Maternal Hypertension Initiative

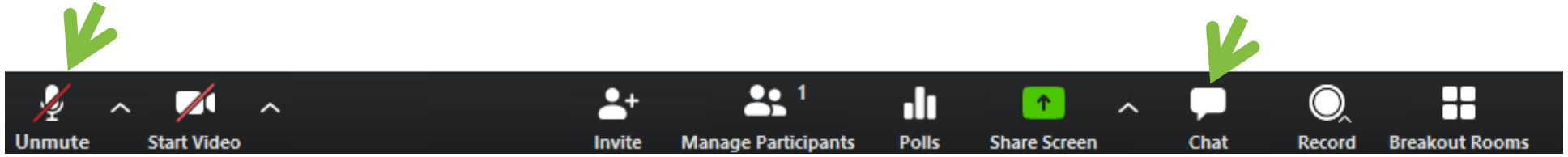
Action Period Call: Hospital Team Share & Severe Maternal Mortality Review

December 16, 2022

12:00 PM – 1:00 PM CST

Welcome

- Please type your name and organization you represent in the chat box and send to ”Everyone.”
- Please click on the three dots in the upper right corner of your Zoom image, click “Rename” and put your name and organization.
- Please also do for all those in the room with you viewing the webinar.
- Attendees are automatically muted to reduce background noise.
- You may enter questions/comments in the “chat” box during the presentation. We will have a Q&A session at the end.
- Slides will be available via email and at http://www.alpqc.org/initiatives/htn
- We will be recording this call to share, along with any slides.



Agenda

Welcome & Updates	12:00 – 12:05
Team Hospital Share	12:05 – 12:45
Questions & Next Steps	12:45 – 1:00

Hospital Team Share

Madison Hospital

Renee Colquitt, CRNP, NNP-BC
Director of Perinatal Services
Amanda Eaker, RN
Clinical Nurse Educator

Successes

- Work with system
- Order Sets and Protocols
- Training staff- Clinical Ladder Program
- Working with IT to create reports
- Discharge Teaching magnet

What to watch for when you get home

CALL 911 if you have:

- Chest pain
- Difficulty breathing or shortness of breath
- Seizures
- Thoughts of hurting yourself or your baby

CALL YOUR HEALTH CARE PROVIDER

if YOU have:

- Bleeding through one pad per hour, or blood clots the size of an egg or bigger
- Temperature of 100.4° F or higher
- Headache that does not get better, even after taking medicine, or bad headache with vision changes
- Incision is not healing
- Leg is red, swollen or painful/warm to touch

if your BABY has:

- Rectal temperature of 100.4° F or higher
- Vomiting and/or diarrhea
- Difficulty in feeding
- Difficulty in waking up for feedings, or is listless
- No wet diapers in 24 hours and/or no dirty diapers in 72 hours
- Increase in jaundice
- Signs of infection near the umbilical cord stump

Trust your instincts.

Always seek medical care if you are not feeling well or have concerns.

To read blogs or learn about classes and tours, visit HH baby.org

MADISON HOSPITAL

Women Children HUNTSVILLE HOSPITAL

Challenges & Barriers

- Staff turnover
- Outreach to other departments
- Follow up with OB Provider

Opportunities

- Upcoming training opportunities
- Data Review

Next Steps

- Task force meeting
- Cont. roll out education to ED staff
- Await TJC visit

Needs

We would be happy to share Policy, Orders, Discharge information, etc.

Renee.colquitt@hhsys.org

256-817-5187

Brookwood Baptist Health

ALABAMA PERINATAL ALPQC QUALITY COLLABORATIVE

ALPQC Maternal Hypertension Initiative

Our Leaders

- Brookwood Baptist Medical Center – Shelly Addison, Jen Piazza, Shannon Lambert
- Princeton Baptist Medical Center – Julie Lee
- Shelby Baptist Medical Center – Shawn Yarbrough
- Walker Baptist Medical Center – Rachael Winston
- BBH Perinatal Quality Improvement - Greta Simmons

Successes

- Obtaining patient list from IT monthly
- Standardized checklists and order sets
- Completion of training for RN’s
- Main ED compliance with treatment and/or consulting OB

Severe Hypertension in Pregnancy

OB Checklist

Brookwood Baptist Medical Center

Severe HTN/Preeclampsia Checklist

If pregnant or < 6 Weeks Postpartum:

- ☐ If BP ≥ 160/110 repeat measurement q 15 min
- ☐ Notify MD after two severe BP's within 1 hour
  Severe BP does not have to be consecutive.
  - ❖ ***Goal is treatment within 1 hr of 1st severe BP when there are TWO severe BP's within the same hour.***
- ☐ Transfer to a higher level of care as applicable, but DO NOT delay treatment
- ☐ Request MD place the OB Hypertension in Pregnancy order set
- ☐ Continuous fetal monitoring as applicable for gestational age
- ☐ Seizure precautions for patients considered pre-eclamptic
- ☐ Place PIV, draw labs
  - o CMP
  - o CBC w/ diff
  - o LDH
  - o Uric Acid

  Consider: PT, PTT, Fibrinogen
- ☐ Ensure meds are appropriate given patient history
- ☐ Administer seizure prophylaxis as ordered
- ☐ Administer antihypertensive therapy
- ☐ Maintain strict I&O (at risk for pulmonary edema)
  - o Obtain Urinalysis
  - o Obtain Urine random protein and urine random creatinine
- ☐ Brain imaging if unremitting headache or neurological symptoms
- ☐ Once controlled (SBP<160 and DBP<110)
  Obtain BP q 10 min x 1 hr > q 15 min x 1 hr > q 30 min x 1 hr > hourly x 4 hrs

† "Active asthma" is defined as:
Ⓐ symptoms at least once a week, or
Ⓑ use of an inhaler, corticosteroids for asthma during the pregnancy, or
Ⓒ any history of intubation or hospitalization for asthma.

