan • A BPA (Best Practice Advisory) will now launch when a patient screens positive For Urine Drug Screen Criteria Row in the OB Patient Profile ○ This BPA will prompt the nurse to place the order for the Inpatient OB Drug Screen Panel. If one or more of the UDS criteria is met, the BPA allows the nurse to place the order directly from the BPA.	• Best Practices for OUD/NAS Pathways • Outpatient Resource Referrals	Sharon Register, Project Manager

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Main Line Health (MLH) - Lankenau Medical Center	• Social Work Evaluation of Outpatient Resources Across 4 Hospitals and 4 Geographic Counties: Goal to Optimize & Standardize • Develop Clinical and Psychosocial Pathways for OUD/SUD and NAS • Coordinate early consultation with Neonatology to optimize therapies and care plan • A BPA (Best Practice Advisory) will now launch when a patient screens positive For Urine Drug Screen Criteria Row in the OB Patient Profile ○ This BPA will prompt the nurse to place the order for the Inpatient OB Drug Screen Panel. If one or more of the UDS criteria is met, the BPA allows the nurse to place the order directly from BPA.	• Best Practices for OUD/NAS Pathways • Outpatient Resource Referrals	Sharon Register, Project Manager
Main Line Health (MLH) - Paoli Hospital	• Social Work Evaluation of Outpatient Resources Across 4 Hospitals and 4 Geographic Counties: Goal to Optimize & Standardize • Develop Clinical and Psychosocial Pathways for OUD/SUD and NAS • Coordinate early consultation with Neonatology to optimize therapies and care plan • A BPA (Best Practice Advisory) will now launch when a patient screens positive For Urine Drug Screen Criteria Row in the OB Patient Profile ○ This BPA will prompt the nurse to place the order for the Inpatient OB Drug Screen Panel. If one or more of the UDS criteria is met, the BPA allows the nurse to place the order directly from BPA	• Best Practices for OUD/NAS Pathways • Outpatient Resource Referrals	Sharon Register, Project Manager

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Main Line Health (MLH) - Riddle Hospital	• Social Work Evaluation of Outpatient Resources Across 4 Hospitals and 4 Geographic Counties: Goal to Optimize & Standardize • Develop Clinical and Psychosocial Pathways for OUD/SUD and NAS • Coordinate early consultation with Neonatology to optimize therapies and care plan • A BPA (Best Practice Advisory) will now launch when a patient screens positive For Urine Drug Screen Criteria Row in the OB Patient Profile ○ This BPA will prompt the nurse to place the order for the Inpatient OB Drug Screen Panel. If one or more of the UDS criteria is met, the BPA allows the nurse to place the order directly from BPA	• Best Practices for OUD/NAS Pathways • Outpatient Resource Referrals	Sharon Register, Project Manager
Penn Medicine-Chester County Hospital	• Strengthening relationships with community partners through monthly meetings • Accessing community resources for mothers after discharge **Next steps:** • Postpartum contraception education and administration before discharge • Improving and standardizing urine toxicology screening • Retrospective analysis of ESC cohort data	• How to more effectively capture mothers prenatally for prenatal counseling?	

Penn State Health- Hershey Medical Center & Children's Hospital	• Spread SBIRT to other sites providing obstetrical care within the health system- In Progress (Tentative Go Live 4/18/22)
	• Complete/Expand staff education regarding:
	  ○ The 5Ps tool and screening rationale- In Progress (e-learning Go Live 4/4/22)
	  ○ The 5Ps screening process and SBIRT- In Progress (e-learning Go Live 4/4/22)
	  ○ Stigma/Words Matter- In Progress (e-learning Go Live 4/4/22)
	• Schedule MDT monthly and Ad hoc
	• Screen all pregnant pts on or before first OB appt for SUD using 5 Ps and/or NIDA quick screen
	• Provide Naloxone
		• What steps has your site taken to develop and consistently utilize unique clinical pathways/order sets for pregnant women with OUD?	Brittany Bogar

