ILPQC: improving outcomes through the magic of collaboration

Texas Collaborative for Healthy Mothers and Babies Summit

January 29, 2019

Ann E.B. Borders, MD, MPH, MSc

Disclosures and Support

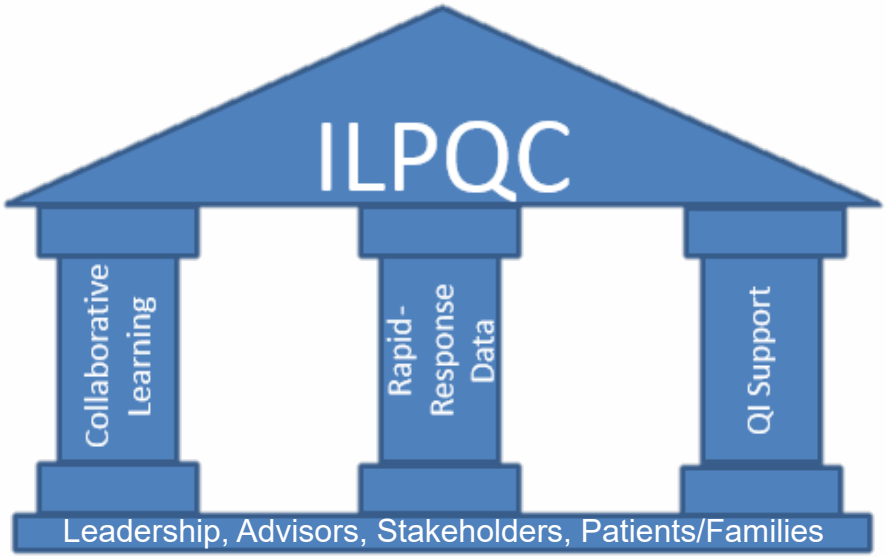
- No conflicts to report
- We would like to thank our funders for their support:
  - Centers for Disease Control and Prevention,
  - Illinois Department of Public Health
  - Alliance for Innovation on Maternal Health (AIM) Maternal Child Health Bureau

Overview

- ILPQC Structure
- Launching an Initiative
- Helping Teams Succeed
- ILPQC in Action
  - MNO: launch and engagement
  - HTN: support hospitals QI success / sustainability

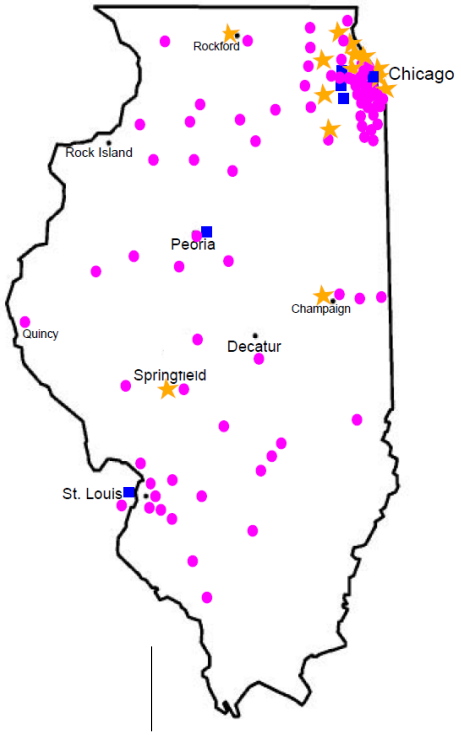
Improving Together

ILPQC is a collaborative of physicians, nurses, hospital teams, public health and other stakeholders implementing data-driven, evidence-based practices to improve maternal and neonatal outcomes in Illinois



State-wide Participation

- 119 hospitals participating in ILPQC initiatives
  - 99% of IL births covered by ILPQC
  - 100% of IL NICU beds covered by ILPQC
- 110 hospitals with 101 OB hospital teams and 70 Neonatal teams participated in ILPQC Face to Face meetings in 2018
- Strong ILPQC advisory group participation
  - OB Advisory Group – 74 members have participated over time representing 30 hospitals
  - Neonatal Advisory Group – 31 members representing 19 hospitals



ILPQC Milestones

2012
- IL Perinatal Advisory Committee Prematurity Task Force Report
- Start Up Funding: CHIPRA / HFS
- Stakeholder Meetings Begin

2013
- Consultation with Perinatal Quality Leaders (OH, CA, NC, FL)
- Website Launch
- ILPQC Kick-Off, 1st Annual Conference

2014
- ILPQC Data System Launched
- CDC Award with IDPH
- Launch EED and Neonatal Nutrition Initiatives

2015
- Launch Golden Hour Initiative
- Launch Birth Certificate Initiative
- Started yearly spring Face to Face Meetings for OB and Neo Teams

2016
- Launch Maternal Hypertension Initiative
- IDPH Funding
- Golden Hour Initiative Ongoing

2017
- Maternal Hypertension and Golden Hour Initiatives Ongoing
- CDC Funding for MNO Initiative
- Pritzker Grant Award for IP LARC Initiative

2018
- Launch Mothers and Newborns affected by Opioids (MNO) Initiative
- Launch Immediate Postpartum LARC Initiative
- Launch Sustainability for Maternal Hypertension and Golden Hour Initiatives

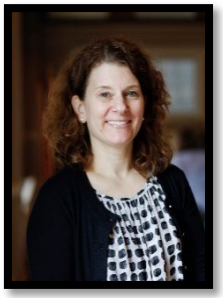
ILPQC Central Team

Ann Borders

ILPQC Executive Director, OB Lead

Leslie Caldarelli & Justin Josephsen

Neonatal Leads



Patricia Lee King

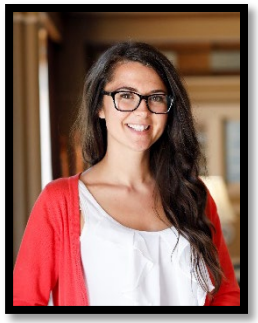
State Project Director

Daniel Weiss & Danielle Young

Project Coordinators

Autumn Perrault

Nurse Quality Manager



info@ilpqc.org OR www.ilpqc.org

ILPQC Provides Responsive QI Services to Hospital Teams

ILPQC
Illinois Perinatal Quality Collaborative

Webinars/ Calls

- Monthly & quarterly collaborative learning and QI Topic Calls
- QI Support Calls with Perinatal Network Administrators
  - Key players meeting
  - RedCap data training

Face to Face

- Spring Face-to-Face Meeting Breakouts
- Annual Conference Breakouts
- Key Player Site Visits
- Grand Rounds speakers group

ILPQC Resources

- Paper/online QI toolkits
- Patient-education materials
- Monthly e-newsletters
- Previous months webinar recording

ILPQC Data

- Rapid Response data system
- Real-time reports for teams to compare data across time & hospitals

Quality Improvement Support Services

ILPQC Data System drives QI

Data Collection

Hospital teams collect data on structure, process, and outcome measures

Input data into ILPQC Data System

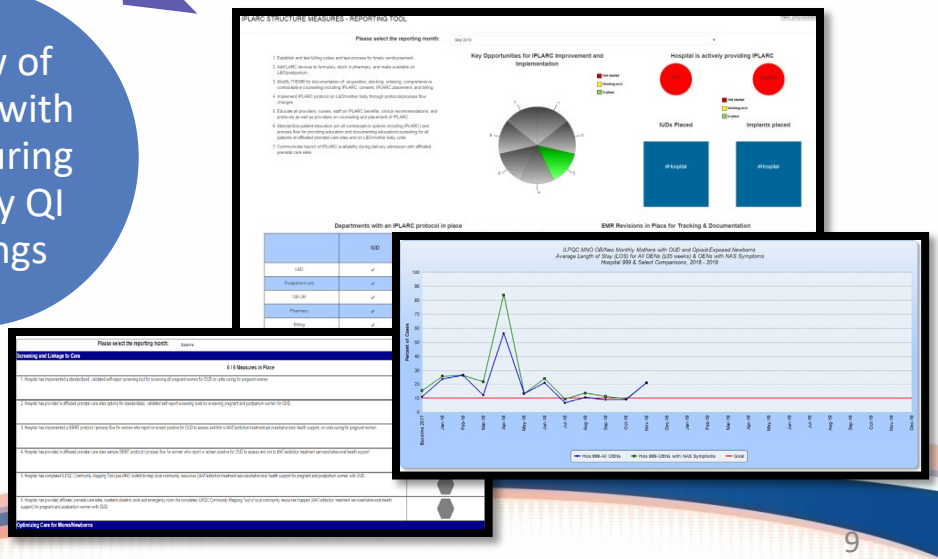
Team input data monthly into ILPQC REDCap Data System for rapid response reports of real time data

Review of reports with team during monthly QI meetings

Review reports on structure dashboards, process, and outcome measures to compare data across time and across hospitals

Decide next QI steps for team

Team uses data to drive Quality Improvement at their hospital



Communication is Key

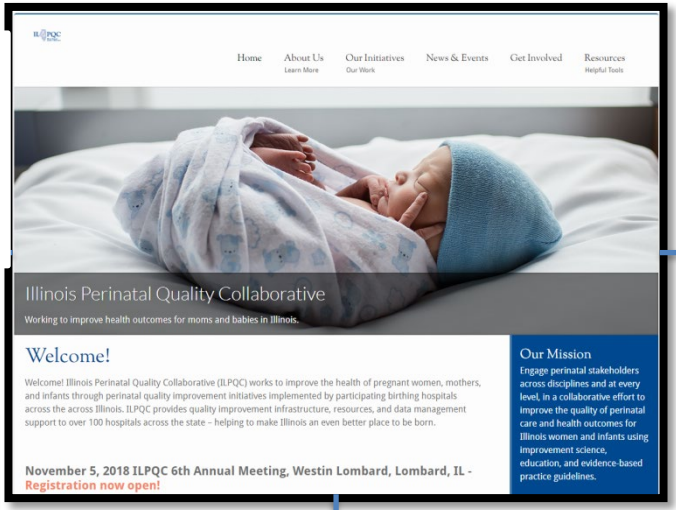
- Monthly hospital team webinars
- Hospital QI support calls
- Website for resources and initiative toolkits

