PA PQC September 24 Learning Collaborative: Handout for the QI Speed Networking Activity

Maternal Mortality: Hypertension

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Evangelical Community Hospital	Multi-disciplinary meetings to accomplish the following: *Patient education opportunities *Assessment, treatment, & follow-up protocols *Standardized order set & discharge instructions *Standardization of patient placement *Staff education i.e. ED providers *Data collection	
Geisinger	*Implementing checklist for HTN Crisis *Providing simulation & drills for education *Reviewing medication access *Creating order sets to avoid unnecessary clinical variation	
Jefferson Health-Abington Hospital	*Standardized guidelines for PP follow-up (current focus on HTN &PPD) *Inter-professional postpartum rounding on inpatient Mother-baby units *Developing standardized guidelines for postpartum follow-up	
Penn Medicine-Chester County Hospital	*Preeclampsia Pathway *Hypertensive Management Pathway *Postpartum Hypertension Pathway *Adoption of Heart Safe Motherhood	

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Penn State Health: Hershey Medical Center & Children's Hospital	*Development of written evidence-based guidelines for management of acute hypertensive emergency in pregnant & postpartum patients *Staff education (initial & ongoing) *Availability of guidelines in the electronic manual(s) & posted on the unit *Development of a quick reference tool/checklist based on the written guidelines *Placement of medications in L&D Pyxis machine for quick & easy access *Expand the adoption & operationalization of guidelines to the ED & other related adult patient care areas.	
Punxsutawney Hospital	*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	
St. Luke's University Health Network	*Verified with ED if current screening process is to determine if patient recently had a baby *Enlisted our EPIC IT team members to assist us with building a screening tool to be used in ED *Contacted WellSpan contact to get input on what they have included in their screening tool *Ordered AWHONN magnets to distribute at discharge for mothers to put on fridge	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
UPMC Womens Health Service Line	*Standardized: • Diagnostic criteria, monitoring & treatment of severe preeclampsia/eclampsia, algorithms, order sets, protocols, staff & provider education, unit-based drills, debriefs. Process defined for timely triage & inpatient, outpatient, & ED evaluation. Medications for treatment stocked & immediately available. *Recognition & Prevention: • Protocol for measurement & assessment of BP & labs for all pregnant & postpartum women • Prenatal & postpartum patient education on signs & symptoms of hypertension & preeclampsia • Implemented Vivify for outpatient B/P monitoring & symptomatology *Response: • Protocols for management & treatment of hypertension • Every 4 hr patient safety rounds in L&D • Post discharge process for monitoring blood pressures • Vivify patient portal monitored through Call Center if B/P elevated reaches out to physician on call to respond to the patient's needs M-F 8am-4:30pm • Support plan for patients & families; Timely scheduled follow-up appts *Reporting: • Multidisciplinary review of all severe hypertension/eclampsia event cases • Post event debriefs • Team monitoring outcomes & metrics, communication to leaders accordingly	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
WellSpan Health	*Education to staff specific to the AIM bundle *Revision of nursing policy specific to the care of women with preeclampsia/severe hypertension *Preeclampsia Order Set severe hypertension *Collaboration with ER-education of ER providers regarding definition of severe hypertension in pregnancy/postpartum, importance of early obstetrics consults in this population, timely treatment of severe hypertension, update early policy to include care of postpartum women *Update EPIC to clearly identify obstetrical history *Bracelets *Looking at SMM and preeclampsia by Race *Reviewing data on severe hypertension treatment	

Maternal Mortality: Hemorrhage

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Jefferson Health-Thomas Jefferson University Hospital	*QBL calculator is revised & will be in-serviced to all staff responsible for QBL including Delivery Room, High Risk, and PP *QBL guideline will be updated to include: • Length of oxytocin infusion post-delivery • Implementation of OB emergency card for hemorrhage *Scheduled simulation for October 2019	
Penn Medicine-Lancaster General/Women and Babies	*Train champions to facilitate QBL process *Investigate EMR tools for hemorrhage risk assess *Inventory tools/equipment required for QBL process *Establish a method for reporting & determining baseline data	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Penn Medicine-Pennsylvania Hospital	*Now include the risk assessment in every pre-op huddle (seen reduction in use of massive transfusion protocol) *Increase in communication of risk assessment & decrease in the need for the massive transfusion protocol	
Temple University Hospital	*Risk assessment for every patient *Implement the hemorrhage protocol *Hemorrhage cart	
UPMC Womens Health Service Line	*Standardized hemorrhage cart to include: • supplies, checklist, algorithms, hemorrhage medication kit, response team, advanced gynecologic surgery, massive transfusion protocols, unit guidelines, unit-based drills with post-drill debriefs, & staff/provider education *Recognition & Prevention: Standardized assessment tool. • prenatally, admissions, other appropriate times • Measurement from EBL to QBL & defined quantity *Response: Support programs for patients, families, staff *Reporting: Event reporting to Risk/Quality Department; Multidisciplinary review for opportunities in systems & processes; Monitor outcomes & metrics; Report to various committees	