Magnesium Sulfate (As Ordered)

Contraindications: Myasthenia gravis; avoid with pulmonary edema, use caution with renal failure

IV access:

- ☐ Load 4-6 grams 10% magnesium sulfate in 100 mL solution over 20 min
- ☐ Magnesium sulfate maintenance 1-2 grams/hour

No IV access:

- ☐ 10 grams of 50% solution IM (5g in each buttock)

Antihypertensive Medications
(MD will choose 1 Regimen Follow Orders)

For SBP ≥ 160 or DBP ≥ 110

- ☐ **Labetalol** - *Contraindications: Avoid with active asthma †, heart disease, or congestive heart failure; use with caution with history of asthma*
  - o Labetalol 20 mg IV over 2 min > If no result in 10 min > give 40 mg IV over 4 min > If no result in 10 min > give 80 mg IV over 8 min. If no result, notify physician.
- ☐ **Hydralazine** - *May increase risk of hypotension*
  - o Hydralazine 5 mg IV over 2 min. If no result in 20 min > give 10 mg IV > If no result in 20 min > give Labetalol 20 mg IV. If no result, notify physician.
- ☐ **Oral Nifedipine** - *Administer orally, not punctured or otherwise administered sublingually*
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Anticonvulsant Medications (As Ordered)

For recurrent seizures or when magnesium sulfate contraindicated

- ☐ **Lorazepam (Ativan)**: 2 mg IV x 1, may repeat once after 10 min
- ☐ **Diazepam (Valium)**: 5 mg IV q 5 min (Max dose 30mg)

Emergency Department Checklist

Brookwood Baptist Medical Center

EMERGENCY DEPARTMENT

Severe HTN/Preeclampsia Checklist

If pregnant or < 6 Weeks Postpartum:

- ☐ If BP ≥ 160/110 repeat measurement q 15 min
- ☐ Notify physician after two severe BP values are obtained in any 60-minute window.
  - ❖ ***Treat within one hour of 1st severe range pressure***
  - ❖ ER MD will call OB MD to arrange transfer as needed. Do not delay treatment.
- ☐ Notify OB department for assessments and transfer as applicable
- ☐ Request MD place the OB Hypertension in Pregnancy ER Quick orders
- ☐ Seizure precautions for patients considered pre-eclamptic
- ☐ Place PIV, draw labs
  - o CMP
  - o CBC w/ diff
  - o LDH
  - o Uric Acid
- ☐ Ensure meds are appropriate per patient history
- ☐ Administer seizure prophylaxis as needed (Magnesium Sulfate)
- ☐ Administer anticonvulsant as needed
- ☐ Administer antihypertensive therapy
- ☐ Maintain strict I&O (at risk for pulmonary edema)
  - o Obtain Urinalysis
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Emergency Department Training

41 yr old female presents to ER with headache, edema and BP of 186/94. Are you concerned?

She answers "*Yes" when asked "Have you had a baby in the last six weeks?"

Now are you concerned?

Scan here to find out why you should be.

YouTube: Voices of Impact: Irving Family's Story

*remember miscarriages and abortions count

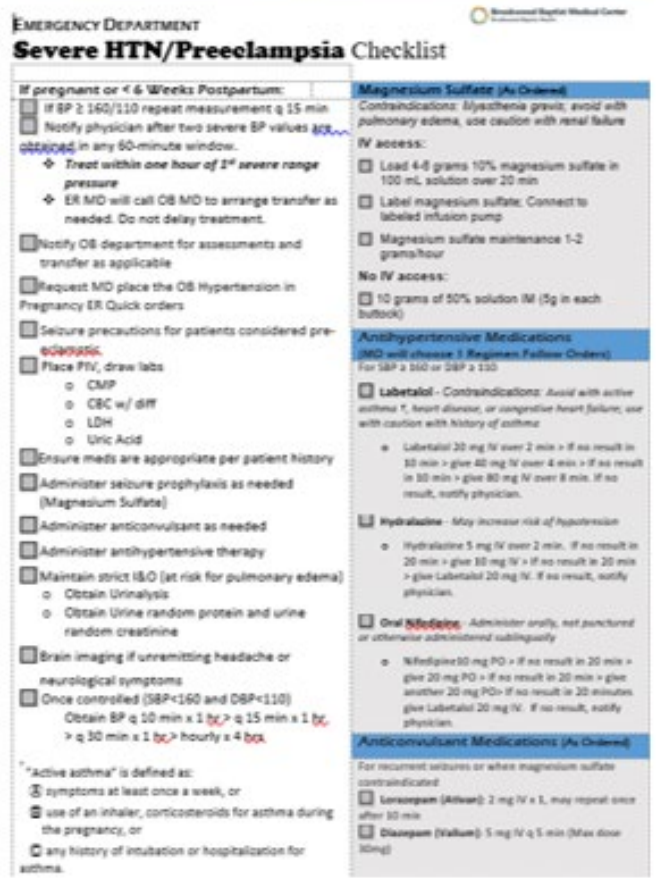
Scan to watch

Under Pressure – Postpartum Hypertensive Emergencies

via Jenny Beck-Esmay, MD

Available for Use

- OB Hypertension in Pregnancy ER Quick orders
- ED SEVERE HTN/PREECLAMPSIA CHECKLIST