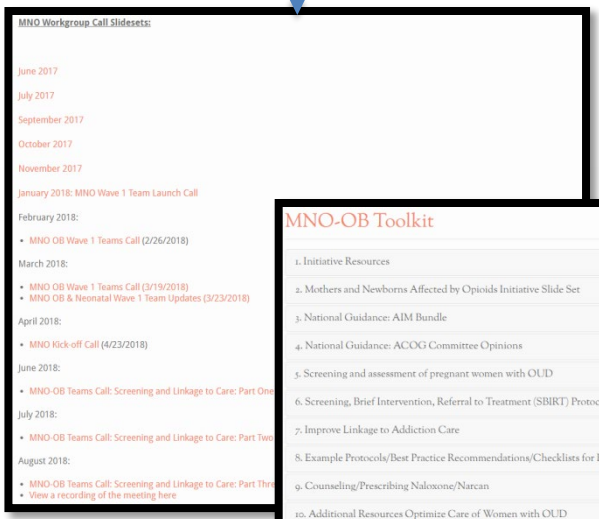
- Monthly e-newsletters per initiative
- Face-to-Face meetings / Annual Conference
  - Teams enjoy meeting in-person, sharing, learning from each other and networking

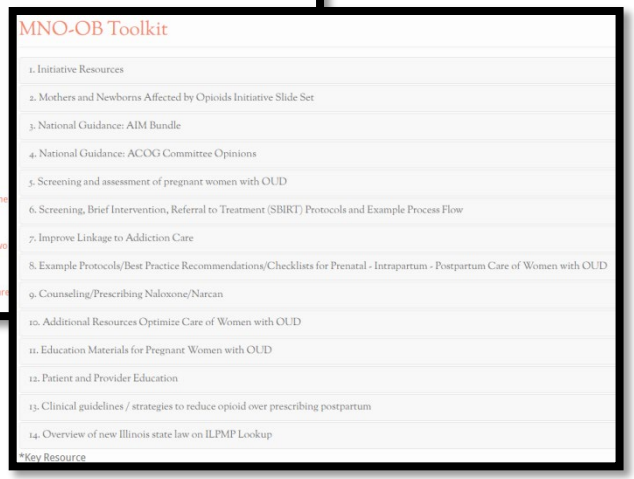
www.ilpqc.org

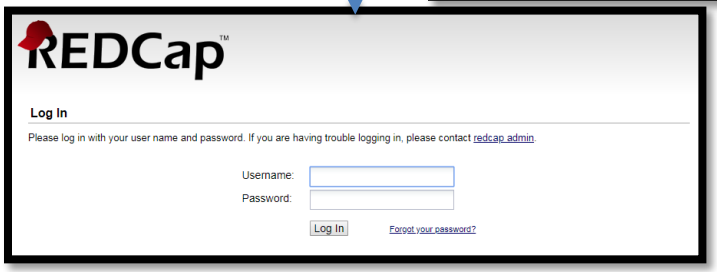
Up-to-date resources, Team Webinars, and QI Toolkits

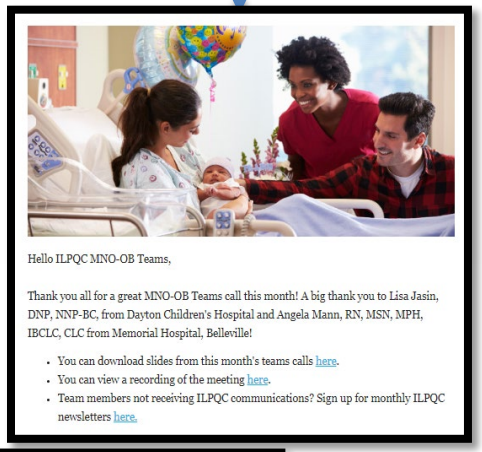
Monthly initiative communications, REDCap











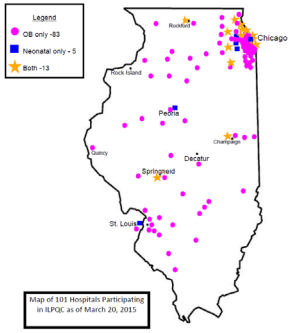
USING ILPQC STRUCTURE TO LAUNCH AN INITIATIVE

Start with Initiative Selection: Achieve Buy-In

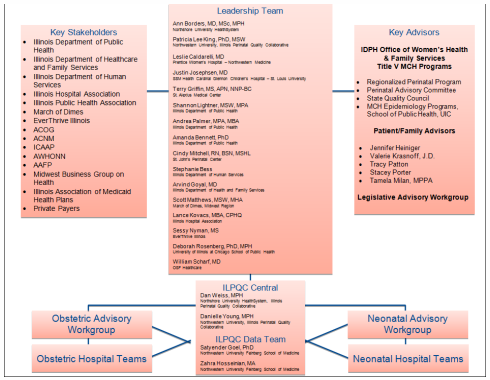
Survey ILPQC hospital teams pre-conference

State PQC leaders share overviews of initiatives at conference

Discuss and vote on initiatives at conference break out sessions



Buy-in with advisory workgroup, perinatal network



Engage key stakeholder buy-in

Getting Ready to Launch:

LEADERSHIP

Identify Clinical Leadership

Review resources with leadership: clinical leads, OB Advisory Work Group, State Quality Council/Perinatal Network Administrators

Update ILPQC Leadership Committee (state agencies, Illinois Hospital Association, national and local partners)

COLLABORATION with other PQCs

Hold calls with other PQCs to learn process/resources

Assessment of state & national resources

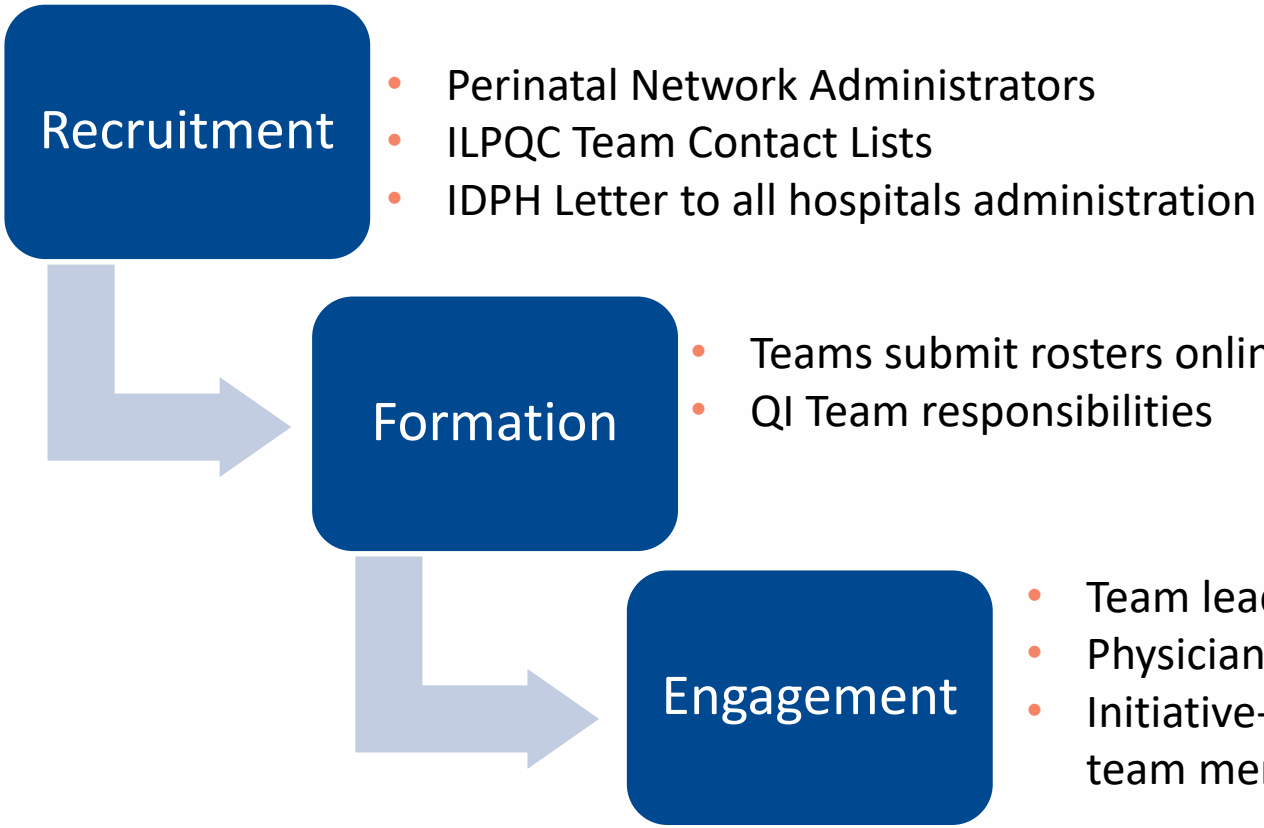
RESOURCE DEVELOPMENT

Develop Toolkit & Data Form

Wave 1 teams test data form and data collection process

Promoting Engagement In Work of the Collaborative

Team Building and Roster Formation



Engaging Hospital Teams

Engage

- Collectively identify initiatives
- Support development of interdisciplinary teams
- Engage providers & nurses as leaders at the collaborative & hospital level

Motivate

- Develop hospital team buy-in
- Break down the work into key steps
- Demonstrate frequent examples of success

Support

- Collaborative learning opportunities support system & culture changes
- Rapid-response data system supports use of data to drive QI
- QI support to ensure equity across hospitals

Implementing the IHI Breakthrough Series through a Collaborative

Planning an Initiative:

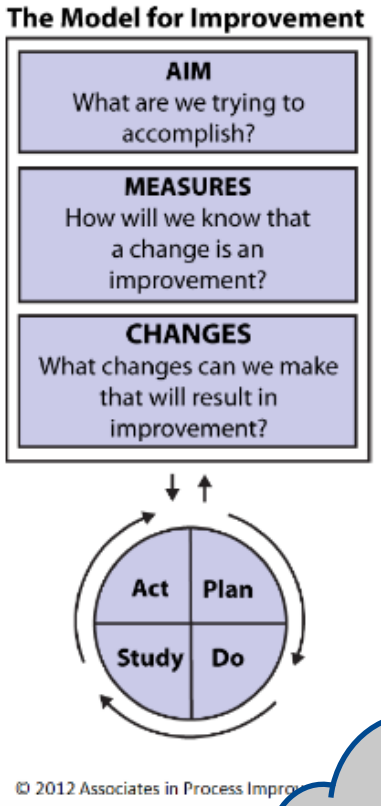
- Create collaborative Key Drivers Diagram, SMART AIMS, and specific measures to track progress across the initiative

