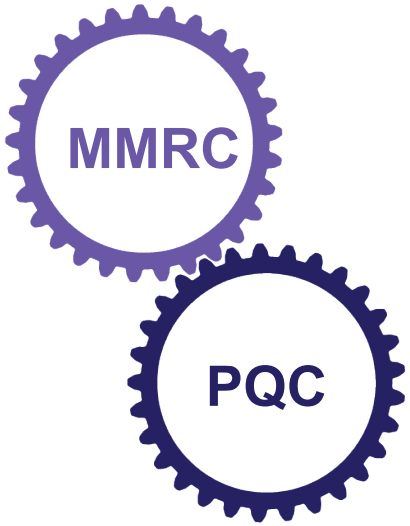


PA PQC

Pennsylvania Perinatal Quality Collaborative

PA PQC January Virtual Session

February 22, 2024

Agenda

1. **Welcome** – Sara Nelis, RN, Project Manager, Jewish Healthcare Foundation

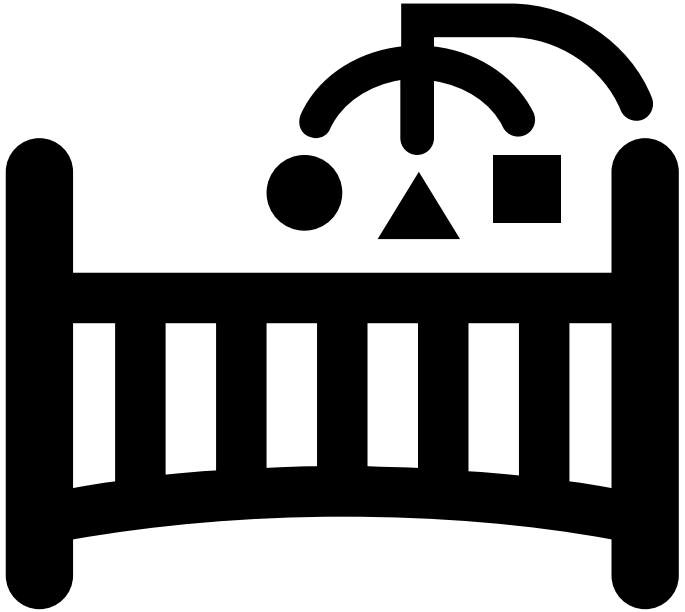
2. **Deep Dive into Safe Sleep** – Karena Moran, PhD, Improvement Optimization Advisor, Geisinger Health System, and Kristen Brenneman, MSN, RN, Quality Improvement Facilitator, Jewish Healthcare Foundation

    a) Driver Diagram
    b) Metrics & Measures
    c) Q&A

3. **Deep Dive into Maternal Sepsis** – Jennifer Condel, SCT(ASCP)MT, Manager of Lean Healthcare Strategy and Implementation, and Maureen Saxon-Gioia, MS HSA, RN, Nurse Project Manager, Jewish Healthcare Foundation