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  - ○ CMP
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  - ○ LDH
  - ○ Uric Acid
- ☐ Ensure meds are appropriate per patient history
- ☐ Administer seizure prophylaxis as needed (Magnesium Sulfate)
- ☐ Administer anticonvulsant as needed
- ☐ Administer antihypertensive therapy
- ☐ Maintain strict I&O (at risk for pulmonary edema)
  - ○ Obtain Urinalysis
  - ○ Obtain Urine random protein and urine random creatinine
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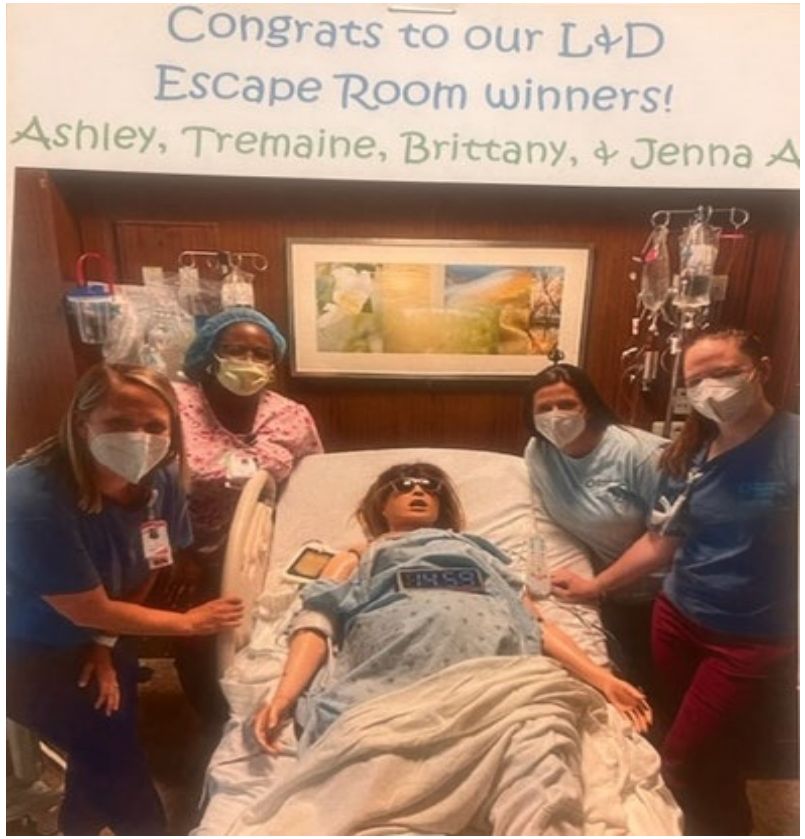
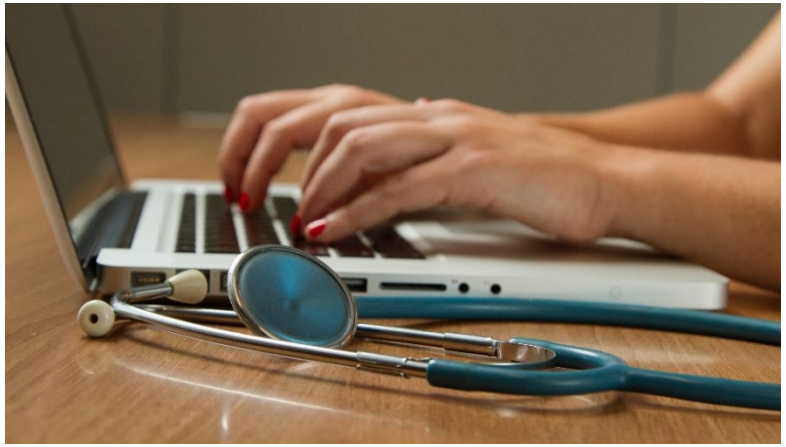
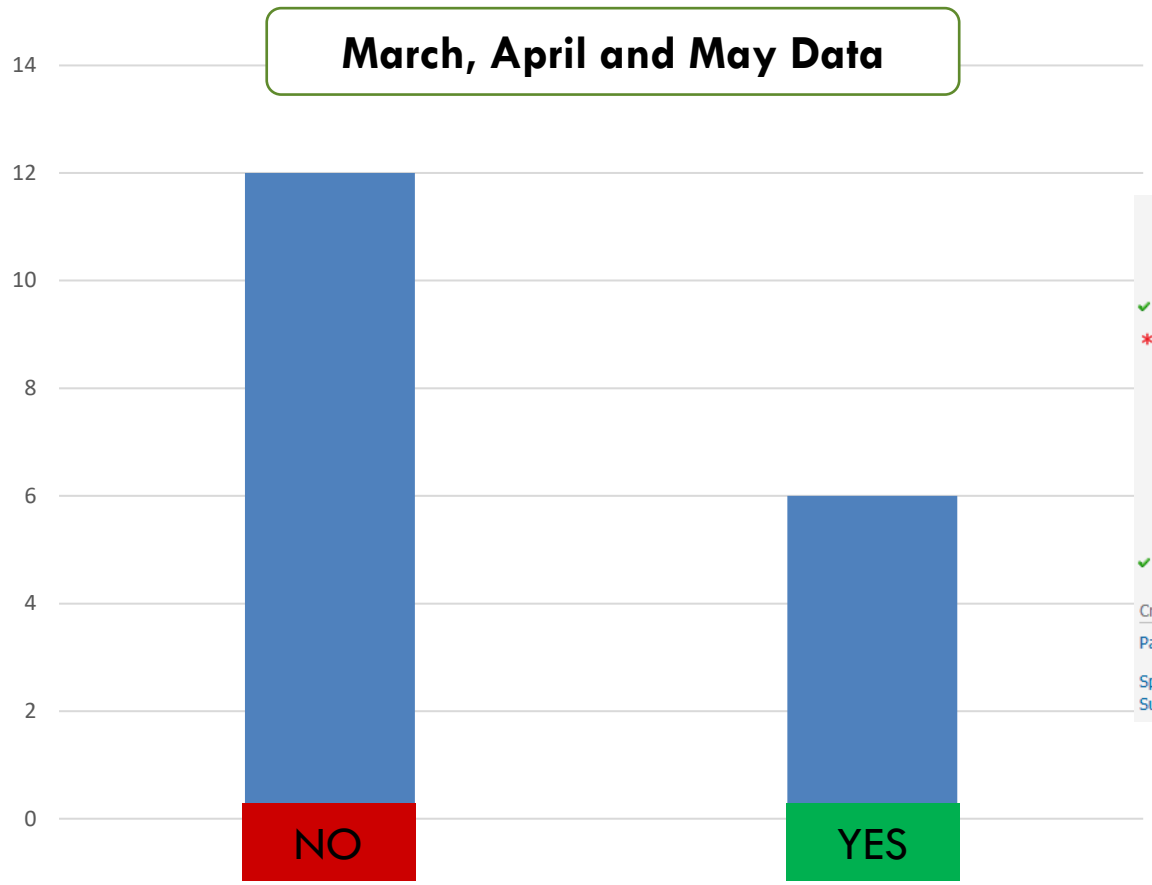
Perinatal Staff Training