ILPQC Collaborative-Level QI:

- Monthly review of specific measures on collaborative learning webinars
- Offer QI topic calls on specific improvement strategies of the initiative
- Recruit national experts to share QI strategies on collaborative learning webinars

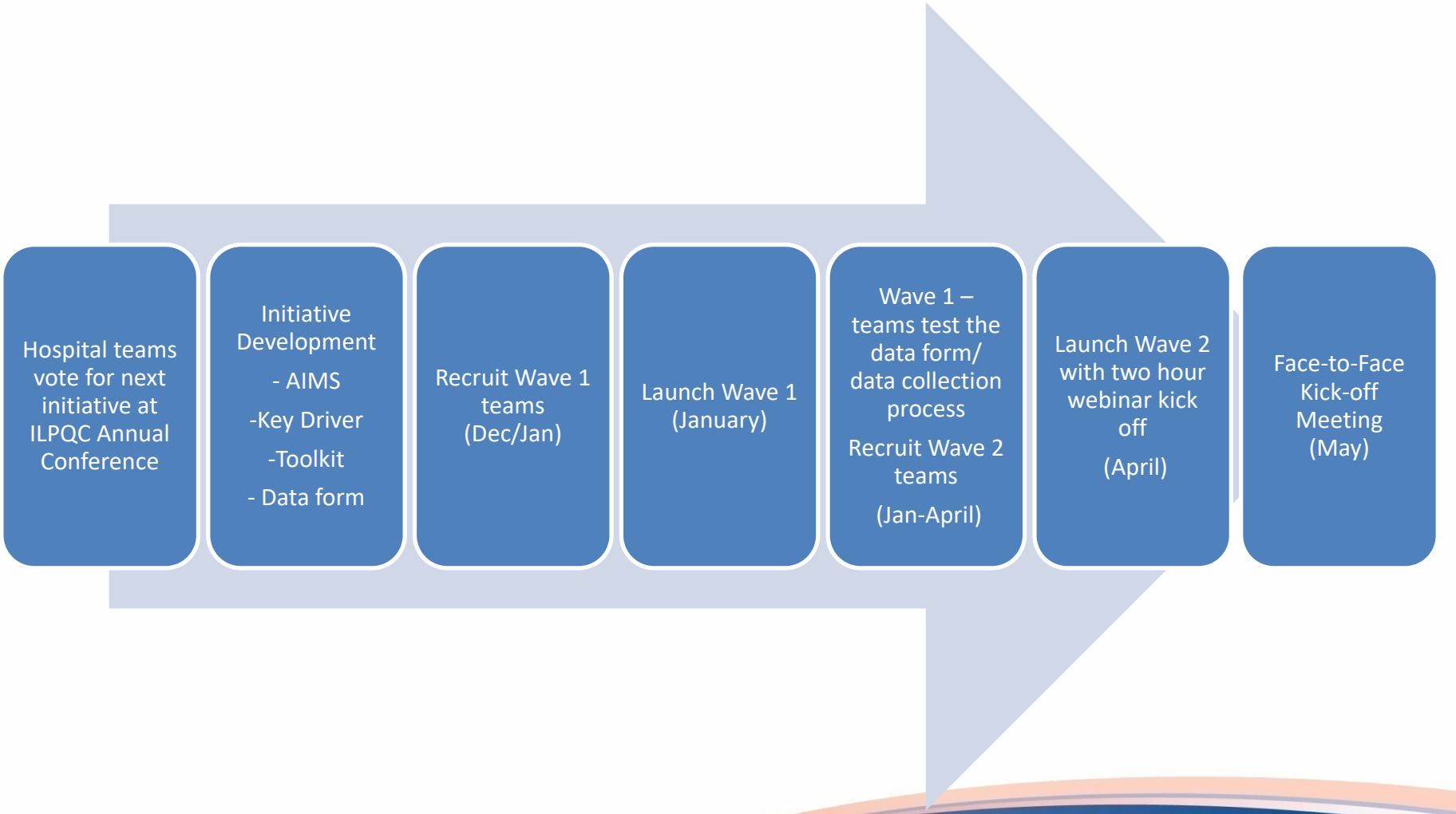
ILPQC Hospital-Level QI Support:

- Review of hospital-level monthly data to provide tailored support
- 1:1 QI Support calls to coach hospitals to implement PDSA cycles and 30-60-90 day plans to achieve hospital-level initiative goals



Hospital QI Work: *What changes can you make to your process/system and test with a PDSA cycle to reach initiative goals?*

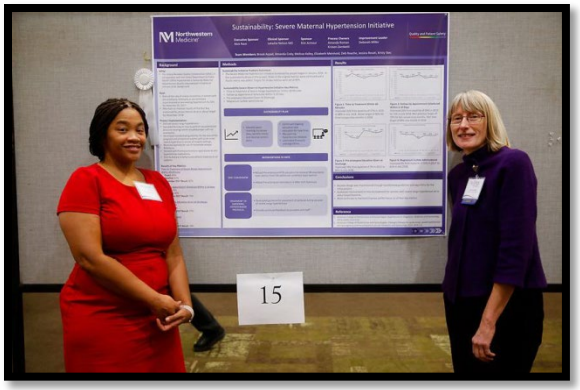
Timeline of Initiative Launch



HELPING TEAMS SUCCEED

Quality Improvement Strategy

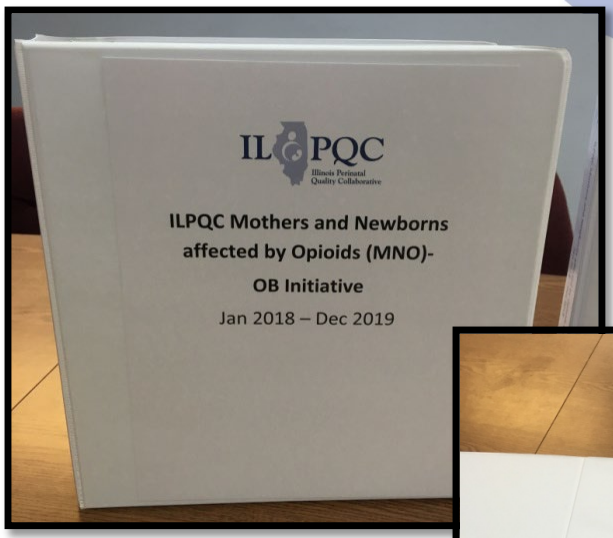
- **Engage statewide stakeholders** and **OB Advisory Workgroup** in development and implementation of QI initiative
- Facilitate development of multidisciplinary **hospital-based QI teams**
- Facilitate monthly **collaborative learning webinars** with national experts, toolkit resources and team sharing and twice annual opportunities for in-person collaborative learning

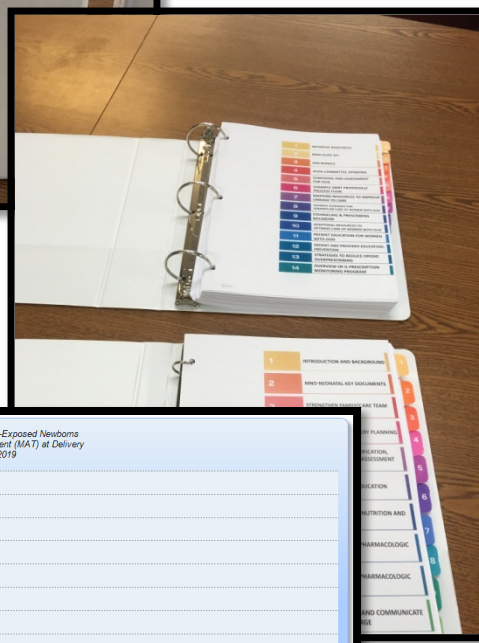


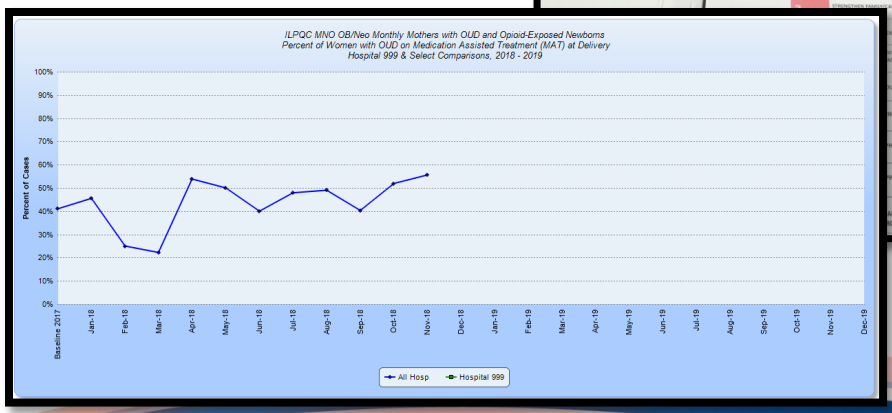
Quality Improvement Strategy

- Disseminate **toolkits and training e-modules** to support hospital system and culture change

- Develop **rapid-response data system** for hospitals to see data on key **process, outcome, and structure measures** over time and compared to other hospitals







Quality Improvement Strategy

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QI Topic Calls
Small Group Format

Review collaborative level data on key measures

Identify Mentor Hospitals among teams demonstrating early improvement on key measures

Host QI Support call with mentor hospital - call is open to all teams and focus is on discussion between teams

QI Support Calls
Individual Hospital Format

Review hospital level data for teams that need or request improvement support on key measures

Reach out to hospital team to schedule and conduct QI support calls

Connect team with resources, support data review to focus PDSA cycles, develop 30-60-90 day plan

Teaching Hospital Teams
Key QI Steps for Success

- Build a multidisciplinary QI team
- Assess where starting from (baseline data)
- Plan where want to get to (30-60-90 day plan, set goals/aims)
- Try small test of change (PDSA cycle), repeat
- Collect data (structure, process and outcome measures) to track progress, challenges, success, compliance
- Review/share rapid response data reports showing change from baseline and comparison across hospitals, key for quality improvement
- Learn from other hospital teams