    a) Change Package
    b) Metrics & Measures
    c) Q&A

4. **Wrap-up and Next Steps** – Sara Nelis, RN



Safe Sleep

KRISTEN BRENNEMAN, MSN, RN

KARENA MORAN, PHD

Q&A

Facilitated by PA PQC Quality Improvement Coaches

Maternal Sepsis

Sepsis in Obstetrical Care

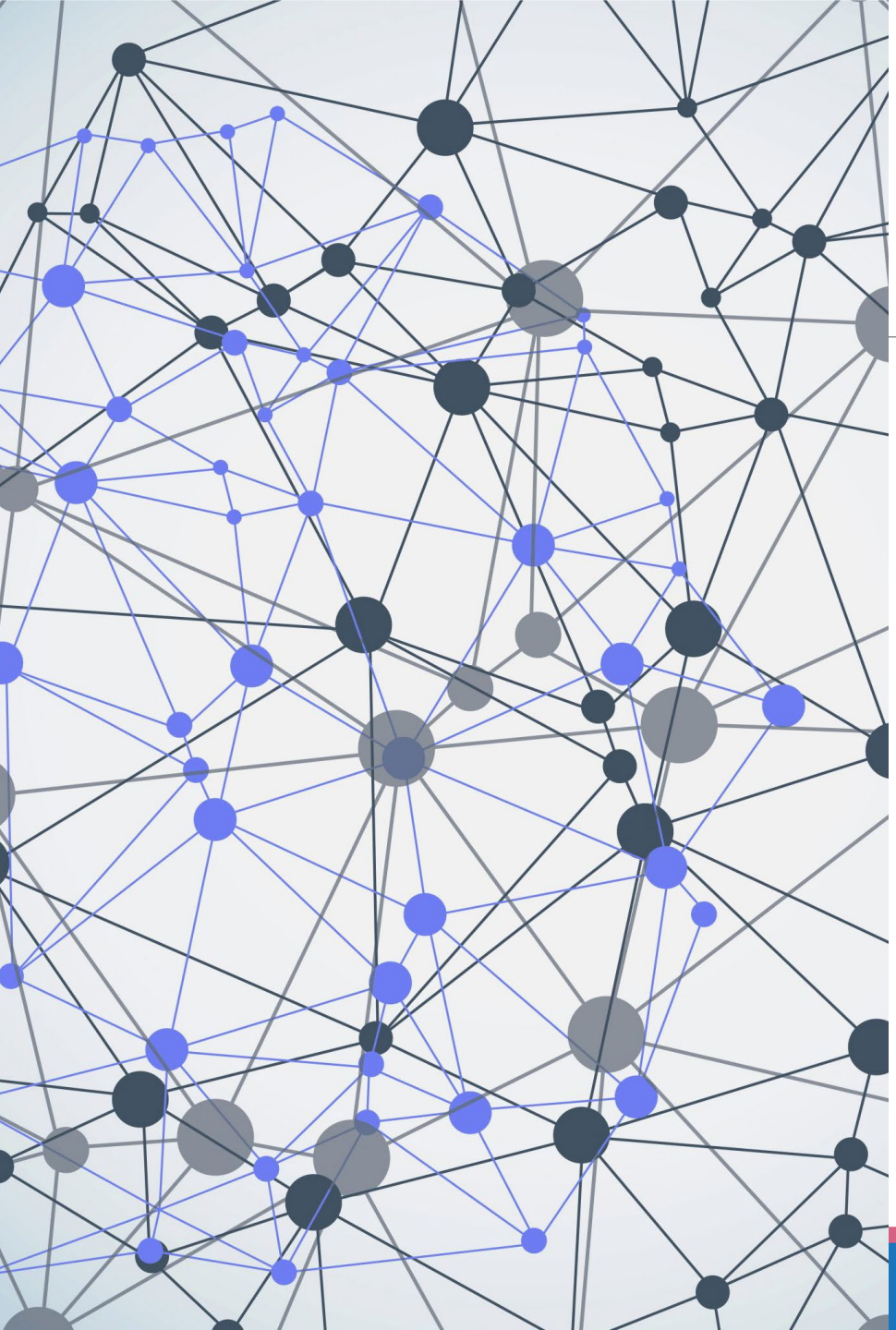
JENNIFER CONDEL, SCT(ASCP)MT

MAUREEN SAXON-GIOIA, MS HSA, RN

Sepsis in Obstetrical Care

https://saferbirth.org/psbs/sepsis-in-obstetric-care/

- 1 year implementation period followed by 1 year sustainment period
- One $5,000 award each quarter
- Virtual Learning Sessions
  - Quality Improvement
  - Content related to Key Interventions
  - Peer-to-Peer learning
- Alliance for Innovation on Maternal Health (AIM) Resources
  - Webinars
  - Implementation Resources
  - Communities of Learning
- Participating Sites will need to complete a MOU/DUA



Why is this important?

- Obstetric sepsis is a leading cause of maternal mortality globally

- Timely recognition, appropriate treatment, and escalation of care can largely prevent maternal deaths due to sepsis

- Sepsis disproportionately affects underrepresented minority groups, reflecting the impact of racism on maternal morbidity and mortality

AIM PATIENT SAFETY BUNDLES

AIM develops multidisciplinary, clinical-condition specific patient safety bundles to support best practices that make birth safer. LEARN MORE

SEPSIS IN OBSTETRIC CARE

For the purpose of this Bundle, sepsis in obstetric care refers to the World Health Organization definition for maternal sepsis as a **life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion, or the postpartum period (up to 42 days)**. Such conditions include infections that are related to delivery and other types of infections that occur during pregnancy or the postpartum period.

https://saferbirth.org/psbs/sepsis-in-obstetric-care/

Sepsis in Obstetrical Care

READINESS

RECOGNITION & PREVENTION

RESPONSE

REPORTING & SYSTEMS LEARNING

RESPECTFUL, EQUITABLE & SUPPORTIVE CARE

QUICK LINKS

- Patient Safety Bundle (PDF)
- Element Implementation Details (PDF)
- Implementation Resources (PDF)
- Data Collection Plan (PDF)
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- Maile's Story (Video)