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
St. Clair Hospital	• 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.	• Growing the role of our newly created perinatal social worker position • Post-discharge patient follow-up strategies	Shawndel Laughner
St. Luke's University Hospital-Anderson campus	• Working to update our current screening tool to a PAPQC validated screening tool • Use of same screening to for both outpatient and inpatient settings • Work with L&D education specialist to develop and distribute education about SUD including stigma	• Is the screening tool questions asked by the health care provider or do you have a tool to allow patient to answer the questions independently?	Jessica Peters BSN, RN
Tower Health-Reading Hospital	• Screening for SUD in conjunction with testing at initial OB (COMPLETED) • Create clinical pathway for pregnant women with OUD (COMPLETED) • Hospital observation for MAT induction, methadone and buprenorphine offered (IN SUSTAINMENT) • Connection with methadone program in county (IN SUSTAINMENT) • Suboxone maintenance program at Women's Health Center for pregnant women with OUD (IN • Soft Landings- support program for pregnant and postpartum women with opioid and stimulant use issues. Case management, therapy, support & educational groups (IN SUSTAINMENT)		Kerin Kohler & Liz Huyett

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	• Prenatal development of a Plan of Safe Care (IN SUSTAINMENT) • Prenatal education about neonatal opioid withdrawal (IN SUSTAINMENT) • Connection to Early Intervention (IN SUSTAINMENT) • Collaboration with ED Amerihealth Caritas representative (ON GOING) • Initiate Naloxone kits in OBGYN offices (ON GOING) QI project to look at results of screening tools and urine tests. **Screening questions asked at initial prenatal visit.** **Urine drug test conducted at initial prenatal visit.** ○ Payers denying claims for patient with no history of OUD/Substance use with negative tests. Patients who have history or test positive are covered by payers at this time. **Improve identification of OUD patients** ○ Working on optimization of reporting/identify OUD patients and begin reporting out identified patients in Life QI portal **Naloxone Kits** ○ Kits incorporated at WHC and available for LD for women admitted for MAT initiation. Working with COCA for supply and reporting.		
Washington Health System	• WHS OBGYN utilizing universal screening tool – 5Ps; AUDIT & DAST-10 for further assessment if needed • OBGYN staff received training re: stigma reduction, SUD overview, SBIRT overview, and Motivational Interviewing. • 2021 Cumulative Data: ○ 451 patients completed the 5Ps ○ 13 patients "concerned about personal substance use ○ 8 patients "concerned about substance use among significant others" ○ 77 patients "concerned about substance use among family/friends"	• Implementing MAT/MOUD in primary care settings while complying with Privacy & Security issues in the electronic medical record. • Establishing a perinatal care delivery model that starts preconception and continues two years after the birth of a child. The development and implementation of a multidisciplinary care delivery model spanning all medical and social agencies to support	Lisa Pareso, Manager Rural Health Model lpareso@whs.org

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
		prevention, treatment, and recovery efforts.	

Wayne Memorial Hospital	• Increase education among patients r/t SUD
	  ○ Provide prenatal education to identified patients.
	• Increase education among healthcare team members to address stigma r/t SUD
	  ○ Use of a social worker who sees patients prenatally and at the hospital who screen positive.
	• Increase universal screening and f/u for SUD
	• increase initiation of MAT for those who screen positive for SUD
	• Coordinate the appropriate referrals for care.
		• Tracking patients for follow up after starting MAT	Janice Pettinato, pettinatoj@wmh.org
			Mary Beth Dastalfo, dastalfom@wmh.org

WellSpan-Ephrata Community Hospital	• Patients screened in standardized process with 4P's tool at OB intake appointment. • A positive screen will trigger best practice advisory to Foundations of Pregnancy Services. • Organized MAT CET. • Foundations of Pregnancy Services will contact patient to discuss available resources and encourage healthy prenatal habits, such as regular prenatal care. • Consider best practice advisory to order Naloxone prior to delivery discharge for patients who screen positive for substance use.	• Innovative ways to provide prenatal education. •	Aimee Fleischman
WellSpan-Gettysburg Hospital	• Patients screened in standardized process with 4P's tool at OB intake appointment. • A positive screen will trigger best practice advisory to Foundations of Pregnancy Services. • Organized MAT CET. • Foundations of Pregnancy Services will contact patient to discuss available resources and encourage healthy prenatal habits, such as regular prenatal care. • Consider best practice advisory to order Naloxone prior to delivery discharge for patients who screen positive for substance use.	• Innovative ways to provide prenatal education.	Aimee Fleischman
WellSpan-Good Samaritan Hospital	• Patients screened in standardized process with 4P's tool at OB intake appointment.	• Innovative ways to provide prenatal education.	Aimee Fleischman

