New CMS Measure: Participating in a Statewide and/or National Perinatal Quality Improvement Collaborative Program

NH AIM/ERASE Monthly Webinar
April 14, 2022

- We will begin shortly.
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- Reminder, this session will be recorded.
- **Please mute your line upon entering and chat in your comments or questions.**
- Maggie Minnock will monitor the chat box and may ask you to unmute yourself.

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH | NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK | NH Division of Public Health Services

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Our presenters have no conflicts of interest to disclose.

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Maternal Morbidity & Mortality Measures

Kris Hering, MSN, RN, NE-BC, FACHE
VP Quality Improvement
Foundation for Healthy Communities

Foundation *for* Healthy Communities

Learning Objectives

- Describe the new CMS Maternal Morbidity Structural Measure
- Discuss maternal morbidity & mortality measures required by other accrediting agencies: The Joint Commission (TJC) and DNV-Healthcare Organization for Hospitals
- Anthem's Quality-in-Sights Hospital Incentive Program (QHIP) maternal morbidity & mortality measures

QSO-22-05-Hospitals

- New CMS structural quality measure for the Hospital Inpatient Quality Reporting (IQR) Program.
- Specifically for hospitals that provide inpatient peripartum care.
- Required beginning with Oct. 1, 2021 discharges for the 4th qtr. of 2021, and then annually starting in 2022.

Maternal Morbidity Structural Measure

- Does hospital or health system participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during labor, delivery and post-partum care, and has implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but not limited to: hemorrhage, severe hypertension/preeclampsia or sepsis?

Answer choices: Yes, No, or N/A (does not provide inpt. L&D care)

❖ CMS considering additional maternal care quality measures for future years

Maternal Safety Bundles- 5 R's

- Readiness
- Recognition and Prevention
- Response
- Reporting & Systems Learning
- Respectful, Equitable, and Supportive Care

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ACOG
The American College of Obstetricians and Gynecologists

TJC Maternal Mortality Measures

The Joint Commission

Provision of Care, Treatment, and Services Chapter:

PC.06.01.01: Reduce the likelihood of harm related to maternal hemorrhage.

- **EP1:** Complete an assessment using an evidence-based tool for determining maternal hemorrhage risk on admission to labor and delivery and on admission to postpartum. (See also PC.01.02.01, EP 2; PC.01.02.03, EP 3; RC.02.01.01, EP 2)
- **EP2:** Develop written evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that include the following:
  - The use of an evidence-based tool that includes an algorithm for identification and treatment of hemorrhage
  - The use of an evidence-based set of emergency response medications that are immediately available on the obstetric unit
  - Required response team members and their roles in the event of severe hemorrhage
  - How the response team and procedures are activated
  - Blood bank plan and response for emergency release of blood products and how to initiate the hospital's massive transfusion procedures
  - Guidance on when to consult additional experts and consider transfer to a higher level of care
  - Guidance on how to communicate with patients and families during and after the event
  - Criteria for when a team debrief is required immediately after a case of severe hemorrhage

  Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, anesthesiology, nursing, laboratory, and blood bank.

- **EP3:** Each obstetric unit has a standardized, secured, and dedicated hemorrhage supply kit that must be stocked per the hospital's defined process and, at a minimum, contains the following:
  - Emergency hemorrhage supplies as determined by the hospital
  - The hospital's approved procedures for severe hemorrhage response
- **EP4:** Provide education to all staff and providers who treat pregnant and postpartum patients about the hospital's hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.
  Note: Education provided should be role-specific.
- **EP5:** Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Drills include representation from each discipline identified in the hospital's hemorrhage response procedure and include a team debrief after the drill.
- **EP6:** Review hemorrhage cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided by the hemorrhage response team during the event.
- **EP7:** Provide education to patients (and their families including the designated support person whenever possible). At a minimum, education includes the following:
  - Signs and symptoms of postpartum hemorrhage during hospitalization that alert the patient to seek immediate care
  - Signs and symptoms of postpartum hemorrhage after discharge that alert the patient to seek immediate care

Provisions of Care, Treatment, and Services Chapter

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

- **EP1:** Develop written evidence-based procedures for measuring and remeasuring blood pressure. These procedures include criteria that identify patients with severely elevated blood pressure.
- **EP2:** Develop written evidence-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes the following:
  - The use of an evidence-based set of emergency response medications that are stocked and immediately available on the obstetric unit
  - The use of seizure prophylaxis
  - Guidance on when to consult additional experts and consider transfer to a higher level of care
  - Guidance on when to use continuous fetal monitoring - Guidance on when to consider emergent delivery
  - Criteria for when a team debrief is required

  Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, emergency department, anesthesiology, nursing, laboratory, and pharmacy.
- **EP3:** Provide role-specific education to all staff and providers who treat pregnant/postpartum patients about the hospital's evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.