READINESS

RECOGNITION & PREVENTION

RESPONSE

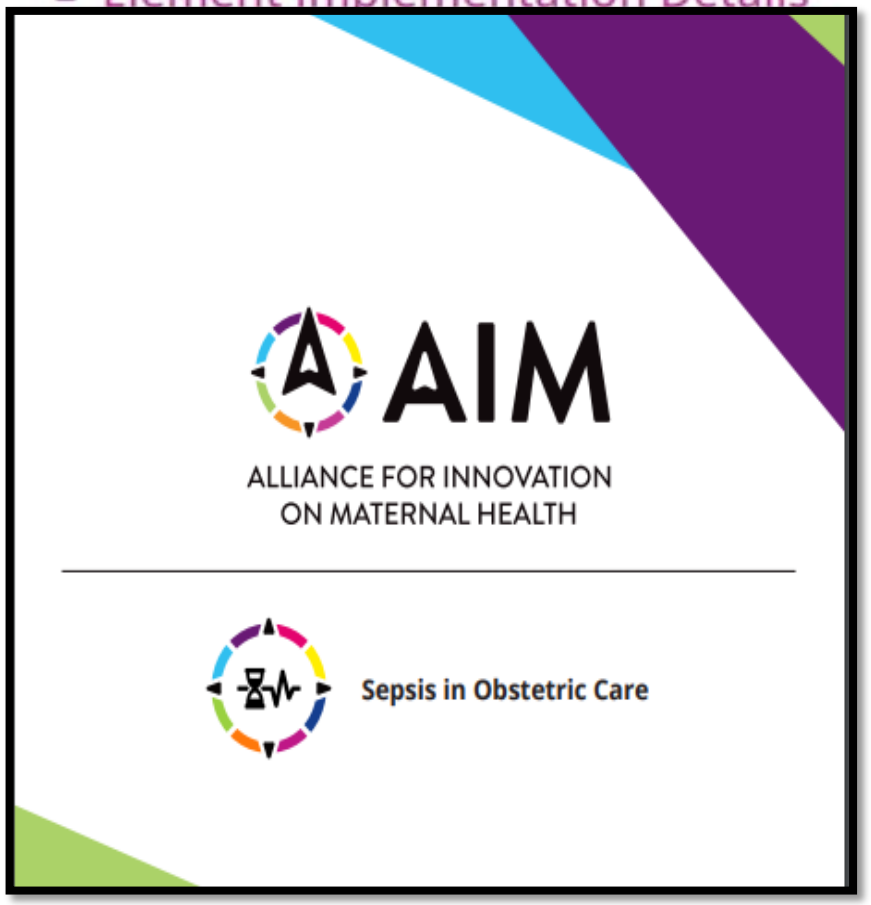
REPORTING & SYSTEMS LEARNING

RESPECTFUL, EQUITABLE & SUPPORTIVE CARE

U3-FINAL_AIM_Bundle_SOC.pdf (saferbirth.org)

QUICK LINKS

- Patient Safety Bundle (PDF)
- Element Implementation Details



5 Bundle Elements

Readiness- Every Unit

- Establish inter- and intradepartmental **protocols and policies** for care
- Provide **multidisciplinary education** on obstetric sepsis **to all clinicians and staff** that provide care to pregnant and postpartum people
- Utilize **evidence-based criteria** for sepsis assessment
- Create a culture that utilizes **non-hierarchical communication**

Recognition & Prevention- Every Patient

- Implement **evidence-based measures to prevent infection**
- **Recognize and treat infection early** to prevent progression to sepsis
- Consider sepsis on the **differential diagnosis** of a person with deteriorating status, even in the absence of fever
- **In all care environments, assess and document** if a patient presenting is pregnant or has been pregnant within the past year
- Provide **patient education** focused on general life-threatening pregnancy and postpartum complications and early warning signs

Response- Every Event

- Initiate **facility-wide standard protocols and policies** for assessment, treatment, and escalation of care for people with suspected or confirmed obstetric sepsis
- Initiate facility-wide standard protocols and policies for **post-stabilization management**
- Engage in **team communication among units** involved in the care coordination
- Facilitate **comprehensive post-sepsis care**

Reporting & Systems Learning- Every Unit

- Conduct **multidisciplinary reviews for systems improvement** of each sepsis case
- Establish a culture of **multidisciplinary planning, huddles, and post-event debriefs**
- Implement a **system to ensure communication occurs** with the pregnant or postpartum person and their identified support network on an ongoing basis during treatment and through follow-up care