Encouraging Providers/Nurses Engagement in QI

- **Buy-In matters:** Sell the initiative to OB providers and nursing staff: why are we doing this work, why it matters, what they need to do, how will compliance be monitored
- **Systems change that assist clinical team doing the right thing every time**: Protocols, checklists, order sets, debriefs, EMR prompts
- **Culture change needs provider and nursing staff education:** Grand Rounds, E-modules, Simulations, Drills
- **Active monthly review and use of QI data is key:** Sharing monthly QI data progress and comparison to other participating hospitals with OB providers and nursing staff and track compliance in sustainability

Engaging Patients & Families in QI Work

Patient /Family Advisors:

- Share personal stories and provide feedback
- Review process flow and identify opportunities for improvement
- Develop, review, and test content of materials
- Discuss quality improvement findings

6 patient/family advisors serving on OB/Neonatal Advisory Groups

Resources for teams seeking patient/family advisors

Motivating Teams to Make Culture and System Changes

- QI award banners for teams meeting initiative goals
- Certificates of achievement for hospital teams submitting timely data
- Letters to hospital leadership acknowledging teams successfully meeting initiative goals

ILPQC IN ACTION:

- MNO INITIATIVE LAUNCH
- IPLARC INITIATIVE LAUNCH
- HTN INITIATIVE SUSTAINABILITY

Working Together on State-wide Initiatives

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Sustain Hypertension Success

- Compliance Monitoring
- New Hire Education
- Ongoing Staff/Provider Education

Launched 2 new statewide QI initiatives in 2018

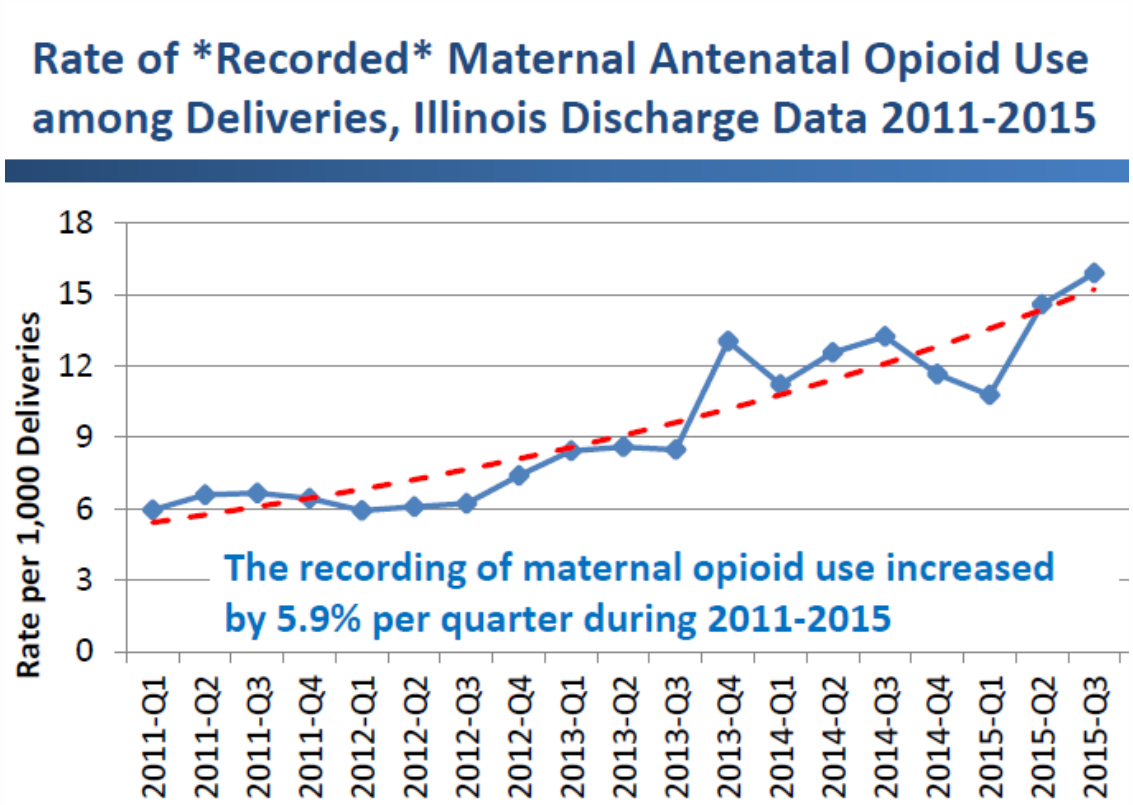
Mothers and Newborns affected by Opioids Initiative

- MNO
  - OB
  - Neo

Immediate Postpartum Long Acting Reversible Contraception Initiative

- IPLARC
  - Wave I

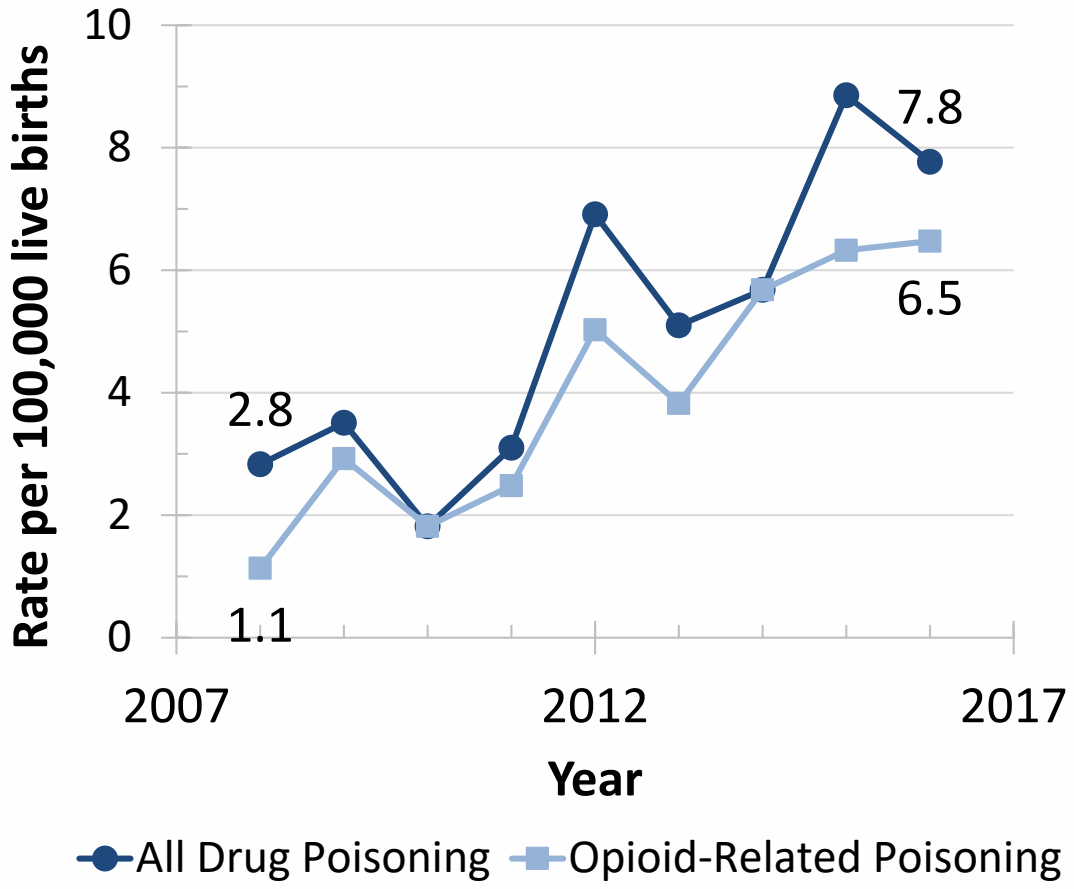
Mothers Affected by Opioids in IL: Scope of the Problem



116% increase in recorded maternal opioid use between 2011 and 2015

Pregnancy is a window of opportunity to identify women with OUD and link to treatment as well as begin to develop a plan for optimizing her baby's care

Rate of Pregnancy-Associated Deaths Due to Drug Poisoning, Illinois Residents, 2008-2016



Between 2008 and 2016:

- Pregnancy-associated deaths specifically related to opioid overdose **increased almost 6-fold.**

Data Source: Illinois death certificates, 2008-2016.