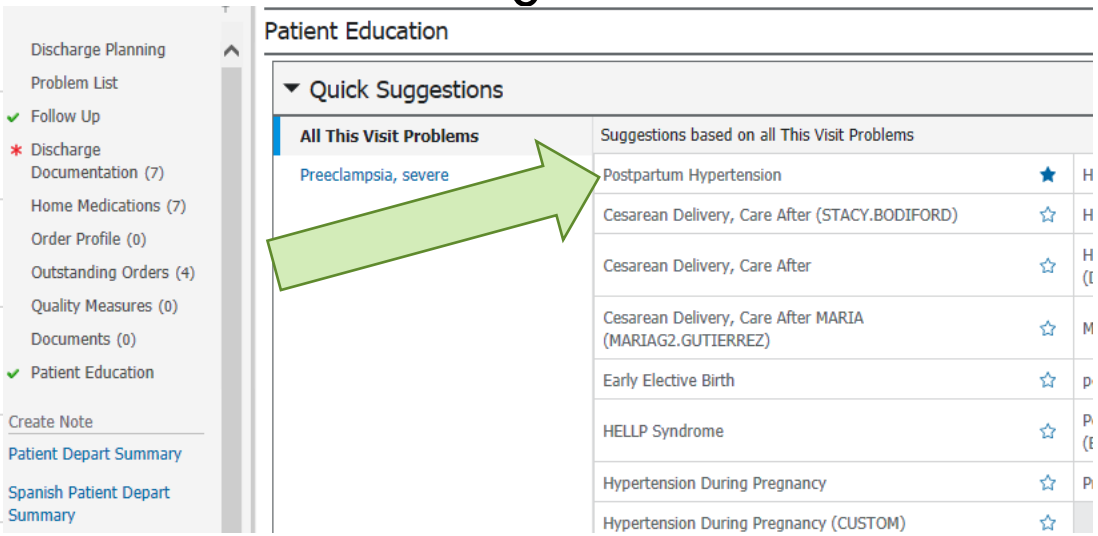




Received Education on discharge

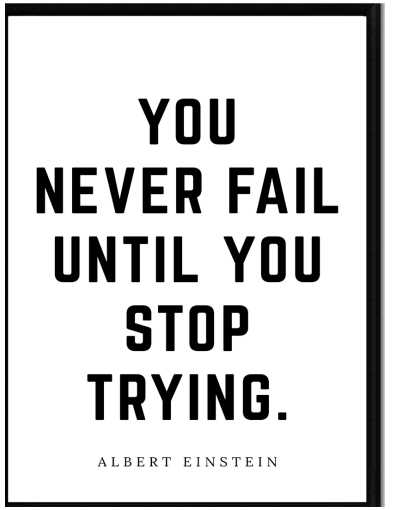


Remember to add Postpartum Hypertension to the patient education section on discharge.



Success is what you make it!

“I have not failed. I’ve just found 10,000 ways that won’t work.” – Thomas A. Edison



The Challenges in our Successes

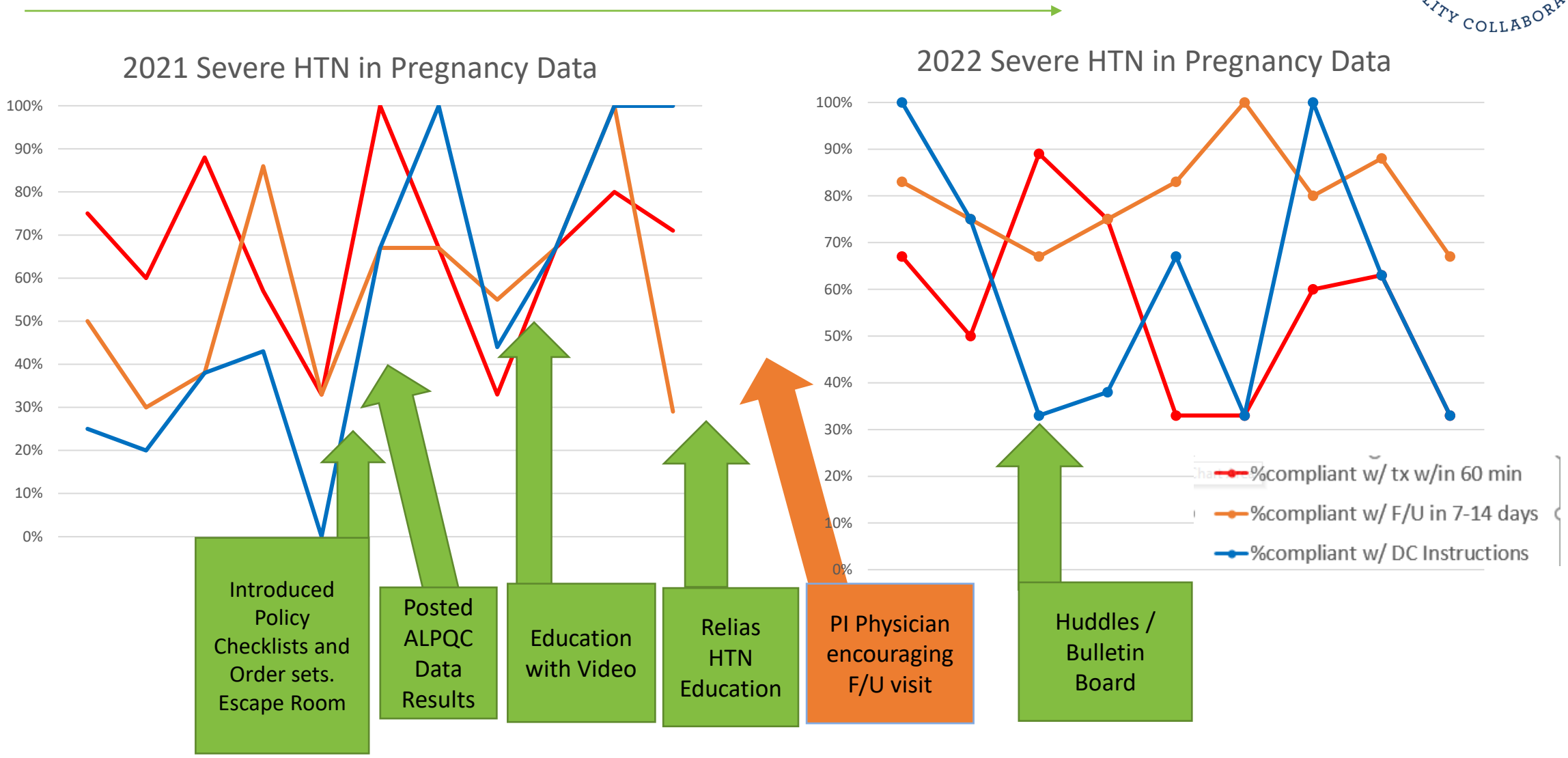
- Standardized checklists – Nurses don't follow the checklist
  - don't take the time to obtain the checklist
  - don't do the follow up q 15min BP, making "sustained" hard to determine
  - don't notify the MD, stating they never want to follow the order set anyway