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	• A positive screen will trigger best practice advisory to Foundations of Pregnancy Services. • Organized MAT CET. • Foundations of Pregnancy Services will contact patient to discuss available resources and encourage healthy prenatal habits, such as regular prenatal care. • Consider best practice advisory to order Naloxone prior to delivery discharge for patients who screen positive for substance use.		
WellSpan-Summit Health Chambersburg Hospital	• Patients screened in standardized process with 4P's tool at OB intake appointment. • A positive screen will trigger best practice advisory to Foundations of Pregnancy Services. • Organized MAT CET. • Foundations of Pregnancy Services will contact patient to discuss available resources and encourage healthy prenatal habits, such as regular prenatal care. • Consider best practice advisory to order Naloxone prior to delivery discharge for patients who screen positive for substance use.	• Innovative ways to provide prenatal education.	Aimee Fleischman
WellSpan-York Hospital	• Patients screened in standardized process with 4P's tool at OB intake appointment. • A positive screen will trigger best practice advisory to Foundations of Pregnancy Services. • Organized MAT CET. • Foundations of Pregnancy Services will contact patient to discuss available resources and encourage healthy prenatal habits, such as regular prenatal care. • Consider best practice advisory to order Naloxone prior to delivery discharge for patients who screen positive for substance use.	• Innovative ways to provide prenatal education.	Aimee Fleischman

Neonatal Abstinence Syndrome (NAS) and Substance Exposed Newborn (SEN)

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
AHN – Forbes Hospital	• Educate staff on ESC model • Educate patients on ESC model	• Long term outcomes for ESC	Tiffany Mayer

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	• Assist in non-pharmacologic treatment options		
Allegheny Health Network-Saint Vincent Hospital	• Met with key stakeholders (neonatologists, pediatrician, pharmacy, NICU nurse manager, MCH educator, two NICU nurses) re: modified Finnegan assessment, pharma logical 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, pharma logical intervention. • ESC implemented on 5N. 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	• All NICU staff will be trained in SENs, trauma-informed care, and state and county guidelines (e.g., Family Care Plans / Plans of Safe) • Prioritization of private rooms for substance exposed newborns. • All NICU nurses will be trained in caring for newborns on validated ESC tool. • Utilization of baby cuddlers to provide consolation in the absence of family.	• Strategies to support mothers and their partners in rooming in with their infant	Kristen Maguire

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Doylestown Hospital	Standardize compassionate, non-judgmental prenatal education and support: • Provide family education abut 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 p at time of discharge to monitor effectiveness of educational process and identify areas of improvement • Follow up phone calls 1 month after discharge • Update our NAS parent folders to provide more information regarding services/support available to them after discharge Encourage breastfeeding or breastmilk feeding: • Provide family education about medications mom is taking and how it can affect breastmilk/breastfeeding • Neonatology to discuss with parents any contradictions to breastfeeding • Lactation Consult • Establish breastfeeding guidelines and parameters based on national guidelines for parents with SUD/OUD Decrease hospital LOS of NAS infants with multiple drug exposures Minimize the number of doses of medications (Morphine/Phenobarbital) to treat NAS infants with multiple drug exposures ○ Maximize use on non-pharmacologic interventions ○ Collect data to determine if Neonatal Abstinence Syndrome (ESC) protocol and ESC Pharmacologic Treatment Algorithm are being utilized appropriately. ○ Increase the number of nurse/physician/parent huddles to discuss progression and response to treatment.	• Comparative information on breastfeeding statistics at other hospitals and what they implemented to help increase that percentage. • Challenges other hospitals are facing with the management of SEN to multiple drugs. Interventions they have found to be effective in the management of these newborns.	Michelle Joseph BSN, Pediatric Clinical Lead mijoseph@dh.org

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
Einstein Medical Center-Montgomery	Sustain: • Multidisciplinary meetings targeted for every two months • Continued distribution of information antenatally (pamphlets), and updated results at OB provider meetings • Non-pharmacologic supportive measures • Pathway revisions and ESC education Improve: • Rates of any breastfeeding at discharge • Unified approach to testing infants in concert with OB to develop standardized screening and testing of mothers • Post discharge follow-up and evaluation of Plan of Safe Care • Community Out-reach through clinics and support groups Start: • Infant massage training • Meeting with pediatricians to disseminate updated treatment for these infants	• 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? • What are people doing to improve BF rates?	Celina Migone, MD