Neonatal Abstinence Syndrome in IL: scope of the problem

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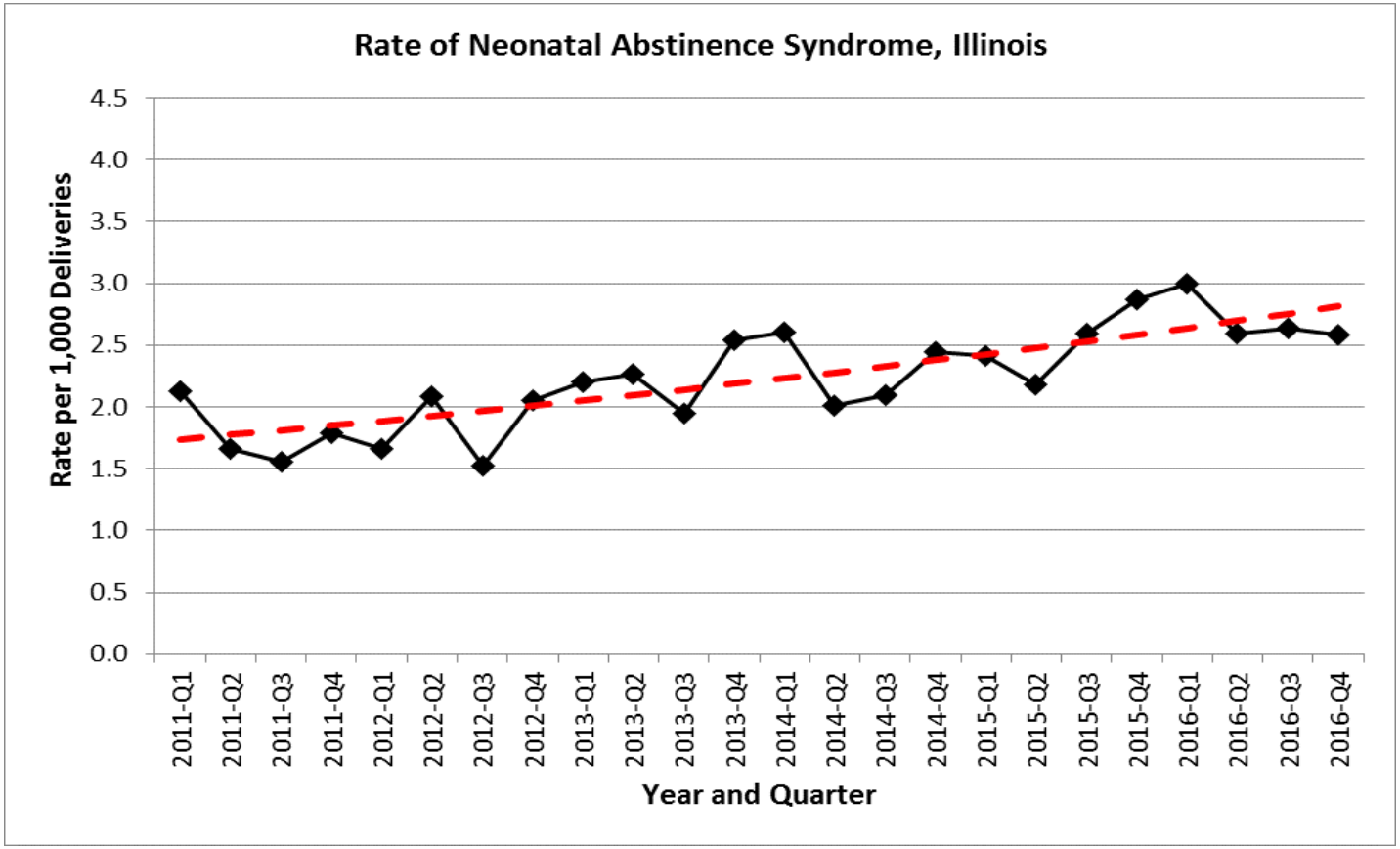

53% increase in rate of NAS from 2011 – 2016

NAS rate increased 2.1% per quarter from 2011-2016

The Faces of OUD

IT CAN HAPPEN TO ANYONE

"Opioid use disorder (OUD) is a chronic treatable brain disease that can be managed successfully by combining mediations with comprehensive care and recovery support, which enables those with OUD to regain control of their health and their lives."

In 2014, an estimated 1.9 million people had an OUD related to prescription pain relievers and an estimated 586,000 had an OUD related to heroin use.

ILPQC Mothers and Newborns affected by Opioids (MNO)

Screening and Linkage to Care | Optimizing Care for Moms/Babies | Prevention

Initiative AIMs

- **Increase** pregnant women affected by opioids **identified, linked to care** prenatally and **receiving Medication Assisted Treatment** (MAT) for opioid disorder at delivery
- Optimize clinical care of pregnant women with OUD through **patient and provider education & implementation of care checklists**
- **Increase non-pharm care** and **decrease pharmacologic treatment** in opioid exposed newborns (OENs)
- **Increase breastfeeding rates** in mothers and newborns affected by opioids at infant discharge
- **Increase safe and optimized discharge plans** for OENs
- Optimize **prevention of OUD** through provider and patient education, provider compliance with PMP lookup, and implementation of clinical guidelines for strategies to reduce opioid over-prescribing after delivery

- 107 hospitals participating in the MNO OB & Neonatal Initiative
  - 101 MNO-OB Hospital QI Teams
  - 88 MNO-Neo Hospital QI Teams
- Facilitated monthly MNO-OB & Neo collaborative learning webinars with ~150 participants/call
- Paper & Online MNO-OB & Neonatal QI toolkit for teams including sample protocols, guidelines, and patient & provider education

Our Goals for MNO

1. **Increase validated screening and linkage to MAT for mothers with opioid use disorder**
   - Implementation of universal OUD screening & documentation
   - Ensure standard SBIRT protocol response for all screened positive women
   - Mapping of available local MAT/OUD Resources Mapping Tool and resources and standardize process to link pregnant and postpartum women to MAT/ support services,

Our Goals for MNO

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2. Optimizing care for mothers and newborns affected by opioids.

- Implement standardized provider and nurse education on OUD screening, the OUD protocol, and stigma/bias
- Standardize patient education on OUD, MAT, Naloxone, NAS, and the importance of breastfeeding and engaging moms in the opioid exposed newborns care
- Implementation of an OUD clinical care check list: such as offering Narcan/Naloxone, Hep C screening, standard consults to optimize prenatal care, delivery, and postpartum care for moms with OUD
- Neo Teams Improve outcomes for opioid exposed newborns (OENs) through key interventions: standardized identification and assessment of OENs, increased maternal participation in OENs newborn care, optimize non-pharmacologic newborn care, standardize pharmacologic treatment, and develop standard safe discharge plans.

Our Goals for MNO

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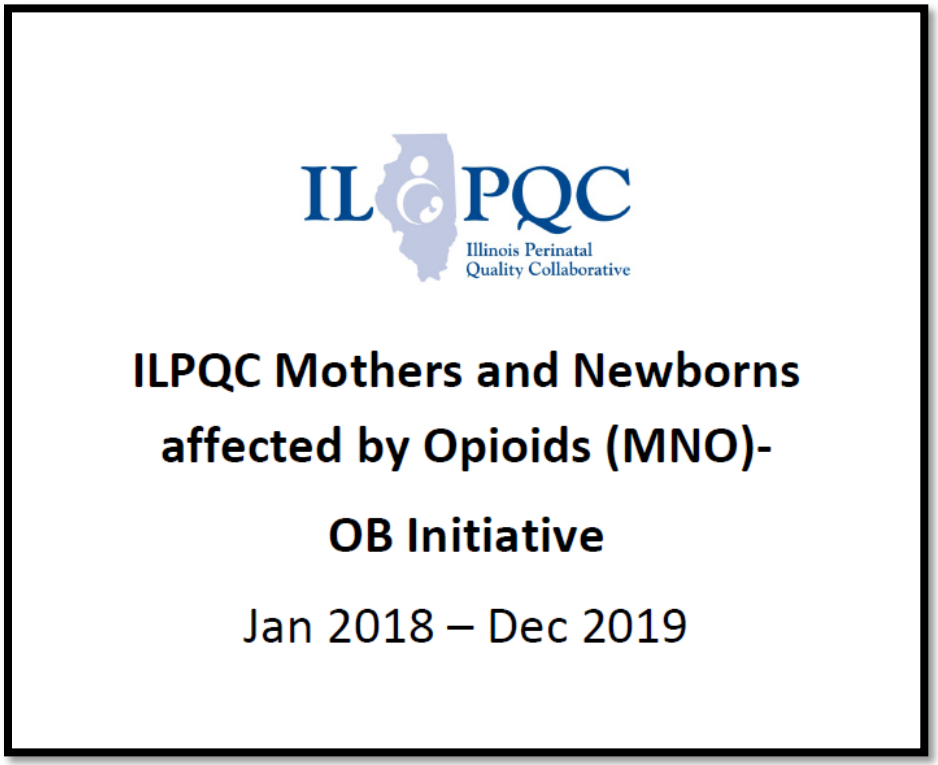
3. Prevent opioid use disorder (OUD)

- Systems changes to reduce the number of opioids prescribed for routine deliveries
- Increase documentation of IL PMP look up by providers prior to prescribing opioids
- Provide education on OUD prevention for providers, staff and pregnant women

Getting Started with MNO

- Jan-April 2018 Wave 1 Teams (XX) evaluated data form, trialed data collection strategies, provided feedback
- April 2018 kick-off 2 hour webinar to introduce MNO Initiative to teams statewide
- May 2018 Face to Face Meeting Springfield: > 300 participants, > 100 hospital teams, storyboards, toolkit launch, patient education materials, breakout sessions, leaders from other state PQC's share strategy
- June 2018 Monthly team webinars start: education, data review, clinical / QI leaders other states, Team Talks
- Baseline data collection 4th quarter 2017 due 8/15/18
- July 2018 Teams start monthly data collection



MNO-OB TOOLKIT

WEB VERSION AVAILABLE

WWW.ILPQC.ORG

OB Toolkit Sections

- Introduction
- Initiative Resources
- Mothers and Newborns Affected by Opioids Slide Set
- National Guidance: ACOG Committee Opinions

Screening & Linkage to Care

- Screening and assessment of pregnant women with OUD
- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- Improve Linkage to Addiction Care

Optimizing Clinical Care for Pregnant/Postpartum Women with OUD

- Example Protocols/Best Practice Recommendations/Checklists for Prenatal-Intrapartum-Postpartum Care of Women with OUD
- Counseling & Prescribing Naloxone/Narcan
- Additional Resources to Optimize Care of Women with OUD
- Education Materials for Pregnant Women with OUD

OB Toolkit Sections (cont.)

Prevention of OUD

- Patient and Provider Education for OUD Prevention
  - Patient education for all pregnant women
  - Provider/nursing/staff education on OUD
- Clinical guidelines/strategies to reduce opioid over prescribing postpartum
- Overview of new Illinois state law on ILPMP lookup

Education Materials for Pregnant Women with OUD

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- Pregnancy and MAT one-pager
- Are you in treatment or recovery
- NAS What you need to know one-pager
- NAS Booklet

State of Illinois
Illinois Department of Public Health

Prescription Pain Medicine, Opioids, and Pregnancy:
What All Pregnant Women Need to Know

What are opioids?

Opioids are a class of drugs that includes prescription pain relievers such as oxycodone and hydrocodone, the illegal drug heroin, and dangerous synthetic opioids such as fentanyl, carfentanil, and other analogues. Opioids work in the brain to reduce pain and can also produce feelings of relaxation and euphoria.