- Standardized order sets – Inconsistent physician use
  - I don't want to cause fetal distress
  - She has chronic hypertension, she is used to high BP's
  - Who says we need to do this? What is ALPQC? What is AIM?

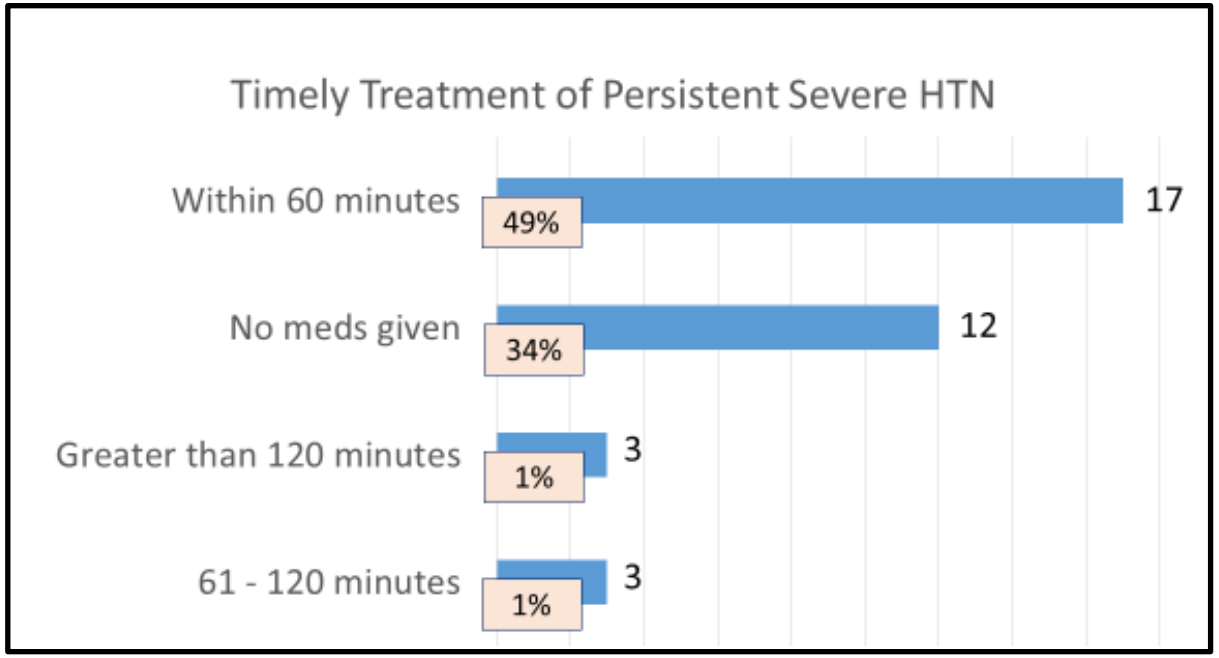
- Completion of training for RN's – Understanding the education
  - Present for the training, but don't really get it
  - Staff turnover – new hires, travelers
  - Drift!

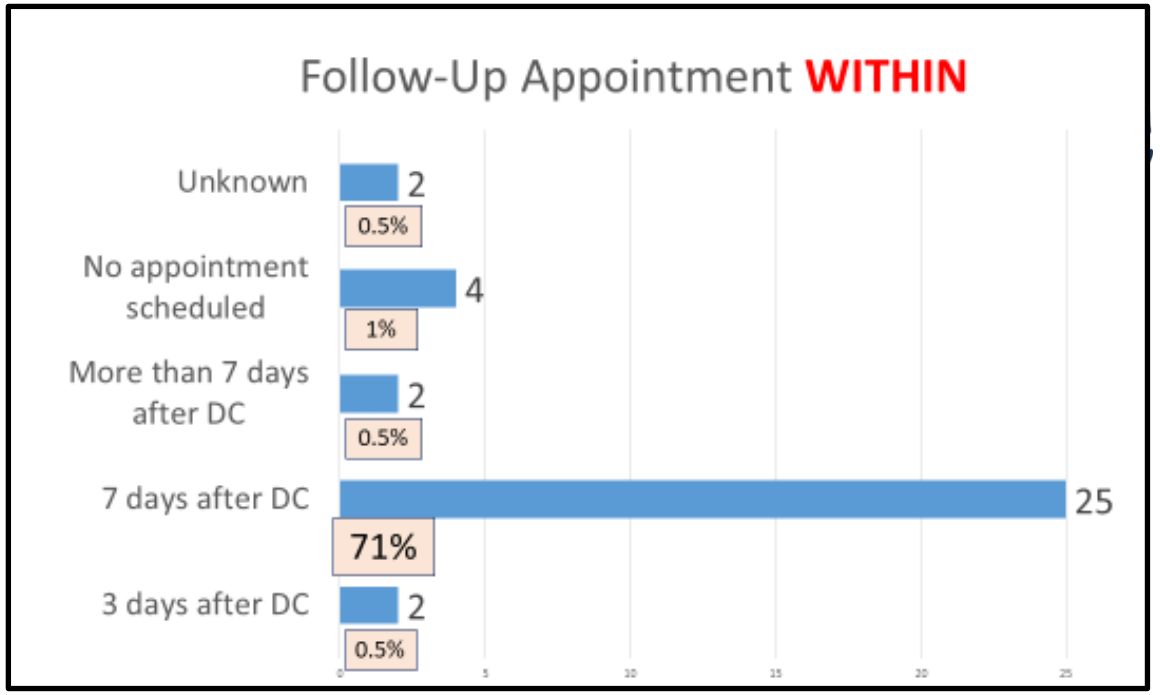
Our Biggest Challenge!