Respectful, Equitable & Supportive Care- Every Unit/Provider/Team Member

- **Include each pregnant or postpartum person** and their identified support network as respected members of and contributors to the multidisciplinary care team
- Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network about **sepsis diagnosis and recommended treatment plans that are aligned with their health literacy, culture, language, and accessibility needs**
- Because maternal mortality and severe maternal morbidity related to **sepsis disproportionately affect Black, Indigenous, and Hispanic people** because of systemic racism, but not race itself, it is necessary to **mitigate this bias** by having a high index of suspicion for sepsis

Sepsis in Obstetric Care

Element Implementation Details

QUICK LINKS

- Patient Safety Bundle (PDF)
- Element Implementation Details (PDF)
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U1_FINAL_AIM_Bundle_SOC-EID-1.pdf (saferbirth.org)

Readiness — Every Unit

Readiness Element	Key Points
Inter- and intradepartmental protocols and policies can include:	**Identifying a readily available multidisciplinary team to assist with the care for people experiencing obstetric sepsis or suspected sepsis.** This team may differ in composition from facility to facility due to available resources but will be the same team for a variety of OB emergencies across bundles. This team might include expertise in: This team might include expertise in: • Obstetrics • Maternal Fetal Medicine • Anesthesiology • Emergency Medicine • Critical Care Medicine • Infectious Disease • Nursing Leadership • Internal and/or Family Medicine • Respiratory therapy
	Implementing rapid response protocol for the unstable patient. Sepsis protocol should include institution-specific processes to do the following: • Antimicrobial initiation within 1 hour • Fluid resuscitation • Vasopressor initiation, as needed • Evaluation of source (cultures), severity of end organ injury • Need for higher level of care (such as ICU) Prioritization of laboratory results Create institution-specific solutions to coordinate and escalate care as necessary

Sepsis in Obetric Care Bundle

Implementation Resources

QUICK LINKS

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U1_AIM_Bundle_SOC-Resources.pdf (saferbirth.org)

Section	Resource	Description	Link

Section	Resource	Description	Link

Section	Resource	Description
Response	Teamwork and Communication for Perinatal Safety *AHRQ,2017*	Teamwork and Communication fo Safety: Built on the foundation of training, the AHRQ Safety Program Care or SPPC is built around three 1. Foster a culture of teamwork communication 2. Implement perinatal safety b 3. Establish a program of in situ
Reporting & Systems Learning		
Reporting & Systems Learning	Incidence of Maternal Sepsis and Sepsis-Related Maternal Deaths in the United States *JAMA,2019*	Maternal sepsis is a leading cause morbidity and mortality. Howeve based estimates of maternal seps after delivery hospitalization have because previous studies have fo select populations or have not fol patients longitudinally. Thus, the maternal sepsis and sepsis-relate may be underestimated. We asse nationwide incidence and outcom sepsis within 42 days of delivery h discharge using all-payer data.

Recognition

Readiness	Sepsis and septic shock in pregnancy *Contemporary OB/GYN, 2018*	infection accounts for 12.7% of maternal mortality in the United States and among this group, 6% are characterized as having sepsis. Recent US data indicate that infection is currently the third most common cause of maternal death, and in contrast	

Sepsis in Obstetric Care Patient Safety Bundle

Core Data Collection Plan
Version 1 January 2023

QUICK LINKS

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Metrics:
State Surveillance: 1
Outcome: 1
Process: 3
Structure: 9

Measurement Statement: Quality improvement projects and associated measurement strategies for obstetric sepsis can cover a wide range of topics, such as prevention of infections, timely recognition and response to infections ranging in specificity of type and timing of infection, and timely recognition and response to suspected and confirmed obstetric sepsis. For the purposes of AIM's Sepsis in Obstetrical Care patient safety bundle, its associated project measurement strategy focuses on the establishment of structures to improve inpatient readiness to respond to obstetric sepsis and its sequalae.

State Surveillance

Metric	Name	Description	Notes
SS1	Cases Coded as Sepsis During the Birth Admission	**Report N/D** Disaggregate by race and ethnicity, payor **Denominator:** All qualifying birth admissions, using the SMM denominator **Numerator:** Among the denominator, those who were diagnosed with sepsis (see ICD-10 codes)	• While monitoring sepsis among all obstetric admissions, including those that occur prenatally and postpartum, is preferable, it is not currently widely feasible identify all obstetric admissions using administrative datasets • This may be analyzed at the hospital level. However, due to

Quality Improvement Projects for Obstetric Sepsis Encompass Diverse Topics

- Prevention of infections
- Timely recognition and response to infections of varying specificity and timing
- Timely recognition and response to suspected and confirmed obstetric sepsis

AIM's Sepsis In Obstetrical Care Patient Safety Bundle Project

Focuses on the establishment of structures

Aimed at enhancing inpatient readiness to respond effectively to obstetric sepsis and its sequelae