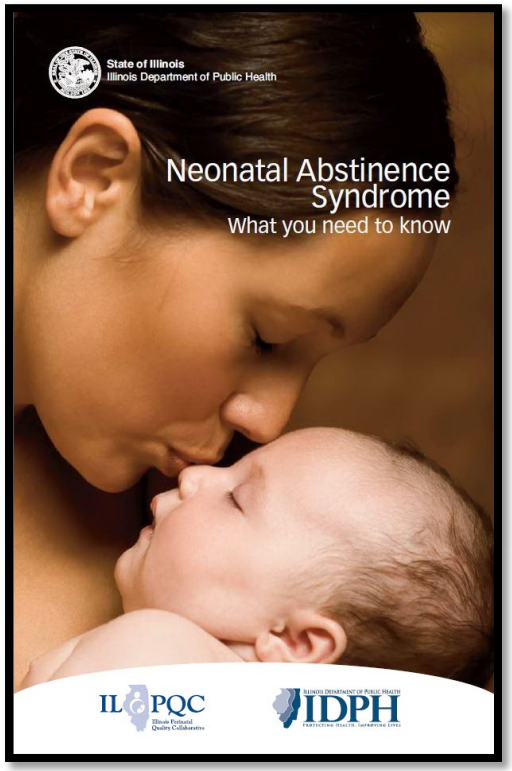
Prescribed opioids include:

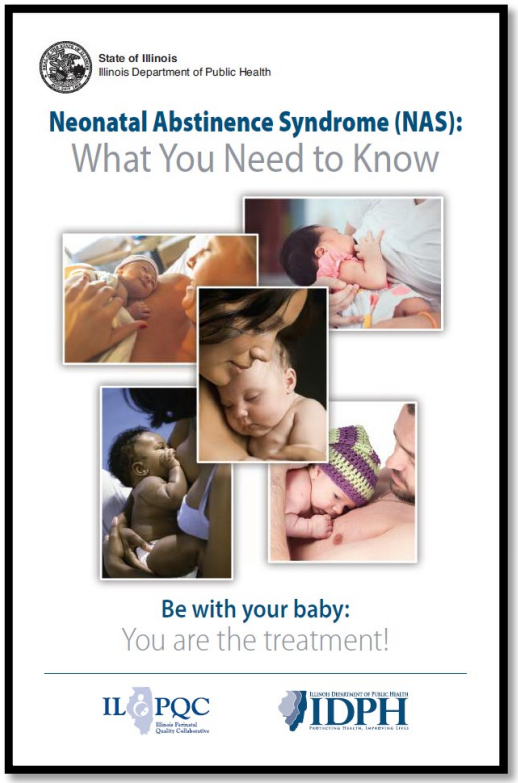
- Buprenorphine (Belbuca, Buprenex, Butrans)
- Codeine
- Fentanyl (Actiq, Duragesic, Sublimaze)
- Hydrocodone (Lorcet, Lortab, Norco, Vicodin)
- Hydromophone (Dalaudid, Exalgo)
- Meperidine (Demerol)
- Methandone (Dolophine, Methadose)
- Morphine (Astramorph, Avinza, Duramorph, Roxanol)
- Oxycodone (OxyContin, Percodan, Percocet)
- Oxymorphone (Opana)
- Tramadol (ConZip, Ryzolt, Ultram)

Your doctor may prescribe an opioid for you if you've had surgery, dental work, an injury, or after you deliver your baby. Prescription opioids are important pain medications that can provide relief for acute or chronic pain. Unfortunately, they can also be prescribed inappropriately and misused. Misuse or chronic use of prescription opioids increases the risk of developing opioid use disorder (OUD) and may lead to overdose. If you take opioids during pregnancy they can also cause serious problems for your baby.

What is opioid use disorder?

Opioid can be dangerous and addictive. Symptoms of opioid use disorder include developing a need for higher doses in order to feel the same effect; using more than the amount of the drug that is prescribed; taking non-prescribed opioids such as heroin; having work, school, of family problems caused by your opioid use; feeling a strong urge or desire ("craving") to use the drug; and experiencing painful withdrawal symptoms if you abruptly stop taking opioids. Taking higher doses of opioids or using opioids for extended periods of time increases the risk of developing OUD.





AIM Bundle and Resources

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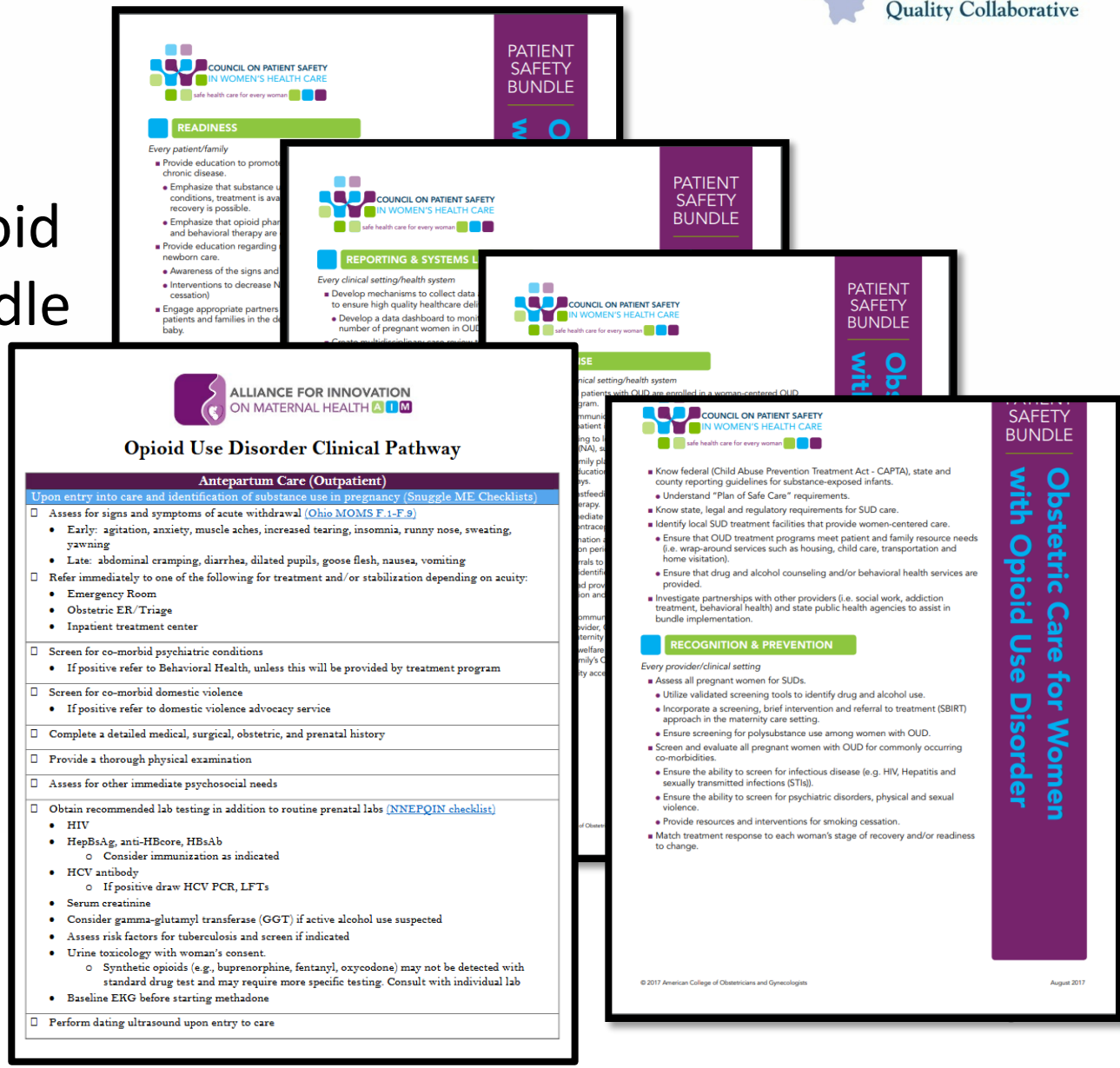
- Obstetric Care for Women with Opioid Use Disorder Bundle and Resources Listing
- OUD Clinical Pathway



MNO-OB work so far...

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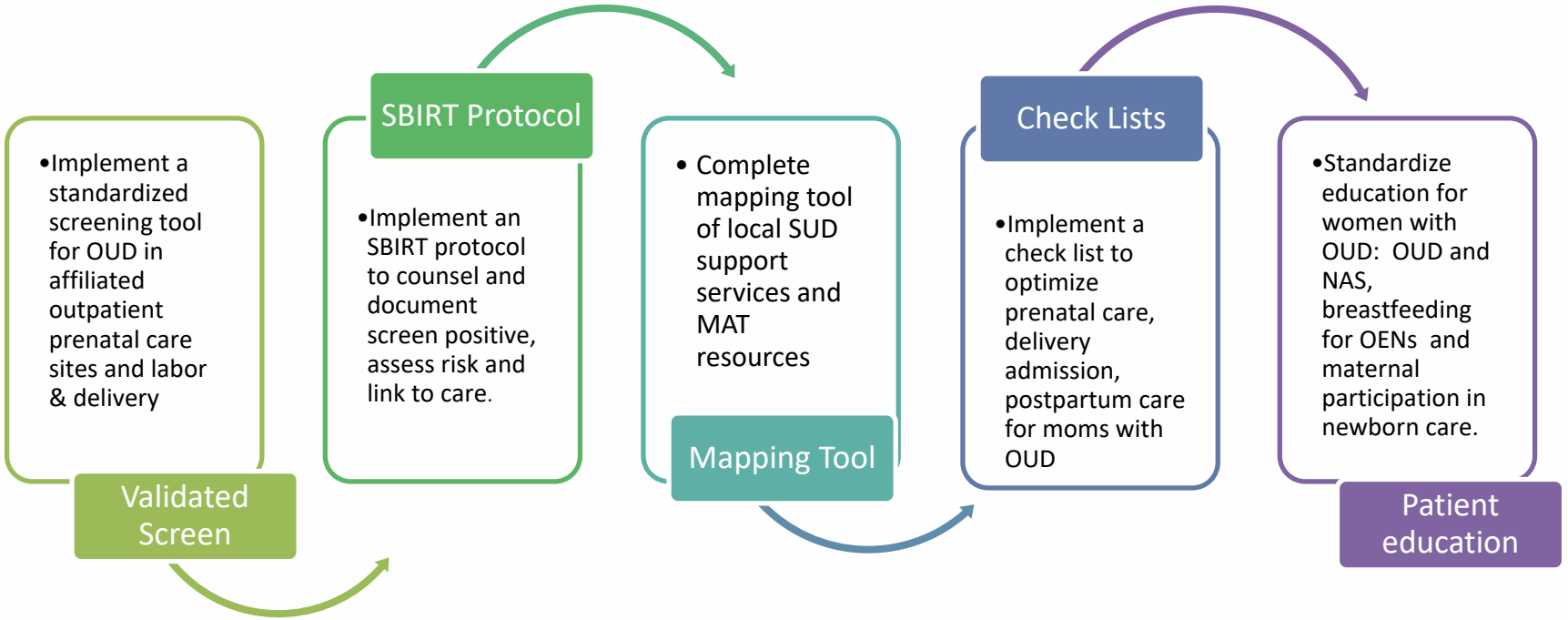