Einstein Medical Center-Philadelphia	ESC
	• Open baby type NICU
	  ○ Solution – adapt ESC methodology to open bay NICU as per pilot case
	• No current protocol in place for ESC at EMCP
	  ○ Solution – Development of policy & procedure by EMCP PA PQC team
	Prenatal Consults
	• Data collection of total opioid use mothers
	  ○ Solution – obtain data from report from coding dept
	• Lack of educational materials in out-pt OB offices
	  ○ Solution – finish informational pamphlet for mothers
	  ○ Solution – with advent of LCSW position being filled, providers often defer to that position for
		• 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:
	follow-up, and cancel the consult. Need to do education for providers.		
Evangelical Community Hospital	• We are laying the groundwork to transition to Eat Sleep Console in December when we go live with EPIC. Currently we are using Finnegan with an emphasis on non-pharmacologic care.	• Any recommendations from units who have transitioned from Finnegan to ESC	Jen Sullivan
Geisinger-Bloomsburg Hospital	• 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 and pharmacists in MFM, prenatal care and pediatric care • Involved Certified Recovery Specialists and care managers • Developed EMR documentation • Developed education for prenatal patients • Survey of patient experience in process	• 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?	Sara Whyne Debra Knittle

Geisinger-Lewistown Hospital (GLH)	• Reviewed maternal risk factors
	• Sought guidance from PQC members
	• Evaluated equipment needs
	  ○ Obtained Mama Roo
	  ○ Halo swaddles
	• Implemented staff education
	• Implemented Eat Sleep Console for NAS monitoring
	• Created process to identify eligible patients
	  ○ MAT & NIDA
	• Involved physicians, nurses, and pharmacists in MFM, prenatal care and pediatric care
	• Involved case managers
	• Developed EMR documentation
	• Developed education for prenatal patients
	• Developed educational folders for mothers and family related to ESC
	• Survey of patient experience in process
	  ○ Leadership Rounds
		• 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.)?
		• Are you collecting feedback from patients about the ESC program/process? How?
			Abby Newman
			Jen Sunderland

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:

Penn Medicine-Hospital of the University of Pennsylvania	• Centered around mother-infant dyad collaborating with newborn nursery to reduce Mom/Baby separation
	• Prenatal Consults
	• Staff & Family education regarding Eat, Sleep, Console
	• Facilitating and participation in ESC escalation huddles to maximize non-pharmacologic interventions:
	  ○ Nonpharmacologic bundle
	  ○ Transfer from S8 to ICN
	  ○ Escalation in treatment in the ICN
	  ○ *Both with discussion of non-pharm measures attempted prior to escalation
	• Volunteer program- on hold (COVID)
	• Feeding policies created: breastfeeding eligibility policy, routine fortification
	• Data collection and discharge phone calls to collect data and patient feedback
		• Creating opportunities for parents to spend more time at the bedside
		• Space; Food; Transport; Childcare
		• Continued education on ESC
		  ○ Strategies for increasing comfort level of the staff.
		  ○ Sustaining education with new 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: How are you deeming infants as “affected by substance use” for plans of safe care.
		  ○ We use ESC huddle, ICN admission for medication treatment
		• 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:

Penn Medicine-Lancaster General/Women and Babies	• Identified physician and unit-based champions to participate in Eat, Sleep, Console (ESC) implementation team
	  ○ 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
	  ○ Validated current NAS report provides correct information
	  ○ % Pharmacologic treatment rates
	  ○ % 30-day readmission rates for NAS infants
		• 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?	Janay DiBerardino, Perinatal Safety Nurse
			Janay.DiBerardino@pennmedicine.upenn.edu

Penn Medicine-Pennsylvania Hospital, Newborn Medicine	Prenatal consultation: • 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 NAS care: • PAH-specific NAS protocol (vs using CHOPs) • Guidelines on obtaining UDS for mothers and infants now live EI referral: • Standardized EI referral (via EMR) by assigning neonatal NP who tracks/reports all OENs	• How to successfully implement Eat Sleep Console without private rooms?	Melissa McKinney, MSN, CRNP Dustin Flannery, DO, MSCE

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	• Use empowering messages to care givers
	  ○ Earlier engagement of OT to educate and empower patients
	• Identify SE as early as possible
	  ○ Complete universal SUD screening on or before first OB appt
	  ○ Improve specimen availability for infant tox testing through implementation of universal meconium collection and storage
	• Maintain IRR in Finnegan Scoring
	  ○ Finnegan soring resource card
	• Plan for huddles / collaboration of scoring at times of key decisions (real time)
	  ○ Identification of team members to be included in huddles
	  ○ Reinforce and remind team to conduct and document huddles
	Standardization of nonpharmacologic care for OEN
	• Revision of NAS Care Guidelines
	• Create an "All About Me" card to communicate infant likes and dislikes
		Does your hospital use a standardized screening protocol to determine which babies will require toxicology testing? If so, what is your screening criteria?	Brittney Bogar