State Surveillance

State Surveillance	Considerations	Recommendations
Cases Coded as Sepsis During the Birth Admission	Preferable to Monitor All Obstetric Admissions (Prenatal/Postpartum • Challenges in Identifying All Obstetric Admissions via Administrative Datasets • Analysis Feasibility: Hospital Level vs. Statewide Monitoring	**AIM Suggests Minimum Statewide Monitoring due to Small Case Counts**

Report N/D *Disaggregate by race and ethnicity, payor*

Denominator: All qualifying birth admissions, using the SMM denominator

Numerator: Among the denominator, those who were diagnosed with sepsis (see ICD-10 codes)

Outcome

Outcome Measure: Severe Maternal Morbidity (Excluding Transfusion Alone)

Report N/D *Disaggregate by race and ethnicity, payor*

Denominator: All qualifying pregnant and postpartum individuals during their birth admission

Numerator: Those among the denominator who experienced severe maternal morbidity, excluding those with transfusion alone

AIM's objective: Reduce preventable severe maternal morbidity (SMM)

**Monitoring SMM among sepsis cases is not feasible as sepsis is an SMM indicator, resulting in a 100% rate for those with sepsis*

Process

P1: Multidisciplinary Case Reviews for Obstetric Sepsis

Denominator: All diagnosed instances of obstetric sepsis during the reporting period, including those that occurred prenatally, during the birth admission, and postpartum

Numerator: Among the denominator, cases that had a structured multidisciplinary case review documented

Note: These reviews may be part of existing sepsis reviews in the general population

Process

Report estimate in 10% increments (round up)

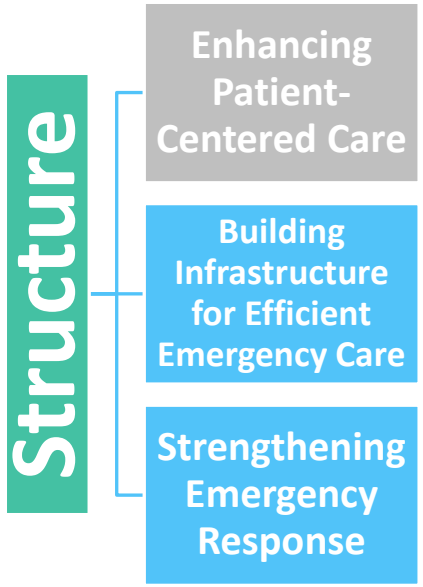
P2: OB Provider and Nursing Education – Obstetric Sepsis

- At the end of this reporting period, what cumulative proportion of clinical OB providers and nursing staff has received within the last 2 years **education on the recognition of and/or unit-standard response to suspected and confirmed obstetric sepsis?**

P3: OB Provider and Nursing Education – Respectful and Equitable Care

- At the end of this reporting period, what cumulative proportion of clinical OB providers and nursing staff has completed within the last 2 years **an education program on respectful and equitable care?**

Structure



S1 Patient Event Debriefs

- **Description:** Rate progress (1-5) towards **establishing standardized debriefs with patients after severe events**
- **Notes:** Severe events may include TJC sentinel event definition, severe maternal morbidity, or fetal death

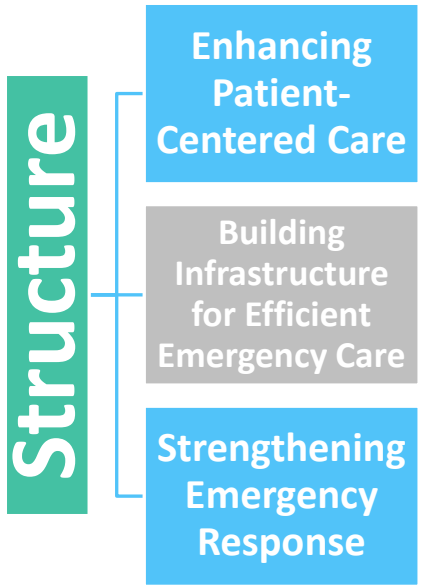
S2 Clinical Team Debriefs

- **Description:** Rate progress (1-5) **towards conducting regular formal debriefs with the clinical team** after cases with major complications
- **Notes:** Major complications defined by each facility based on volume, with a minimum being The Joint Commission Severe Maternal Morbidity Criteria

S3 Multidisciplinary Case Reviews for Obstetric Sepsis

- **Description:** Rate progress (1-5) towards **establishing multidisciplinary systems level reviews on cases of sepsis** occurring **during pregnancy, birth, and postpartum**

