Maternal Learning Collaborative (MLC): Improving Treatment & Reducing Disparities in Maternal Severe Hypertension (SHTN)

Presented by the NJ Department of Health (DOH) in partnership with Public Consulting Group (PCG)

Information Session #1 June 28, 2022 12:00-1:00pm





DOH Leadership



Judith M. Persichilli, R.N., B.S.N., M.A.

Commissioner
Office of the Commissioner

Andrea Martinez-Mejia, MPA, MA

Chief of Staff
Health Systems, Office of the Commissioner

Erica Holmes, JD

Executive Director
Office of Health Care Financing

Robin Ford, MS

Deputy Commissioner Health Systems, Office of the Commissioner

Christina Cartisano

Analyst
Office of Health Care Financing



Welcome & Introductions

Program Sponsor

NJ DOH

Collaborative Director

Elise Memmo

Improvement Advisor

Christina Southey

Collaborative Coordinator

Dak Ojuka

Collaborative Assistant

Grace Mecha

Additional Faculty and Speakers TBA



Your hospital is invited to participate in the QIP-NJ MLC!

Today's Objectives

- Provide an overview of the Learning Collaborative framework.
- Review the MLC aim and design.
- Understand the benefits of and factors driving – successful MLC participation.
- Provide information on how to join.

OIP-NJ¹ MATERNAL COLLABORATIVE

NJ Health



All NJ hospitals serving the maternal health population are invited!

Starting October 2022

GOAL: Improve time to treatment of severe hypertension episodes among pregnant and postpartum women and birthing people with a focus on identifying, addressing, and eliminating racial inequities for Black women and birthing people.









relationships with community partners



Engaging patients and chosen family



maternal health equity lens to addressing disparities in care

BENEFITS



Increasing impact in some OIP-NJ performance goals



Training and coaching for frontline care team and leadership by experts



Access to a peer learning network



improvement capacity



across team members education credits





interprofessional



Attend learning session



coaching sessions



Collect and report

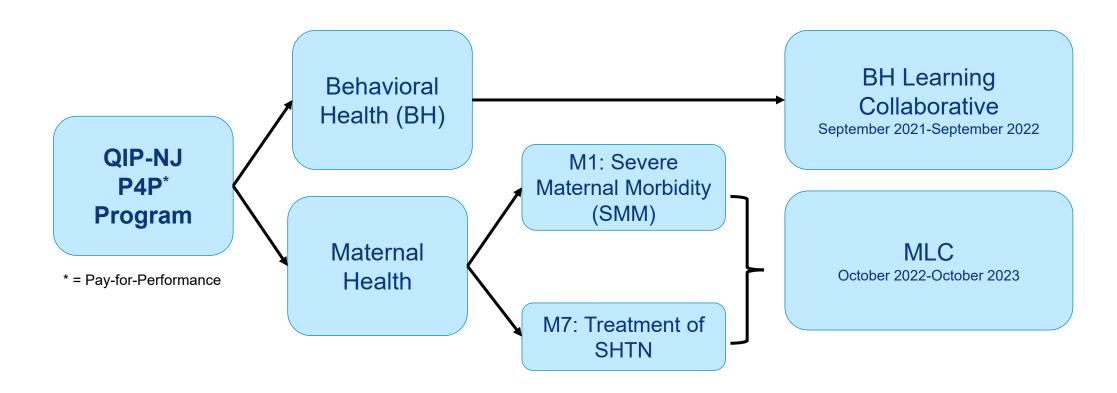


YOUR TEAM: Your team should consist of an interprofessional mix of clinical and non-clinical maternal health care team members, quality staff, a patient or chosen family representative, and other individuals supporting connections to maternal health care, specifically from L&D3 and the ED4. Your team should also include a representative from your system DEI5 team to build off current initiatives.

Form by August 12th to join. This form can be found on the Learning Collaborative Website

For more information, email qip-nj@pcgus.com.

MLC Background / Overview





Topic Selection: SHTN

Hypertensive disorders of pregnancy are a leading cause of maternal morbidity and mortality in the U.S. and globally.^{2, 8}

Delayed or inadequate treatment of SHTN may lead to maternal death, stroke, or other serious complications.^{5, 6}

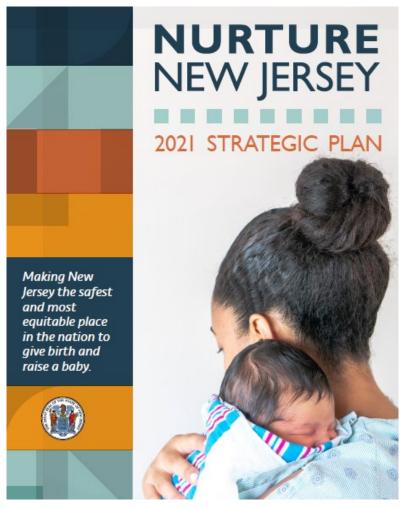
ACOG* recommends that antihypertensive treatment for persistent SHTN should be initiated between 30-60 minutes.^{1, 3}

^{*} ACOG = The American College of Obstetricians and Gynecologists



First Lady's Office **Nurture NJ Initiative Maternal** Strong **Care Quality** SHTN **Evidence for** Collaborative **Improvement** (MCQC) **Priority Modified** Medical Research Council (MMRCs)

Why are we focusing on health equity and reducing disparities for Black birthing people in the QIP-NJ MLC?