  Note: The emergency department is often where patients with symptoms or signs of severe hypertension present for care after delivery. For this reason, education should be provided to staff and providers in emergency departments regardless of the hospital's ability to provide labor and delivery services.

- **EP4:** Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Severe hypertension/preeclampsia drills include a team debrief.
- **EP5:** Review severe hypertension/preeclampsia cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided to the patient during the event.
- **EP6:** Provide printed education to patients (and their families including the designated support person whenever possible). At a minimum, education includes:
  - Signs and symptoms of severe hypertension/preeclampsia during hospitalization that alert the patient to seek immediate care
  - Signs and symptoms of severe hypertension/preeclampsia after discharge that alert the patient to seek immediate care
  - When to schedule a post discharge follow-up appointment

NIAHO® Accreditation Requirements, Interpretive Guidelines and Surveyor Guidance Revision 20-1, 09-21-2020: No specific maternal mortality standards.

NIAHO (National Integrated Accreditation for Healthcare Organizations) standards are currently being reviewed and revised. DNV expects the organizations they accredit, as part of their quality management system, to be responsible for considering accepted standards of practice or recommendations, any applicate state laws, federal regulations, etc., in coming to a decision about organizational policy and procedure development in regard to specific practices.

Anthem

Anthem Quality-In-Sights Hospital Incentive Program (Q-HIP) CO, CT, ME, NH,and NV (2022)

Measure Title: Maternal Safety Bundles

Description: The Facility has implemented the following NPMS Patient Safety Bundles:

- **Hypertension**
  - Unit-standard* protocol for treatment of acute-onset severe hypertension: share OB unit protocol (policy or procedure), revised within the last 2 years
  - Report number of cases of acute-onset severe hypertension (≥160 systolic or ≥110 diastolic) reviewed to document treatment within 60 minutes in the last year
  - Unit Standard* protocols for blood pressure measurement and diagnosis of preeclampsia using latest criteria: share policies/procedures/or protocols for both BP measurement and diagnosis
  - Education: report the percent of nurse and physician staff trained in the protocols for acute treatment of severe hypertension and to the latest criteria for preeclampsia. Reeducation is required every two years for all OB clinical staff. At least 50% of medical and nursing personnel who care for OB patients must complete the education within the measurement year or the year prior.
  - Preeclampsia Discharge Education: share materials used on the OB unit that describe signs and symptom that call for prompt follow-up with healthcare provider

*Unit standard means one common protocol for all providers

- **Obstetric Hemorrhage**
  - Unit-standard*, Stage-based, Obstetric Hemorrhage Management Plan: share the protocol itself and supporting materials including policy(s) or procedure(s), revised within the last 2 years
  - Education: report the percent of nurse and physician staff trained to the Management Plan. Reeducation is required every two years for all OB clinical staff. At least 50% of medical and nursing personnel who care for OB patients must complete the education within the measurement year or the year prior.
  - Hemorrhage drills: report the number of multidisciplinary hemorrhage drills during the last year. A minimum of one drill per year is required.
  - Hemorrhage cart: share the policy/procedure with the contents of the cart
  - Rapid access to blood: share policy/procedure for emergency release/procurement of O-negative or Type-specific uncross-matched blood for obstetric hemorrhage use

*Unit standard means one common protocol for all providers

Evaluation Criteria: The Facility must have all the components of the above two Patient Safety Bundles in place during the Measurement Year, as evidenced by documentation such as policies, procedures and case

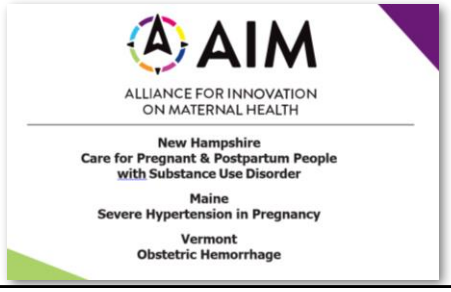
Detailed information about the Maternal Safety Bundles measure can be found at the National Partnership for Maternal Safety website -Released 9/30/2021 18
http://safehealthcareforeverywoman.org/