Maternal OUD

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Allegheny Health Network	*Identify a standardized tool to use at all OB care practices by June 30th *Work with the IT team to build the screening tool within the Welcome tablet for consistent screening of all AHN patients *Meet with IT data collection/reports team to review PAPQC quality metrics for OUD/SUD	
Commonwealth Health- Moses Taylor Hospital	*Introduction of a drug screening tool (5P's) distributed to a single provider for the patient's initial prenatal visit *Intervention- 30 day Duration	
Geisinger	*Implementing universal NIDA screening *Implementing a clinical pathway for positive screens *Re-educating on urine toxicology protocol	
Guthrie Hospital	*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)	
Jefferson Health-Abington Hospital	*Universal Screening with 5Ps tool at first prenatal visit & all triage & inpatient admissions to L&D	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Lehigh Valley Health Network-Pocono	*Educate all prenatal care providers on 4P's scripting *Educating on referral process to LSW *Provide educational material to pregnant women with OUD	
Main Line Health (MLH)	*Formed OUD Inpatient Team *Mapped Current State of OUD Assessment & EPIC Documentation *Requested EPIC Clinical Informatics/IT to optimize EMR by adopting the 5P's Risk Assessment *Performed crosswalk of measurements from MLH to PA PQC with MLH Analytics to ascertain data collection ability	
Penn Medicine-Chester County Hospital	*Completed process mapping, gap analysis, Affinity Diagram, & brainstorming *Evaluated screening tools; Agreed to use 5P's screening tool *Engaged County & Community representatives	
Penn Medicine-Hospital of the University of Pennsylvania	*Creation of a template for a prenatal consult for pregnant women in OUD *Educate/email OB staff about need for prenatal consultation when able (& why) *Assigned EI referral (through EMR) to neonatal NP who tracks all OENs in our hospital	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Penn State Health: Hershey Medical Center & Children's Hospital	*Gain consensus & approval on a validated screening tool to screen all pregnant women for substance use *Draft a paper patient-friendly form to screen patients at the time of the first prenatal appoint. *Develop an ambulatory tool- OUD worklist to enhance the workflow & care of patients with OUD & to enhance data collection capabilities *Complete staff education regarding: 5Ps tool & screening rationale; 5Ps screening process & SBIRT; education on the OUD worklist & documentation *Complete follow-up phone calls & track data via the ambulatory tools-OUD worklist	
St. Clair Hospital	*Began using the 5Ps tool for outpatient prenatal visits & inpatient admissions to our hospital in June 2019 *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 & then again in the 2nd & 3rd trimester *Provided OB offices with referral forms to be faxed to our Level 2 Nursery Coordinator for follow-up care. Once receive referral, Nursery Coordinator reaches out to the family to discuss the care they can expect when they arrive for their delivery. *Educated inpatient nursing staff on 5Ps screening tool, & implemented it to be used on all patients admitted	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
UPMC Womens Health Service Line	*Access: • Maternal medical support to prevent withdrawal during pregnancy; • On call service for all UPMC hospital 24/7; • Provide regular prenatal & other medical appointments; • 4 Outreach Community Centers; • Same day or next day within 24 hr appointments *Prevention: • Community education; • Obstetrical provider education; • Minimize fetal exposure to opioid substances; • Early engage mother as a leader in her recovery; • Narcan "to go" *Response: • Pregnancy Recovery Center (Prenatal & Postpartum); UPMC Health Plan engagement; • Support programs for patients, families, staff (multidisciplinary team OB, MFM, SW, RNs, Mental Health therapists); • Methadone Conversion to buprenorphine from inpatient to outpatient; • Outpatient buprenorphine medication treatment; • Warm hand offs; • ED Physician & APP Trained n buprenorphine treatment *Reporting: Centers of Excellence • State, Allegheny County, UPMC Health Plan • Report as appropriate to various committees	

Neonatal Abstinence Syndrome (NAS)

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Commonwealth Health- Moses Taylor Hospital	*Revised NAS protocol for medication administration & weaning process for NICU admissions	
Einstein Medical Center Philadelphia	*Create pamphlet for families *Provide anticipatory guidance to families during prenatal visits *Chart review for adherence to NAS protocols *Create OB trigger at 28 weeks for NICU consult *Obtain prenatal joint medicine/nursing consult: Create template for this team consult *Add Picker-type question to discharge phone calls	
Jefferson Health – Abington Hospital	*Implementation of Eat, Sleep, Console tool for NAS assessment	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
Mount Nittany Health System-Mount Nittany Medical Center	*Invite mothers with welcome brochure *Implement Eat/Sleep/Console *Maximize non-pharmacologic interventions *Consider PRN medication dosing	
Penn Med-Pennsylvania Hospital, Newborn Medicine	*Review pharmacologic treatment for every OED newborn from 3/1/2019 - 8/31/2019 to determine total medication use & weaning process	
Penn State Health: Hershey Medical Center & Children's Hospital	*Baseline assessment of IRR *Refresher education *Plan for huddles/collaboration of scoring at times of key decisions: Identification of team members/champions to be included in huddles; Additional education for huddle team members	
St. Luke's University Health Network	*Working with IT to create an EPIC report to accurately identify any babies with NAS & who are affected by OUD *PA PQC core team is working on completing the required NAS education to build competence & consistency within our NAS scoring throughout the network	

Site Name:	Key Interventions:	This is what I learned from my peers on this topic:
UPMC Womens Health Service Line	*Access: Maternal medical support to prevent withdrawal during pregnancy; Provide regular prenatal & other medical appointments *Prevention: Minimize fetal exposure to illicit substances; Engage mother as a leader in her recovery *Response: Newborn pharmacological treatment protocol in place; Parent Partnership Unit (PPU) Eat, Sleep, Console; Cuddler Program; Increased lactation education & support; Social service support; Behavioral Health assistance; Buprenorphine management; Longer gestational time till delivery *Reporting: PA DOH of all NAS occurrences; Internal leadership & committees (NICU)	
Wayne Memorial Hospital	*Create & use standardized coding & documentation for SEN's & NAS including specific ICD-10 codes for OEN's *Educate staff regarding OEN & NAS, trauma informed care & MDWISE guidelines *Develop screening criteria for prenatal identification of infants at risk for NAS *Provide family education about NAS & what to expect	