Structure



S4 Obstetric Sepsis Screening & Diagnosis System

- **Metric Name:** Obstetric Sepsis Screening & Diagnosis System
- **Description:** Rate progress (1-5) towards **implementing a system for screening and diagnosis of pregnant and postpartum individuals for sepsis**

S5 Protocols for Management of Suspected and Confirmed Obstetric Sepsis

- **Metric Name:** Protocols for Management of Suspected and Confirmed Obstetric Sepsis
- **Description:** Rate progress (1-5) towards **establishing standard protocols and escalation policies for managing suspected and confirmed obstetric sepsis**

S6 Patient Education Materials on Urgent Postpartum Warning Signs

- **Metric Name:** Patient Education Materials on Urgent Postpartum Warning Signs
- **Description:** Rate progress (1-5) towards **developing patient education materials on urgent postpartum warning signs aligned with culturally and linguistically appropriate standards**

Structure

Structure
- Enhancing Patient-Centered Care
- Building Infrastructure for Efficient Emergency Care
- Strengthening Emergency Response

S7 Emergency Department (ED) Screening for Current or Recent Pregnancy

- **Metric Name:** ED Screening for Current or Recent Pregnancy
- **Description:** Rate progress (1-5) towards **establishing standardized verbal screening for current pregnancy and pregnancy in the past year as part of the ED's triage process**

S8 Identification of Post-Obstetric Sepsis Resources and Referral Pathways

- **Metric Name:** Identification of Post-Obstetric Sepsis Resources and Referral Pathways
- **Description:** Rate progress (1-5) towards **creating a comprehensive list of resources and referral pathways** tailored to individuals who have experienced obstetric sepsis
- **Notes:** Resources and referral pathways should include occupational therapy, physical therapy, pain clinics, psychiatry, at minimum

S9 Emergency Department (ED) Education Program on Recognition of Obstetric Emergencies

- **Metric Name:** ED Education Program on Recognition of Obstetric Emergencies
- **Description:** Rate progress (1-5) towards **developing a process and/or program for educating ED staff on signs and symptoms** of potential obstetric emergencies

Institute for Healthcare Improvement

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Sepsis in Obstetric Care Change Package

QUICK LINKS

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Sepsis in Obstetric Care Change Package (saferbirth.org)

Contents

Understanding Change Packages

What is a change package?

- A document listing evidence-based or best-practice changes specific to a topic, often organized around a framework or model
- **The Sepsis in Obstetric Care Change Package is structured around the Sepsis in Obstetric Care Patient Safety Bundle**

Components of Change Packages:

- **Primary Drivers:** Major processes, rules, or structures contributing to the aim
- Based on frameworks like AIM's Five Rs Framework
- **Change Concepts:** Broad concepts used to generate specific change ideas
- Not yet actionable on their own
- **Change Ideas:** Actionable, specific ideas for changing a process.
- Derived from research, best practices, or successful examples from other organizations

Implementation Approach:

- Begin with **small tests** connected to your aim, using iterative **Plan-Do-Study-Act** (PDSA) cycles.
- Start with small-scale tests to gauge improvement and gradually expand

Institute for Healthcare Improvement | AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Readiness

Change Concept	Change Idea	Key Resources and Tools
Establish inter- and intradepartmental protocols and policies for the care of patients experiencing obstetric sepsis or suspected sepsis	Establish a reliable and efficient system to order, obtain, and promptly administer appropriate antimicrobials *Have antibiotics in an automated medication dispensing system with a reliable system to monitor expiration date ** *Implement "code sepsis" to alert pharmacy to immediately dose, prepare, and deliver antibiotics to the bedside ** Create an obstetric-focused, mu with the ability to consult at the rapid deterioration	Risk Factors, Etiologies, and Screening Tools for Sepsis in Pregnant Women: A Multicenter Case-Control Study[8] California Maternal Quality Care Collaborative (CMQCC): Improving

How to prioritize changes?

No team is expected to test all the listed change ideas. Consider this a menu of options from which you may choose what to tackle first. Each team will review their baseline data, progress to date, organizational priorities, and select an area(s) to prioritize. For example, some may start with one driver. Others may start by tackling one idea across all drivers. Start by choosing an area that you think could lead to an easy win.