Maine Hospital Association Supports Perinatal QI

- Maine Hospital Association: Steve Michaud, President
  - 36 hospitals in Maine, 25 birthing hospitals
  - 12,000 (approx.) births in 2021
  - QI is a key pillar of MHA support to hospitals
  - Assists in engaging CEOs, CMOs, CNOs
- Past and current Perinatal QI initiatives
  - PQC4ME/Center for Quality Improvement – ongoing (MHA representation)
  - Snuggle ME
  - Eat Sleep Console
  - Safe Sleep
    - MHA assisted with messaging to get all birth hospitals Cribs for Kids Certified between 2019-2021
    - 2020 – 2021, 50% reduction in unsafe sleep practices – sustained for 2 years!)
  - AIM Severe Maternal Hypertension Bundle
  - Risk Assessment and Preterm Labor Transport Pilot
  - Maternal Naloxone
- Other
  - LOCATe (Levels of Care) Guidance Document – 100% hospital site visits in 2021-22
  - Perinatal Systems of Care Working Partners Group

Questions for Kris and Steve?

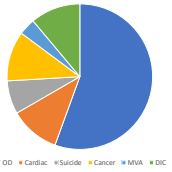
Each NNEPQIN State is Working on a Different Bundle



New Hampshire Pregnancy-Associated Deaths

Ellen Stickney, RN, BSN, RNC-OB, NH Maternal Mortality Review Coordinator, Concord, NH

- 2019 – 2021
- 26 Pregnancy-Associated Deaths (including 3 non-residents)
- 15 substance-related (~58%)



Department of Public Health Services

Slide created in collaboration with Dr. David Laflamme

Care for Pregnant and Postpartum People with Substance Use Disorder Patient Level Data Elements

Screen all Pregnant and Postpartum People

for SUDs using validated self-reported screening tool during prenatal care and the delivery admission

Eligibility

Is there evidence that the patient is using a sedative (benzodiazepines), opioid, or non-prescribed stimulant?

- ☐ F11 (Opioids)
- ☐ F13 (Sedative, hypnotic or anxiolytic)
- ☐ F14 (Cocaine)
- ☐ F15 (Stimulants)
- ☐ O99.32 (Drug use complicating pregnancy)
- ☐ None of the above

Demographics

Ethnicity
Race
Principal source of payment for this delivery

Process and Outcome Measures

Did this pregnant or postpartum patient with OUD:

- Receive or get referred to medicati… …isorder?
- Counseled on medicati… …enatally or during th…
- R… …ent services?
- … …nt services prenatally or …ission?
- C… …aloxone prior to delivery discharge?
- Receive Naloxone or a prescription prior to delivery discharge?

Was the newborn discharged home with either birth parent?
Did severe maternal morbidity (SMM) occur during the birth admission?

Plan of Safe Care

Severe Hypertension in Pregnancy Maine Data & Decision to Focus on this Bundle

Gestational hypertension appears to be increasing among Maine birthing people

SMM among **all hospital deliveries** 2016 - 2020

85.4 per 10,000 (with transfusion)

54.0 per 10,000 (excluding transfusion)

SMM among deliveries with **severe preeclampsia or eclampsia** 2016 - 2020

504.4 per 10,000 (with transfusion)

444.1 per 10,000 (excluding transfusion)

- Maternal, Fetal & Infant Mortality Reviews
- Maine Medical Mutual, malpractice insurer selected HTN as the topic for hospitals to focus on this year
- Hospital choice-we offered them the SUD bundle or the HTN bundle
- Transport case reviews and HTN a common topic

Reference: Fleur Hopper, MSW, MPH, Epidemiologist, MCDC and University of Southern Maine, January 23, 2022

Severe Hypertension in Pregnancy
Patient Level Data Elements

PATIENT SAFETY BUNDLE
Hypertension

- Notification of physician or primary care provider if :
  systolic BP =/> 160 or diastolic BP =/> 110
  for two measurements within 15 minutes
- After the second elevated reading a standard antihypertensive agent should be administered within 60 min of episode onset
- Data with include any interventions for those unresponsive to standard treatment

Reference: https://www.ajog.org/article/S0002-9378(21)01108-X/fulltext#secsectitle0020 [ajog.org]