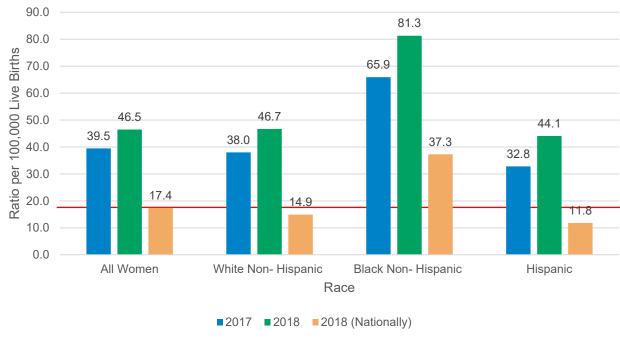


- First Lady of New Jersey, Tammy Murphy, officially launched the "Nurture NJ" statewide initiative in 2019.
- Eleven-year commitment to address inequity in maternal health and infant outcomes for Black birthing people.
- QIP-NJ P4P goal to reduce overall maternal and infant mortality and morbidity in the State.



What is the health status of Black birthing people in the State of NJ?

NJ & National Pregnancy- Associated Deaths By Race/Ethnicity



Tigure 1: Data from NJ DOH and CDC

Black birthing people in NJ experience:

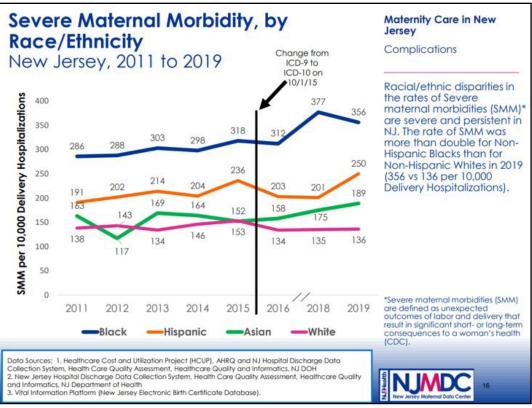


Figure 2: New Jersey Maternal Data Center

- Nearly 2xs the rate of death from pregnancy-associated causes compared to all women (2018). 7
- More than 2xs the rate of SMM when compared to White women (2019).
- 3.5xs higher rate of infant death compared to their White counterparts (2017). 7



What about racial disparities specific to hypertension in the NJ maternal population?

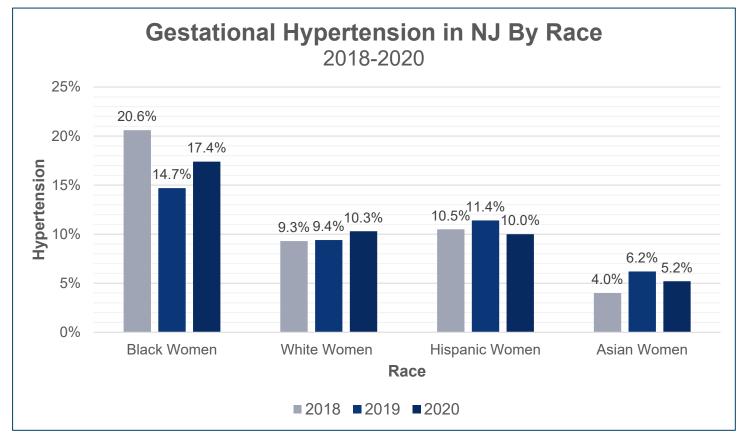


Figure 3: NJ State Health Assessment Data (NJ SHAD)

Over this three-year sample, the relative percentages of gestational hypertension among mothers in New Jersey remained significantly above the average amongst all races (10.1%)

In New Jersey, Black women made up 14% of births in 2018, 13.9% in 2019, and 13.6% in 2020.⁷



MLC Aim

By December 31st, 2023, improve by 15% the rate of SHTN episodes treated with a first line agent within 30-60 minutes among birthing people ≥20 weeks GA-7 days postpartum receiving care at New Jersey acute care hospital inpatient maternity and emergency department (ED units).

A focus of this initiative will be to identify, address, and reduce racial inequities and disparities for Black birthing people.