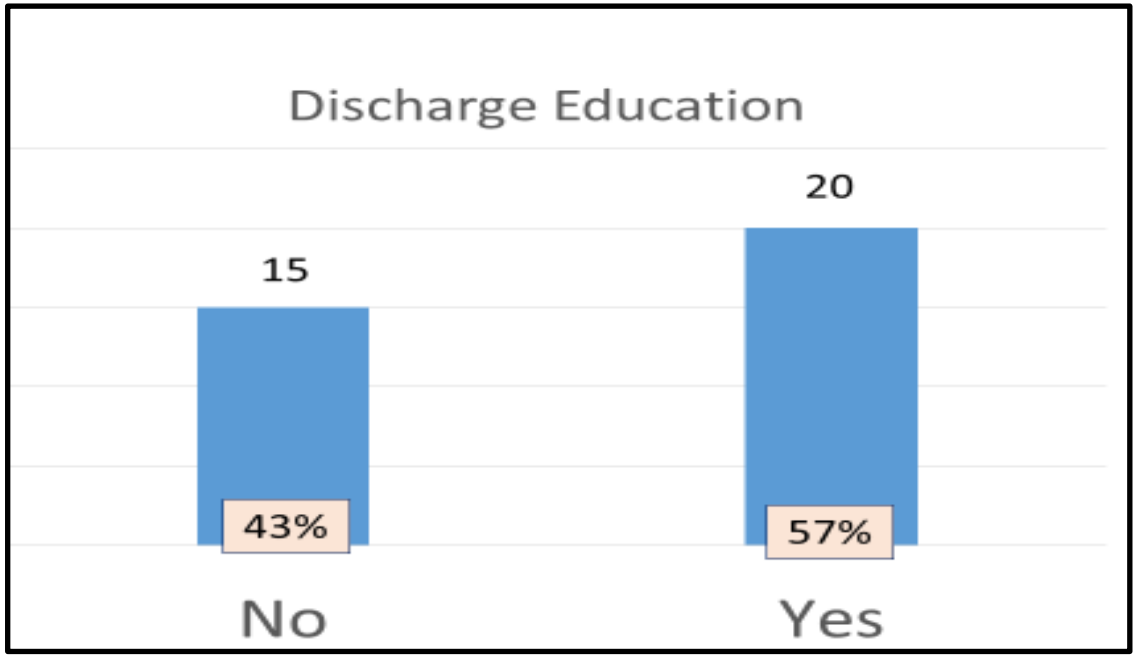
DRIFT!


2021 Severe HTN in Pregnancy Data
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2022 Severe HTN in Pregnancy Data
%compliant w/ tx w/in 60 min
%compliant w/ F/U in 7-14 days
%compliant w/ DC Instructions
Introduced Policy Checklists and Order sets. Escape Room
Posted ALPQC Data Results
Education with Video
Relias HTN Education
PI Physician encouraging F/U visit
Huddles / Bulletin Board

Alabama Perinatal Quality Collaborative (ALPQC)
Maternal Hypertension Initiative







Appendix L: FAQs for Timely Treatment for Acute-Onset Severe Hypertension during Pregnancy and the Postpartum Period

ACOG Practice Bulletin 222 (June 2020) and the AIM Hypertension Bundle are the sources of these guidelines.

Severe hypertension that is accurately measured using standard techniques and is persistent for 15 minutes or more is considered a hypertensive emergency.

- It can occur during pregnancy or postpartum
- Either systolic ≥ 160 mm Hg or diastolic ≥ 110*mm Hg
- Can present as new acute-onset, or in women with chronic hypertension who are developing superimposed preeclampsia with acutely worsening, difficult to control, severe hypertension

If severe BP elevations persist for 15 minutes or more, administer antihypertensive medication.

- The 15 minutes is the definition of a hypertensive emergency that needs immediate treatment, NOT the definition of preeclampsia which in other guidelines calls for elevated BPs measured 4 hours apart.
- The second confirmatory blood pressure measurement should be done within 15 minutes. The 15-minute window provides a sufficient gap to formally confirm persistent elevated blood pressure that is independent of other causes, and that the patient requires treatment. More frequent readings (every 5 minute) are acceptable for observation purposes.
- Repeat BP measurement to ensure accuracy. Initial first line management can be with labetalol, hydralazine, or immediate-release PO nifedipine – the most important thing is that antihypertensive medications need to be initiated in a hypertensive emergency.
- Treatment of acute-onset severe hypertension is an emergency and should take precedence over starting magnesium sulfate.
- Two thirds of the preeclampsia deaths in the most recent UK Confidential Enquiries resulted from stroke. Identical findings were noted in the recent California review of maternal deaths. It should be noted that very few women die from seizures.
- Strokes can occur in women with acute-onset hypertension with systolic pressures in the 160s and diastolic pressures in the 110s.*
- Treatment of acute-onset severe hypertension is an emergency and demands an immediate response. Aim for initiation of antihypertensive medications "as soon as possible", ideally by 30 minutes and not more than 60 minutes after the confirmation. Ultimately, the goal is to not delay care. Hospitals that address the systems issues around immediate treatment have been

Alabama Perinatal Quality Collaborative (ALPQC) Maternal Hypertension Initiative FAQ's

WHAT IS THE MATERNAL HYPERTENSION INITIATIVE?
This initiative from the ALPQC aims to achieve a 20% reduction in the rate of severe maternal morbidity among pregnant and postpartum patients with preeclampsia/eclampsia by implementing the Alliance for Innovation on Maternal Health (AIM) Severe Hypertension in Pregnancy Bundle.