Stigma, Bias, and Trauma Informed Care

Standardize a process to systematically educate providers, nurses and staff on stigma, bias and trauma informed care

MNO-OB in 2018: Making Change Happen

Key QI Strategies

- Implement universal screening and documentation (prenatal/L&D)
- Ensure standard SBIRT protocol response for all screen positive
- Complete and share Mapping Tool to identify local resources for MAT/ SUD support services & standardize process for linking patients to care
- Implement OUD Clinical Care Checklist (prenatal / L&D medical record)
- Standardize patient education on OUD & NAS, and importance of participation in newborn care
- Complete Provider/Nurse Training on stigma and bias, screening, SBIRT, clinical care checklist and activating the OUD Protocol

OUD Protocol: Activate for every screen positive patient

Screen and document positive result

Provide SBIRT risk assessment and brief counseling re: benefits of treatment, next steps for linking patient to care

Activate care coordination and navigation to link woman to MAT, addiction services and behavioral health support

Insert and complete OUD clinical care checklist in electronic medical record (or paper chart) (prenatal / L&D)

Provide patient education re: OUD and NAS, and engaging in newborn care via neonatology consult, counseling, hand-outs.

THE CHALLENGE

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Barriers to treatment

- **Prenatal provider lacks experience and process for linking to MAT providers**
- **Limited MAT providers near by**
- Economic obstacles to entering and staying in treatment.
  - Cash only options
  - Insurance provider issues
- Accessibility to services:
  - Lack of flexible service times
  - Location to patient's home or work
  - Transportation issues to/from clinic
- Threat of legal sanction – child custody.
- Lack of affordable child care.
- Oppositions for entering treatment from family/friends.
  - Partner substance abuse
  - Lack of support systems
- Caretaker role for dependent family.

Maintenance MAT

HELPING OUR PATIENTS NAVIGATE TO TREATMENT

Map local resources for MAT providers and SUD support services

Establish process flow to link all patients with OUD to care

Expand the number of Buprenorphine providers

Maintenance MAT

MNO Teams Track Key Measures

- Monthly Data (by the 15th of the following month)
  - **OB Teams**
    - All women with OUD collect process outcomes and measures
    - Random sample of 10 charts from all deliveries to collect % of patients screened for OUD
  - **Neo Teams**
    - All opioid exposed newborns
  - **All teams:**
    - Structure measures to track our QI work: screening tool and SBIRT implementation, patient and provider education, protocol implementation, mapping resources, process flow, etc.
    - Red / yellow / green (haven't started / working on / implemented)

MNO-OB Project Aims

By December 2019, for all pregnant/postpartum women with OUD across participating hospitals:	Goal
Increase proportion of all pregnant women screened with a universal validated screener during prenatal period / during delivery admission	≥ 80%
Increase proportion of women with OUD receiving MAT prenatally or by delivery discharge	≥ 70%
Increase proportion of women with OUD connected to Behavioral Health Counseling/Recovery Services prenatally or during delivery admission	≥ 80%
Increase proportion of women with OUD with an OUD clinical care checklist completed prenatally or during delivery admission	≥ 70%
Increase proportion of women with OUD receiving: Narcan, contraception plan, Hep C screen, behavioral health /social work consult, prenatally or during delivery admission	≥ 70%
Increase proportion of women with OUD receiving pediatric / neonatal consult, on NAS and role in non-pharmacologic newborn care, prenatally or during delivery admission	≥ 70%
Increase proportion of women with OUD receiving OUD/NAS education, prenatally or during delivery admission	≥ 80%

MNO-OB Baseline Data (Q42017) Opportunities for Improvement

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3%
Women with screening documented prenatally and on L&D

2.6%
Narcan counseling and prescription

53.7%
Of mothers and newborns roomed together during maternal hospitalization

40%
Women with OUD on MAT at delivery

40.7%
Hep C screened and documented

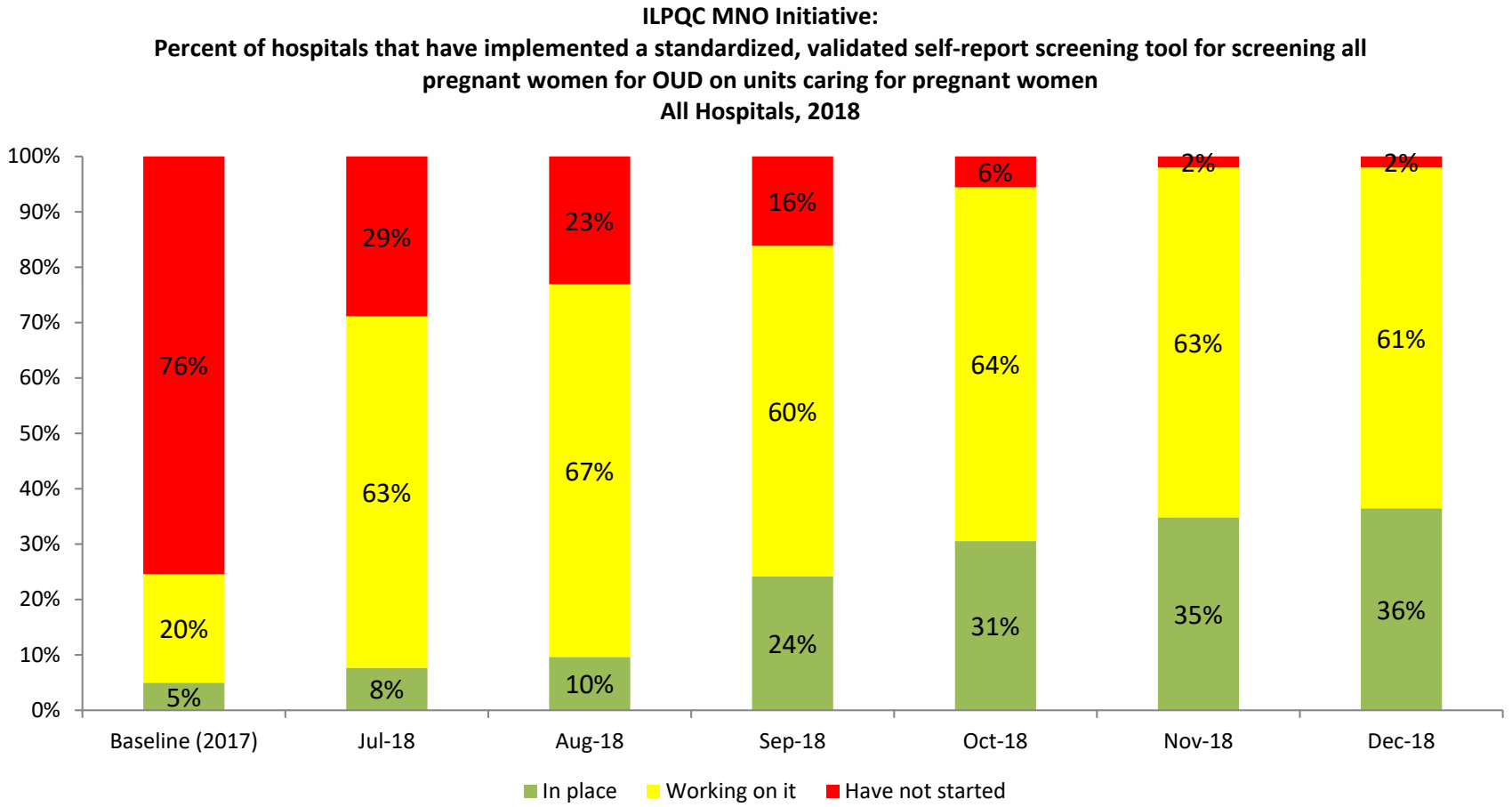
56.2%
Eligible mothers with OUD breastfeeding/providing breastmilk during maternal hospitalization