AIM CMQCC

LABETALOL

IF SEVERE BP ELEVATIONS PERSIST FOR 15 MINUTES OR MORE, ADMINISTER
LABETALOL 20 MG IV FOR >2 MINUTES

AFTER 10 MINUTES, IF EITHER BP THRESHOLD IS STILL EXCEEDED, ADMINISTER
LABETALOL 40 MG IV FOR >2 MINUTES

AFTER 10 MINUTES, IF EITHER BP THRESHOLD IS STILL EXCEEDED, ADMINISTER
LABETALOL 80 MG IV FOR >2 MINUTES

AFTER 10 MINUTES, IF EITHER BP THRESHOLD IS STILL EXCEEDED, ADMINISTER
HYDRALAZINE 10 MG IV FOR >2 MINUTES

ACOG Protocol for Treatment of Severe HTN in Pregnancy

sBP≥160 or dBP≥110, (persisting 15min)

- **ACOG Practice Bulletin 203** January 2019: Chronic Hypertension in Pregnancy
- **ACOG Practice Bulletin 222** June 2020: Gestational Hypertension and Preeclampsia

Reference: Elliot Main presentation to Maine PQC January 23, 2022

Severe Maternal Mortality in Vermont 2013-2015
PPH & HTN are the Largest Contributors

	VERMONT	
	Count	Rate per 10,000
Total delivery discharges	16,285	N/A
Any SMM		
Any severe maternal morbidity (21 conditions)	322	197.7
Any severe maternal morbidity (excluding transfusion)	143	87.8
Severe hypertension		
Severe hypertension cases	372	228.4
SMM among severe hypertension cases	54	1,451.6
SMM (excluding transfusion) among severe hypertension cases	36	967.7
Severe hemorrhage		
Severe hemorrhage cases	1,144	702.5
SMM among hemorrhage cases	238	2,080.4
SMM (excluding transfusion) among hemorrhage cases	59	515.7

Contribution of HTN and PPH on SMM: 91%

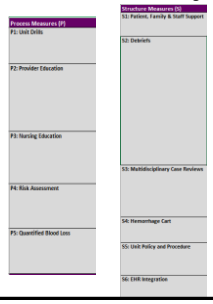
VERMONT:

Following the Joint Commission requirements to implement Post Partum Hemorrhage

Each VT Hospital's responsibility is to:

Be actively involved in implementation (Note: almost all are required by JCAHO for hospital accreditation)

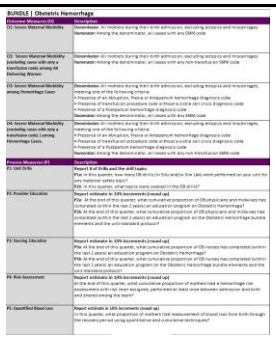
- **Participate in structured education that is required for every provider and role as a process measure includes anesthesiology and ED, per JCAHO.**
- **Use and participate in Process and Structural Measures**



https://safehealthcareforeverywoman.org/aim-program/

Vermont's Activities

- **Get baseline data for the state and hospital**
- **Send data quarterly to AIM on each measure**
- **Measure implementation**
- **See how outcomes in each measure change as implementation is performed**
- **Benchmarked nationally, regionally, by hospital size, location**



Status of Vermont Activities

- All hospitals in AIM
- Rolled out PPH bundle and sent quarterly reports
- In the process of getting the data uploaded to the AIM Portal
- Completing structural measures: working on quick drill book and hope to strengthen section on Patient, Family, Staff Support
- Finalizing mandatory module to PPH and HTN education which will include anesthesiology and ED: this is done and is in the required software, just getting to final edits

- Note: CMQCC just updated PPH Toolkit, is excellent and has a few modifications:
  - No miso unless can not use methergine or hemabate
  - Institutions should select a preferred second agent (we will use methergine)
  - Oxytocin boluses and infusion recommendations rom AWHONN were updated in the last year

- Next Steps: Plan to roll out Hypertension Bundle in the fall
- Currently meet JCHAO requirements for HTN and PPH

NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK A DARTMOUTH-HITCHCOCK PROGRAM

Next Steps?
Learn from each other as these Bundles are rolled out!

Collaborative Learning

Rapid Response Data

Quality Improvement Science Support

Provider & Nursing Staff Education Every 2 Years

- **All Bundles:** Respectful and Equitable Care
- **SUD Bundle:** Care for Pregnant & Postpartum People with Substance Use Disorders

SAVE THE DATES!
May 12th 12-1pm

Peter Y. Fifield, EdD, LCMHC, MLADC
Manager, Behavioral Health Services
Wentworth-Douglass Hospital, Dover, NH

Farrah Sheehan, MSN, RN, IBCLC, CCBE(BFW)
BirthingYou | Perinatal Nurse Educator
Researcher & Consultant, Bedford, NH

&

NNEPQIN
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