WHAT IS AIM?
AIM is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improving maternal safety and outcomes. The program provides implementation and data support for the adoption of evidence-based patient safety bundles. (ACOG)

WHAT DATA ELEMENTS ARE BEING EVALUATED?

1. *Timely Treatment of Persistent Severe HTN:* Pregnant and postpartum patients with acute-onset persistent severe hypertension (≥160 systolic or ≥110 diastolic BP that persists for 15 minutes or more) who were treated within 60 minutes with IV Labetalol, IV Hydralazine, or PO Nifedipine. (Chronic Hypertension in Pregnancy. Practice Bulletin No. 203 , 2019) (Gestational Hypertension and Preeclampsia. Practice Bulletin No. 222, 2020)

2. *Patient discharged with a postpartum BP and symptoms check scheduled to occur within:* Blood pressure evaluation is recommended for women with hypertensive disorders of pregnancy no later than 7–10 days postpartum, and women with severe hypertension should be seen within 72 hours; other experts have recommended follow-up at 3–5 days (Optimizing Postpartum Care. Committee Opinion No. 736, 2018)

3. *Did your hospital provide education (including in written form) to the patient* and their family, including the designated support person whenever possible, on the signs and symptoms of severe hypertension/preeclampsia during hospitalization and after discharge?

References

ACOG. (n.d.). *Partnerships: Alliance for Innovation on Maternal Health (AIM).* Retrieved from acog.org: https://www.acog.org/practice-management/patient-safety-and-quality/partnerships/alliance-for-innovation-on-maternal-health-aim

Chronic Hypertension in Pregnancy. Practice Bulletin No. 203 . (2019, January). Retrieved from acog.org: https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/01/chronic-hypertension-in-pregnancy?utm_source=redirect&utm_medium=web&utm_campaign=otn

Gestational Hypertension and Preeclampsia. Practice Bulletin No. 222. (2020, June). Retrieved from acog.org: https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/06/gestational-hypertension-and-preeclampsia

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- ***Did your hospital provide education (including in written form) to the patient*** and their family, including the designated support person whenever possible, on the signs and symptoms of severe hypertension/preeclampsia during hospitalization and after discharge?

Opportunities

Next Steps

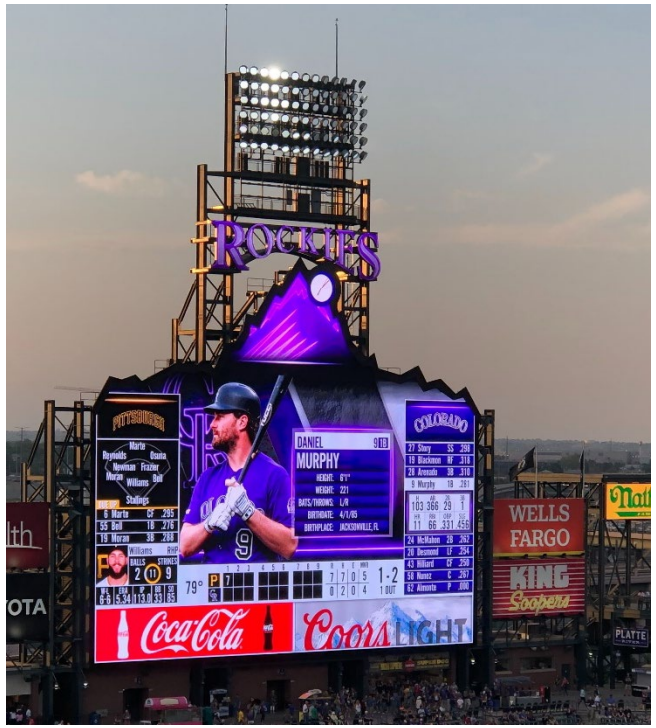
- Simulation for 2023 yearly competency
- Improve physician buy-in
  - OB Process Improvement physician support
- Implicit bias and stigma education
- Intentional rounding by HTN champions/leadership
- Ongoing data sharing and discussion for physicians and nurses

Create a Compelling Scoreboard

People Play Differently When Keeping Score

1. Is it simple?
2. Can I see it easily?
3. Does it show lead and lag measures?
4. Can I tell at a glance if I'm winning?

   If you can' tell within five seconds whether you're winning or losing, you haven't passed this test.



https://www.franklincovey.com.au/discipline-3-keep-a-compelling-scoreboard

Q & A

Please feel free to **unmute** and ask questions.

You may also enter comments or questions in the “chat” box.

Severe Maternal Mortality Review

ICD-9 & 10 SMM Numerator Codes

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Changes Made since the June 2021 Version

ICD-9 & 10 SMM Numerator Codes

Changes to 2021 version dated 06/22/2021

All changes are highlighted in green.