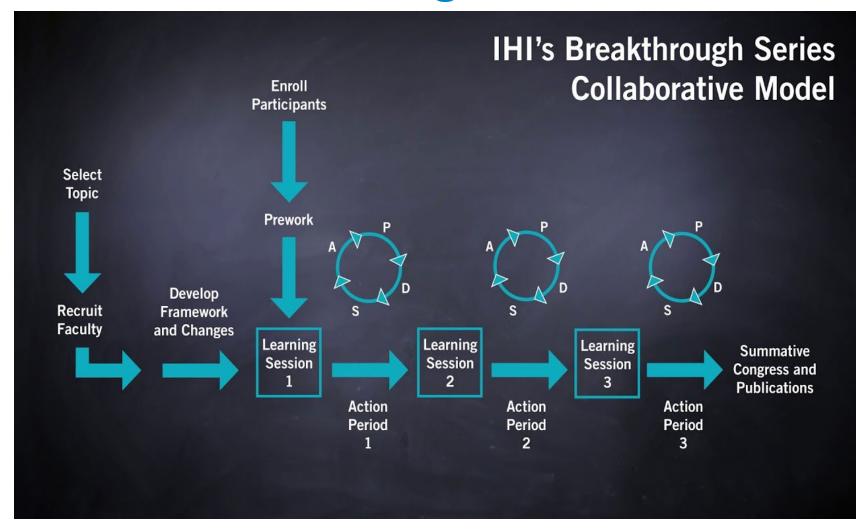
Chat Waterfall:

What work has your system done to date to address treatment for SHTN?





Collaborative Design



Poll: Was your institution involved in the BHLC over the last year?

- 1. Yes
- 2. No
- 3. Unsure



Key Driver Diagram

Aim

By December 31st, 2023, improve by 15% the rate of SHTN episodes treated with a first line agent within 30-60 minutes among birthing people ≥20 weeks GA-7 days postpartum receiving care at New Jersey acute care hospital inpatient maternity and emergency department (ED units). A focus of this initiative will be to identify, address, and reduce racial inequities and disparities for Black birthing people

Primary Drivers

1. Readiness -

Every Care

Setting

<u>ers</u>

Secondary Drivers

- 1.1 Processes for management of pregnant and postpartum patients with severe hypertension.
- 1.2 Ensure rapid access to all medications used for severe hypertension with a brief guide for administration and dosage in all areas where patients may be treated.
- 1.3 Conduct interprofessional and interdepartmental team-based drills with timely debriefs that include the use of simulated patients.
- 1.4 Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families.
- 1.5 Develop trauma-informed protocols and provider education to address health care team member biases to enhance
 equitable care.
- 2. Recognition & Prevention – Every Patient
- 2.1 Assess and document if a patient presenting is pregnant or has been pregnant within the past year in all care settings.
- 2.2 Ensure accurate measurement and assessment of blood pressure for every pregnant and postpartum patient.
- 2.3 Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans and
 provide linkage to resources that align with the pregnant or postpartum person's health literacy, cultural needs, and
 language proficiency.
- 2.4 Provide ongoing education to all patients on the signs and symptoms of hypertension and preeclampsia and empower them to seek care.
- 3. Response Every Event
- 3.1 Utilize standardized protocol with checklists and escalation policies including a standard response to maternal early warning signs, listening and investigating patient-reported and observed symptoms, and assessment of standard labs for the management of patients with severe hypertension or related symptoms.
- 3.2 Standardize post-discharge systems of care.
- 3.3 Provide trauma-informed support for patients, identified support network, and staff for serious complications of severe hypertension, including discussions regarding birth events, follow-up care, resources, and appointments.
- 4. Reporting & Systems Learning – Every Unit
- 4.1 Establish a culture of multidisciplinary planning, huddles, and post-event debriefs for every case of severe
 hypertension, which identifies successes, opportunities for improvement, and action planning for future events.
- 4.2 Perform multidisciplinary reviews of all severe hypertension/eclampsia cases per established facility criteria to identify systems issues.
- 4.3 Monitor outcomes and process data related to severe hypertension, with disaggregation by race and ethnicity due to known disparities in rates of severe hypertension.
- 5. Respectful, Equitable & Supportive Care – Every Unit/Provider/Te am Member
- 5.1 Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans.
- 5.2 Include pregnant and postpartum persons as part of the multidisciplinary care team to establish trust and ensure informed, shared decision-making that incorporates the pregnant and postpartum person's values and goals.
- 5.3 Recognize and address language and behaviors that negatively impact treatment for Black pregnant and birthing people.



