We will begin shortly.
• Please type your name into the chat box.
• 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.

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

NH AIM/ERASE Monthly Webinar
April 14, 2022

Our presenters have no conflicts of interest to disclose.

Maternal Morbidity & Mortality Measures

Kris Hering, MSN, RN, NE-BC, FACHE
VP Quality Improvement
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

CMS - 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.

CMS - 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

TJC Maternal Mortality Measures

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; PC.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

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
- 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
- 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 applicable state laws, federal regulations, etc., in coming to a decision about organizational policy and procedure development in regard to specific practices.

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

**Description:** The facility has implemented the following NPSN Patient Safety Bundles:

- **Obstetric Hemorrhage**
  - Unit-standard*: Share-based, Obstetric Hemorrhage Management Plan. The plan was supported and updated by a protocol(s) or procedure(s), reviewed annually.
  - Education: Report the percent of nurses and physicians staff exposed to the Management Plan, reviewed 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 next year.
  - Hemorrhage skills: The number of obstetrician-gynecologists practicing the plan.

**Evaluation Criteria:** The facility must have all the components of the above two Patient Safety Bundles in place during the measurement year as validated by documentation and/or follow-up procedures, guidelines, and case reviews.

*Unit standard means one common protocol for all providers.

Detailed information about the Maternal Safety Bundles measure can be found at the National Partnership for Maternal Safety website - Released 9/30/2021

http://safehealthcareforeverywoman.org/
Maine Hospital Association Supports Perinatal QI

- Maine Hospital Association: Steve Michaud, President
  - 46 hospitals in Maine, 25 birthing hospitals
  - 12,000 (approx.) births in 2021
  - QI is a key pillar of MHA support to hospitals
  - QI is a key pillar of MHA support to hospitals

- 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
Data released under network 80 legal agreement

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 substance (heroin, cocaine, etc.) or was prescribed medication?

Demographics
Ethnicity
Race
Last source of payment for this delivery

Process and Outcome Measures:
Did the patient or postpartum patient with OUD:
• Receive or get referred to medication-assisted treatment?
• Have contact with mental health or substance use services?
• Have contact with social services?
• Have contact with primary care services?
• Have contact with maternity services?
• Receive education or counseling prior to delivery discharge?
• Receive education or counseling prior to delivery discharge?

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

Gestational hypertension appears to be increasing among Maine-born people

• 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, MDHHS and University of Southern Maine, January 23, 2022
Severe Hypertension in Pregnancy

Patient Level Data Elements

- 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.acog.org/article/S0002-9378(21)01108-X/fulltext#secsectitle0020

Severe Maternal Mortality in Vermont 2013-2015

PPH & HTN are the Largest Contributors

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate per 10,000 Total Delivery Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any SMM</td>
<td>197.7</td>
</tr>
<tr>
<td>Any SMM (excluding transfusion)</td>
<td>87.8</td>
</tr>
<tr>
<td>Severe Hypertension</td>
<td>228.9</td>
</tr>
<tr>
<td>SMM among severe hypertension cases</td>
<td>1,451.6</td>
</tr>
<tr>
<td>SMM (excluding transfusion) among severe hypertension cases</td>
<td>36 367.7</td>
</tr>
<tr>
<td>Severe Hemorrhage</td>
<td>702.5</td>
</tr>
<tr>
<td>SMM among hemorrhage cases</td>
<td>2,080.9</td>
</tr>
<tr>
<td>SMM (excluding transfusion) among hemorrhage cases</td>
<td>58 515.7</td>
</tr>
</tbody>
</table>

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: CINDIC 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 JCAHO requirements for HTN and PPH
Next Steps?
Learn from each other as these Bundles are rolled out!

Collaborative Learning
Rapid Response Data
Quality Improvement Science Support

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

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, LCAC, MLAAC
Manager, Behavioral Health Services
Wentworth-Douglass Hospital, Dover, NH

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

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Enter Activity Code: fgpt

Need help? clpd.support@hitchcock.org
Signing in on-line? http://www.dh.org/clpd-account

Our presenters have no conflicts of interest to disclose.