SMM Indicator	D/P Code?	ICD-9 or ICD-10	Code	Notes
5. Amniotic fluid embolism	Diagnosis	ICD10	O88.112	Changed from shorthand O88.1x to align with FAD Resource Document's sample SAS code for SMM. Shorthand includes 1 erroneous code - **O88.111 was removed from v2 of the AIM 2021 SMM Code List.**
	Diagnosis	ICD10	O88.113	
	Diagnosis	ICD10	O88.119	
	Diagnosis	ICD10	O88.12	
	Diagnosis	ICD10	O88.13	
14. Sepsis	Diagnosis	ICD10	I76	2021 code addition was not reflected in original AIM 2021 SMM codes list. **These codes were added to v2 of the AIM 2021 SMM Code List.**
	Diagnosis	ICD10	T81.12XA	
17. Air and thombotic embolism	Diagnosis	ICD10	I26.01	Changed from shorthand I26.x to align with FAD Resource Document's sample SAS code for SMM. Shorthand includes 2 erroneous codes - **I26.0 and I26.9 were removed from v2 of the AIM SMM Code List.**
	Diagnosis	ICD10	I26.02	
	Diagnosis	ICD10	I26.09	
	Diagnosis	ICD10	I26.90	
	Diagnosis	ICD10	I26.92	
	Diagnosis	ICD10	I26.93	
	Diagnosis	ICD10	I26.94	
	Diagnosis	ICD10	I26.99	

Additions from 2020 Version

SMM Indicators

- Amniotic fluid embolism
- Sepsis
- Air and thrombotic embolism
- Adult respiratory distress syndrome
- Disseminated intravascular coagulation
- Puerperal cerebrovascular disorders
- Pulmonary edema/acute heart failure
- Severe anesthesia complications
- Shock
- Sickle cell disease with crisis
- Hysterectomy
- Ventilation
- Temporary tracheostomy

Inclusion Criteria

Include patients that meet the following criteria:

- Pregnant (during delivery admission) / postpartum (up to 6 weeks after delivery) with sustained elevated systolic ≥160 and/or diastolic BP ≥110 (105) (2 reading 15 mins apart)

- Any inpatient location (L&D, triage, ED, antepartum, postpartum) Include patients with chronic / gestational HTN

MATERNAL HYPERTENSION INITIATIVE
FREQUENTLY ASKED QUESTIONS

IDENTIFICATION AND TREATMENT PROTOCOL

https://www.alpqc.org/files/2022/06/ALPQC-HTN-FAQs-2022.pdf

Calculating Monthly Outcome Measures

ALPQC Maternal Hypertension Initiative
Monthly OUTCOME Measures Form

Hover mouse over cells with red triangles for additional information

*Denotes required field

O1. Severe Maternal Morbidity (SMM) (excluding transfusion codes)			
	Denominator: All pregnant and postpartum patients during their birth admission	⇨	**Numerator:** **Among the denominator,** patients who experienced severe maternal morbidity, excluding those who experience transfusion alone.
***All patients**	0		0
Asian	0		0
***Black/African American**	0		0
***Hispanic/Latino**	0		0
Multi Racial	0		0
Native American	0		0
Native Hawaiian/ Pacific Islander	0		0
***White**	0		0
Other race/ethnicity	0		0
Race Not Reported	0		0
Unknown race/ethnicity	0		0

O2. Severe Maternal Morbidity (SMM) among patients with Preeclampsia (excluding transfusion codes)			
	Denominator: All pregnant and postpartum patients during their bith admission with Preeclampsia	⇨	**Numerator:** **Among the denominator,** patients who experienced severe maternal morbidity, excluding those who experienced transfusion alone
***All patients**	0		0
Asian	0		0
***Black/African American**	0		0
***Hispanic/Latino**	0		0
Multi Racial	0		0
Native American	0		0
Native Hawaiian/ Pacific Islander	0		0
***White**	0		0
Other race/ethnicity	0		0
Race Not Reported	0		0
Unknown race/ethnicity	0		0

Next Steps

Data Submission Reminders

MONTHLY Measures

Measure Type	Measures	Measurement Period	Reporting Due*
Outcome	1. SMM (excluding transfusion codes)	~~Aug 2022~~	~~Oct 15, 2022~~
Outcome	2. SMM among people with preeclampsia (excluding transfusion codes)	~~Sep 2022~~	~~Nov 30, 2022~~
For pregnant and postpartum patients with persistent severe HTN during hospitalization:			
Process Patient-level	1. Timely treatment of persistent severe HTN	~~Oct 2022~~	~~Nov 30, 2022~~
Process Patient-level	2. Patient discharged with a postpartum BP and symptoms check scheduled	Nov 2022	**Dec 31, 2022**
Process Patient-level	3. Patient and family education on preeclampsia signs & symptoms prior to discharge	Dec 2022	**Jan 31, 2022**

All Measures Reported by Race/ Ethnicity

Find data forms, including ICD-10 codes, on our website at http://www.alpqc.org/initiatives/htn, under the "Data Resources" menu

Data Submission Reminders

QUARTERLY Measures

Measure Type	Measure	Measurement Period	Reporting Due*
Process Facility-level	4. Provider education: Severe HTN/preeclampsia & *Respectful and Equitable Care*		
	5. Nursing education: Severe HTN/preeclampsia & *Respectful and Equitable Care*		
	6. ED: Provider and Nursing Education: signs & symptoms severe HTN/preeclampsia in pregnant and postpartum patients	~~July – Sep 2022~~	~~Nov 30, 2022~~
	7. Unit drills		
Structure Facility-level	1. Severe HTN/Preeclampsia policy and procedure	Oct – Dec 2022	**Dec 31, 2022**
	2. Established system to perform regular formal debriefs with the clinical team after cases with major complications	Jan – Mar 2023	**Mar 31, 2022**
	3. Established standardized process for debriefs with patients after a severe event	Apr – Jun 2023	**Jun 30, 2022**
	4. Established process for multidisciplinary systems-level reviews on SMM cases	July – Sep 2023	**Sep 30, 2023**
	5. Developed/curated patient education materials on urgent postpartum warning signs that align with culturally and linguistically appropriate standards		
	6. ED established or continued standardized verbal screening for current pregnancy and pregnancy in the past year as part of its triage process		

Find data forms, including ICD-10 codes, on our website at www.alpqc.org/initiatives/htn, under the "Data Resources" menu

Thank You!

Next Meeting:

Friday, January 27th, 2023

12:00 PM – 1:00 PM CT

Guest Speaker:

Bekah Bischoff

Preeclampsia Foundation & Momma's Voices