Benefits of Participation

1. Support to meet performance targets on some QIP-NJ P4P measures.

2. Access to State and national clinical experts in the field.

3. Ability to merge current efforts in quality improvement and equity in your hospital/broader health system.

4. Training for frontline care team and leadership.

5. Personalized coaching from improvement advisors.

6. Increased quality improvement capacity across team members.

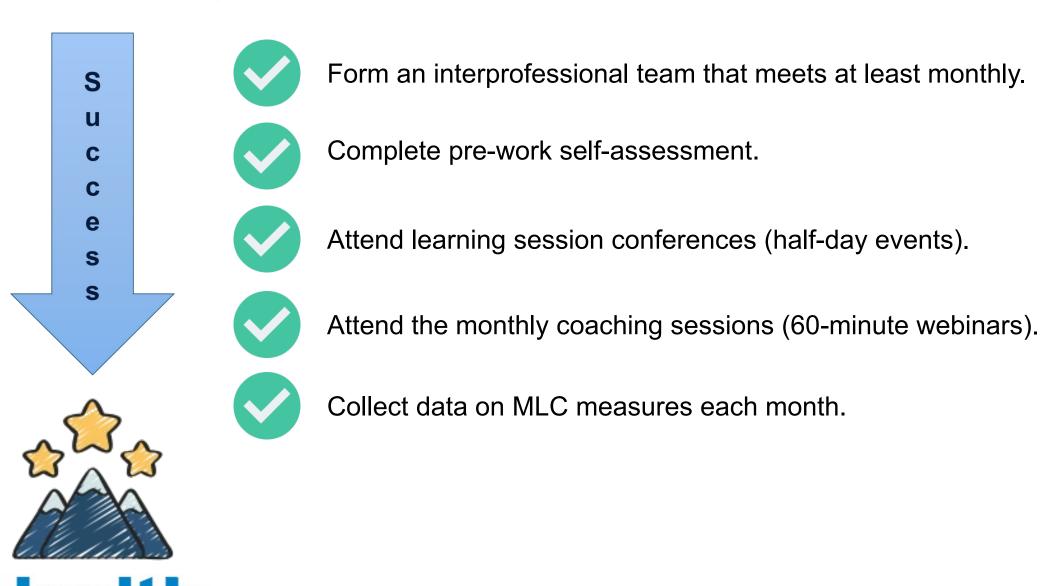
7. Access to a peer learning network.

8. Continuing professional education credits.*

*Credits for physicians, nurses, social workers, pharmacists and psychology credits for psychologists or certified counselors.



Factors Driving Successful MLC Participation



How to Join

- 1 Review the MLC materials posted on the QIP-NJ Website.
- 2 Identify a team leader and/or clinical champion to lead your hospital in the MLC.
- 3 Complete a <u>Participation Interest Form</u> due by August 12, 2022.
- 4 Have hospital leadership sign a letter of support for team's participation in the MLC.



Questions?

- ✓ Schedule a one-on-one with us to go over any questions.
- ✓ Send questions, comments or requests for additional support in this process to qip-nj@pcgus.com.



Key Dates

| Event | Date |
|------------------------------|--|
| Info Session #2 | August 9, 2022, 11:00AM to 12:00PM EST |
| Participation Interest Forms | Due August 12 th , 2022, 5:00PM EST |
| Prework Webinar | September 13 th , 2022, 12:00PM to 1:00PM EST |
| Learning Session 1 | October 4 th & 5 th , 2022, 1:00PM to 4:00PM EST |



Questions & Comments

What additional information do you need to make a decision about joining the MLC?



Poll: Based on the information presented today, how likely are you to join the MLC?

- 1. Very likely
- 2. Somewhat likely
- 3. Unlikely
- 4. Unsure
- 5. Need more information



References

- 1. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Obstetrics. ACOG Practice Bulletin No. 203: chronic hypertension in pregnancy. Obstet Gynecol 2019;133:e26–50.
- 2. GBD 2015 Maternal mortality collaborators. Global, regional, and national levels of maternal mortality, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015. Lancet 2016;388:1775–812.
- 3. Gestational hypertension and preeclampsia: ACOG Practice Bulletin, Number 222. Obstet Gynecol 2020;135:e237–60.
- 4. Judy AE, McCain CL, Lawton ES, Morton CH, Main EK, Druzin ML. Systolic hypertension, preeclampsia-related mortality, and stroke in California. Obstet Gynecol 2019;133:1151–9.
- 5. Martin JN, Thigpen BD, Moore RC, Rose CH, Cushman J, May W. Stroke and severe preeclampsia and eclampsia: a paradigm shift focusing on systolic blood pressure. Obstet Gynecol 2005;105:246–54.
- 6. Petersen EE, Davis NL, Goodman D, et al. Vital signs: pregnancy-related deaths, United States, 2011-2015, and strategies for prevention, 13 states, 2013-2017. MMWR Morb Mortal Wkly Rep 2019;68:423–9.