St. Luke's University Health Network- Anderson Campus	• Data in EMR	• When there are times of high census how do you accommodate moms/families staying for a 5 day stay?	Jessica Peters BSN, RN

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)	• Previous interventions now in place
	  ○ Standardized non-pharm bundle of care
	  ○ Standardized pharmacologic treatment
	  ○ Family care plans prior to discharge
	  ○ EI, lactation, home visits, developmental medicine follow up referrals prior to discharge
	  ○ Improving breast feeding –pumping in DR, education about importance
	  ○ Expand interventions/measurement to all NAS population, not just those receiving pharmacologic treatment and admitted to our "NAS room"
	  ○ Expand standard bundle of care to well-baby nursery and remainder of intensive care nursery
	  ○ Expand donor milk use to NAS population as needed as a bridge to maternal breast milk use
		• Improving % eligible to breast feed at time of admission – we have a large percentage of polysubstance use mothers that we currently precluded from breast feeding
		• Implementing ESC without moms being able to stay in house past their recovery from delivery and without cuddlers available
			Dave Carola

UPMC Womens Health Service Line- Magee Altoona Cole Hamot Horizon Northwest	• 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. • Updated our ABCD Poster to include: Tell us where baby will sleep for naps and nighttime! • This will be in every pt room to trigger the conversation of where the baby will sleep – to assess if the parents have a safe place to sleep. We know	• 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

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
	that our SUD moms are very high risk for unsafe sleep deaths • Applying for system-wide Cribs 4 Kids Safe Sleep Designation for all 15 birthing hospitals		
UPMC – Pinnacle Harrisburg	• Nurse education/IRR		Patti Miller
Wayne Memorial Hospital	• Reviewing and revising the NAS policy and order set • Building non-pharm interventions in the EMR • Producing a "Welcome Booklet" for all SEN's and the family.	• IRR with NAS scoring	Janice Pettinato pettinatoj@wmh.org
WellSpan-Ephrata Community Hospital	• Focus group review of NAS cases to determine opportunities in standardizing care, review data and discussion. • Standardized care of the non-pharmacologic bundle use for all NAS infants per standardized tool and nursing policy. • Standardized order set in place which includes case management referral to address discharge planning and needs.	• Innovative opportunities for prenatal education related to NAS expectations during the hospital stay.	Aimee Fleischman
WellSpan-Gettysburg Hospital	• Focus group review of NAS cases to determine opportunities in standardizing care, review data and discussion. • Standardized care of the non-pharmacologic bundle use for all NAS infants per standardized tool and nursing policy. • Standardized order set in place which includes case management referral to address discharge planning and needs.	• Innovative opportunities for prenatal education related to NAS expectations during the hospital stay.	Aimee Fleischman
WellSpan- Good Samaritan Hospital	• Focus group review of NAS cases to determine opportunities in standardizing care, review data and discussion. • Standardized care of the non-pharmacologic bundle use for all NAS infants per standardized tool and nursing policy. • Standardized order set in place which includes case management referral to address discharge planning and needs.	• Innovative opportunities for prenatal education related to NAS expectations during the hospital stay.	Aimee Fleischman

Site Name:	Key Interventions:	Our team would most like to learn from our peers:	Key Contact:
WellSpan- Summit Health Chambersburg Hospital	• Focus group review of NAS cases to determine opportunities in standardizing care, review data and discussion. • Standardized care of the non-pharmacologic bundle use for all NAS infants per standardized tool and nursing policy. • Standardized order set in place which includes case management referral to address discharge planning and needs.	• Innovative opportunities for prenatal education related to NAS expectations during the hospital stay.	Aimee Fleischman
WellSpan- York Hospital	• Focus group review of NAS cases to determine opportunities in standardizing care, review data and discussion. • Standardized care of the non-pharmacologic bundle use for all NAS infants per standardized tool and nursing policy. • Standardized order set in place which includes case management referral to address discharge planning and needs.	• Innovative opportunities for prenatal education related to NAS expectations during the hospital stay.	Aimee Fleischman