You can also leverage the following tools to help you decide where to start:

1. Pareto chart: A type of bar chart in which the various factors that contribute to an overall effect are arranged in order according to the magnitude of their effect. This ordering helps identify the "vital few" — the factors that warrant the most attention.[5]
2. Priority matrix: A tool that can better help you to understand important relationships between two groupings (e.g., steps in a process and departments that conduct that step) and make decisions on where to focus.[6]
3. Impact-effort matrix: A tool that helps identify which ideas seem easiest to achieve (least effort) with the most effects (highest impact). The ideas identified via this tool would be

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OBSTETRICS & GYNECOLOGY

Sepsis in Obstetric Care

Readiness

Element	Context & Rationale	Evidence
Establish inter- and intradepartmental protocols and policies for the care of patients experiencing obstetric sepsis or suspected sepsis.	Development of protocols and policies containing bundled sepsis interventions for non-obstetric patients has been shown to significantly improve time to treatment [1], decrease mortality [2,3], and improve overall compliance with protocols [3] in observational studies. As early recognition and rapid therapy for sepsis is associated with increased odds of survival, there is a need for the appropriate development of protocols and policies for sepsis in obstetric care [4].	1. Moore WR, Vermuelen A, Taylor R, Kihara D, Wahome E. Improving 3-Hour Sepsis Bundled Care Outcomes: Implementation of a Nurse-Driven Sepsis Protocol in the Emergency Department. J Emerg Nurs. 2019;45(6):690-698. doi: 10.1016/j.jen.2019.05.005 2. Majid A, Arain E, Ye C, Gilbert E, Xie M, Lee J, et al. Patient outcomes and cost-effectiveness of a sepsis care quality

Recognition & Prevention

Element	Context & Rationale	Evidence
Implement evidence-based measures to prevent infection.	The Centers for Disease Control and Prevention (CDC) has developed core infection prevention and control practices for safe healthcare delivery in all settings, including obstetric care. According to the CDC, these standards "…represent fundamental standards of care that are not expected to change based on emerging evidence or to be regularly altered." [1] These core practices "…are considered basic and accepted as standards of medical care." A systematic review on evidence-based surgery for Cesarean births identified high-level certainty recommendations of infection prevention methods [2], and ACOG provides recommendations for the use of prophylactic antibiotics in labor and delivery [3].	1. Centers for Disease Control and Prevention. CDC's Core In Prevention and Control Practices for Safe Healthcare Delivery Settings. Accessed August 18, 2023. https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html 2. Dahlke JD, Mendez-Figueroa H, Rouse DJ, Berghella V, Ba Chauhan SP. Evidence-based surgery for cesarean delivery: a updated systematic review. Am J Obstet Gynecol 2013;209:2 doi: 10.1016/j.ajog.2013.02.043 3. Use of prophylactic antibiotics in labor and delivery. ACOG Practice Bulletin No. 199. American College of Obstetricians a Gynecologists. Obstet Gynecol 2018;132:e103-19. doi: 10.1097/AOG.0000000000002833

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- Patient Safety Bundle
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Webinar Series: Using Change Packages to Support AIM Bundle Implementation

…actionable change packages aligned with each AIM Patient Safety Bundle

January – April 2024, 2nd Wednesday of Each Month, 2-3 PM ET

Registration Link: https://ihi-org.zoom.us/meeting/register/tZMsdOmvqz0sGt1xNL3G0ahGYaE3In6XgYon#/registration

1. Getting Started: What are change packages?

January 10th, 2024, 2-3 PM ET

This webinar will provide an overview of change packages and the elements included in them. We will discuss how change packages are built, and how these change packages align with the AIM bundles.

https://vimeo.com/903849695

2. Getting Focused: How to prioritize a path through a change package

February 14th, 2024, 2-3 PM ET

This webinar will discuss how change packages are used in clinical settings to drive improvement, on the front lines, at the system level, and at the state level. Presenters will share strategies for prioritizing changes that will be most impactful in your setting and figuring out where to get started.

https://vimeo.com/913417483

3. Getting Momentum: Moving out of the change package and into testing

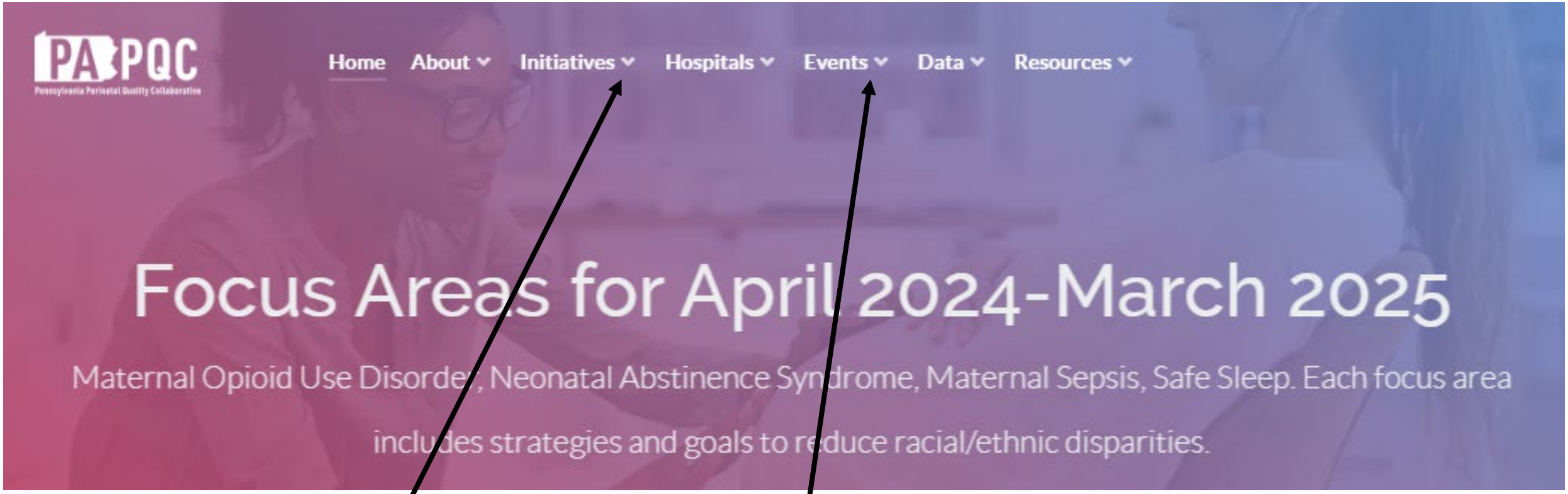
March 13th, 2024, 2-3 PM ET

This webinar will cover strategies for testing changes from the change package, including how to test changes using Plan-Do-Study-Act (PDSA cycles) and when to move from testing to implementation.

4. Getting Results: Stories from the field of change packages in action

April 10th, 2024, 2-3 PM ET

This webinar will share case examples from hospitals and states who have used at least one of the change packages to support bundle implementation. Presenters will share tips, tricks, and lessons learned.



Learn about the Initiatives

Access Session Materials

https://www.papqc.org/

Initiatives

Maternal Sepsis Project Tools

- Patient Safety Bundle
- Data Collection Plan
- Change Package

Introduction to Sepsis in Obstetric Care: AIM Patient Safety Bundle from AIM on Vimeo.

Q&A

Facilitated by PA PQC Quality Improvement Coaches

Sepsis in Obstetrical Care

Wrap-Up

SARA NELIS, RN

Upcoming Learning Sessions

MARCH 21

Peer-to-Peer Report Out

11:00 a.m. – 12:00 p.m.

Zoom

APRIL 17

Quality Improvement & Change Management

11:00 a.m. – 12:00 p.m.

Zoom

SAVE THE DATE

05.22.24

Annual In-Person Meeting

Harrisburg, PA

PA PQC

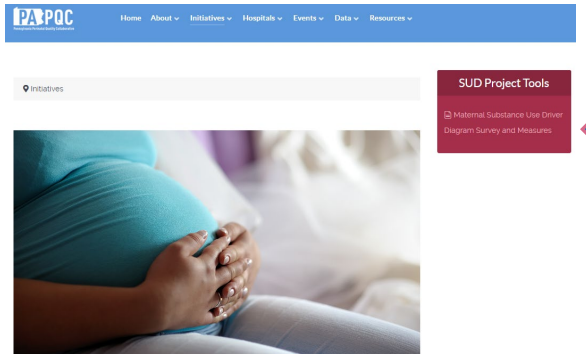
Pennsylvania Perinatal Quality Collaborative

BEST WESTERN PREMIER the Central HOTEL & CONFERENCE CENTER

Enrollment

ENROLLMENT PACKET

- Checklist
- PA PQC Overview
- Programming
- Initiatives
- LifeQI
- Blank Forms



ENROLLMENT SURVEY

- **ONE** per Hospital
- Be prepared:
  - Know which initiatives your Healthcare Team has chosen to participate in
  - Read and understand:
    - https://www.papqc.org/hospitals/participation-requirements
  - Project Tool links in red box on each initiative page for those that your Team will be participating in
  - Due ***March 31, 2024***

PA PQC QI Coaches

Kristen Brenneman, MSN, RN
Quality Improvement Facilitator, Jewish Healthcare Foundation

Jennifer Condel, SCT(ASCP)MT
Manager, Lean Healthcare Strategy and Implementation, Jewish Healthcare Foundation

Karena Moran, PhD
Improvement Optimization Advisor, Geisinger Health & NEPaPQC

Maureen Saxon-Gioia, MSHSA, BSN, RN
Nurse Project Manager, Jewish Healthcare Foundation

Thank You!

www.papqc.org

papqc@whamglobal.org