Screening & Linkage to Care

Clinical Care Checklist

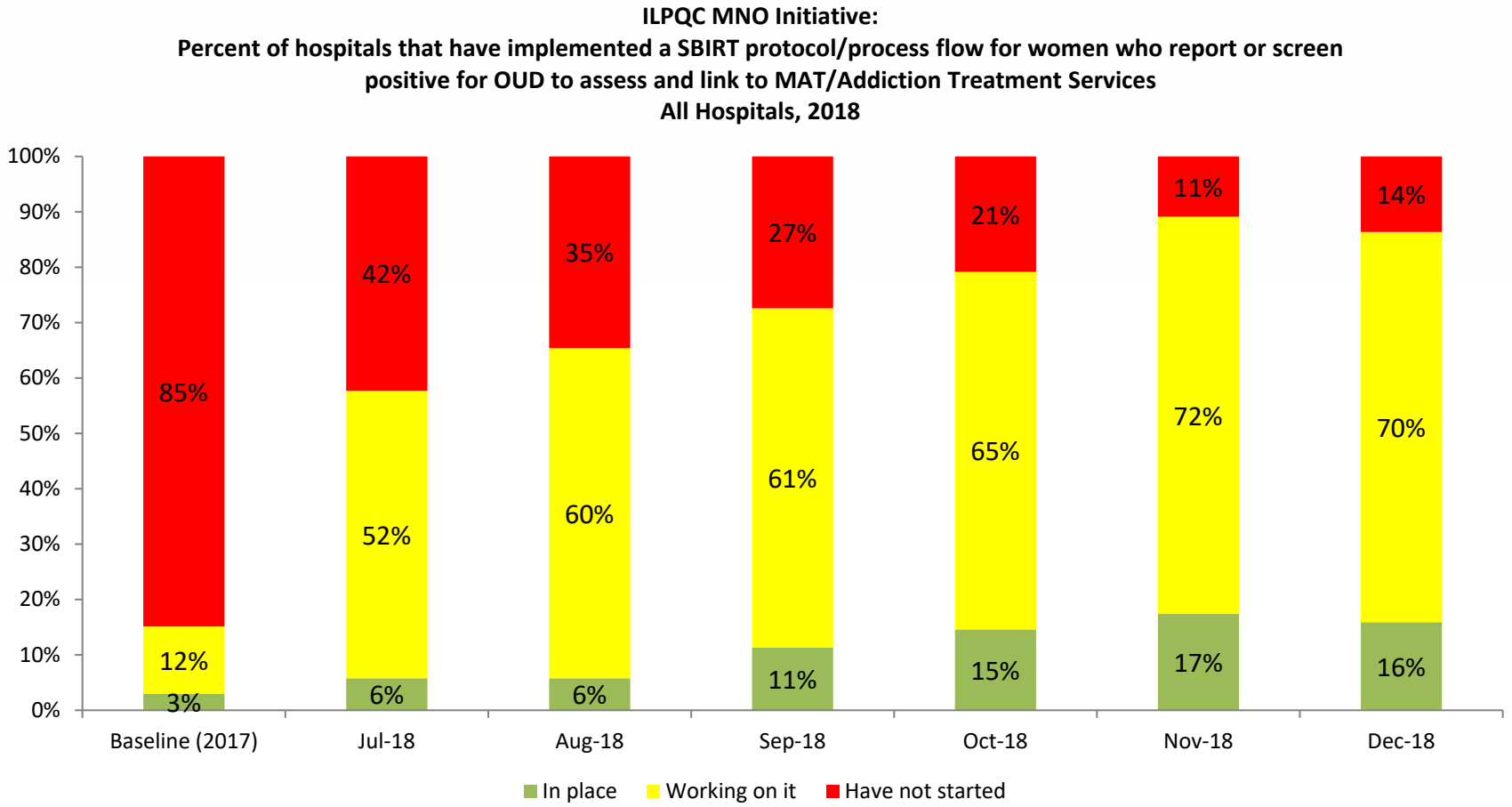
Engaging Moms in Care

Screening & Linkage to Care: Standardized Screening Tool on L&D (Structure Measure)



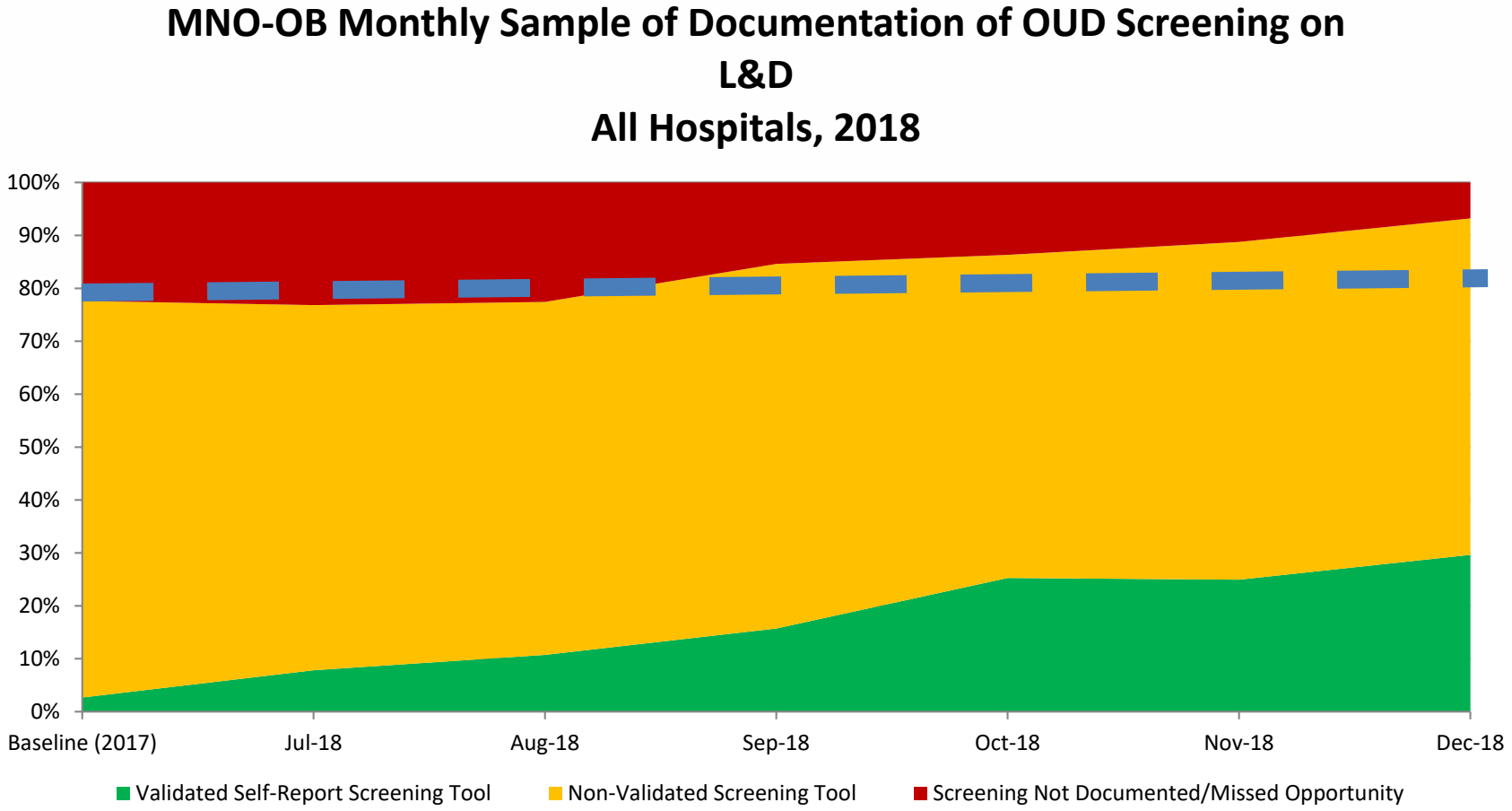
AIM: Increase proportion of all pregnant women screened with a universal validated screener on L&D

Screening & Linkage to Care: Standardized SBIRT (Structure Measure)



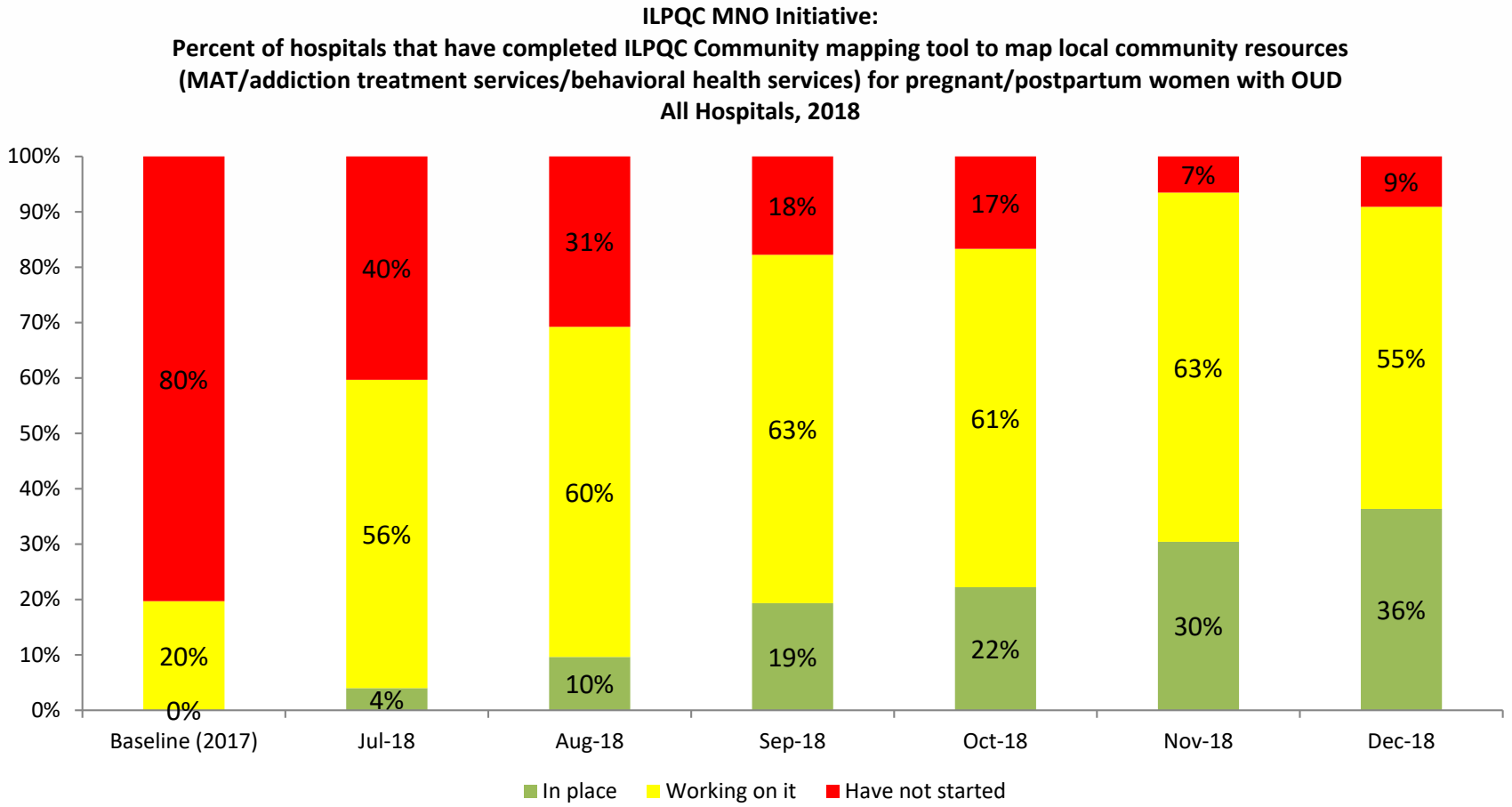
AIM: Increase proportion of women with OUD receiving MAT and Behavioral Health Counseling/Recovery Services prenatally or by delivery discharge

Screening & Linkage to Care: Sample of Documentation of Screening for OUD on L&D

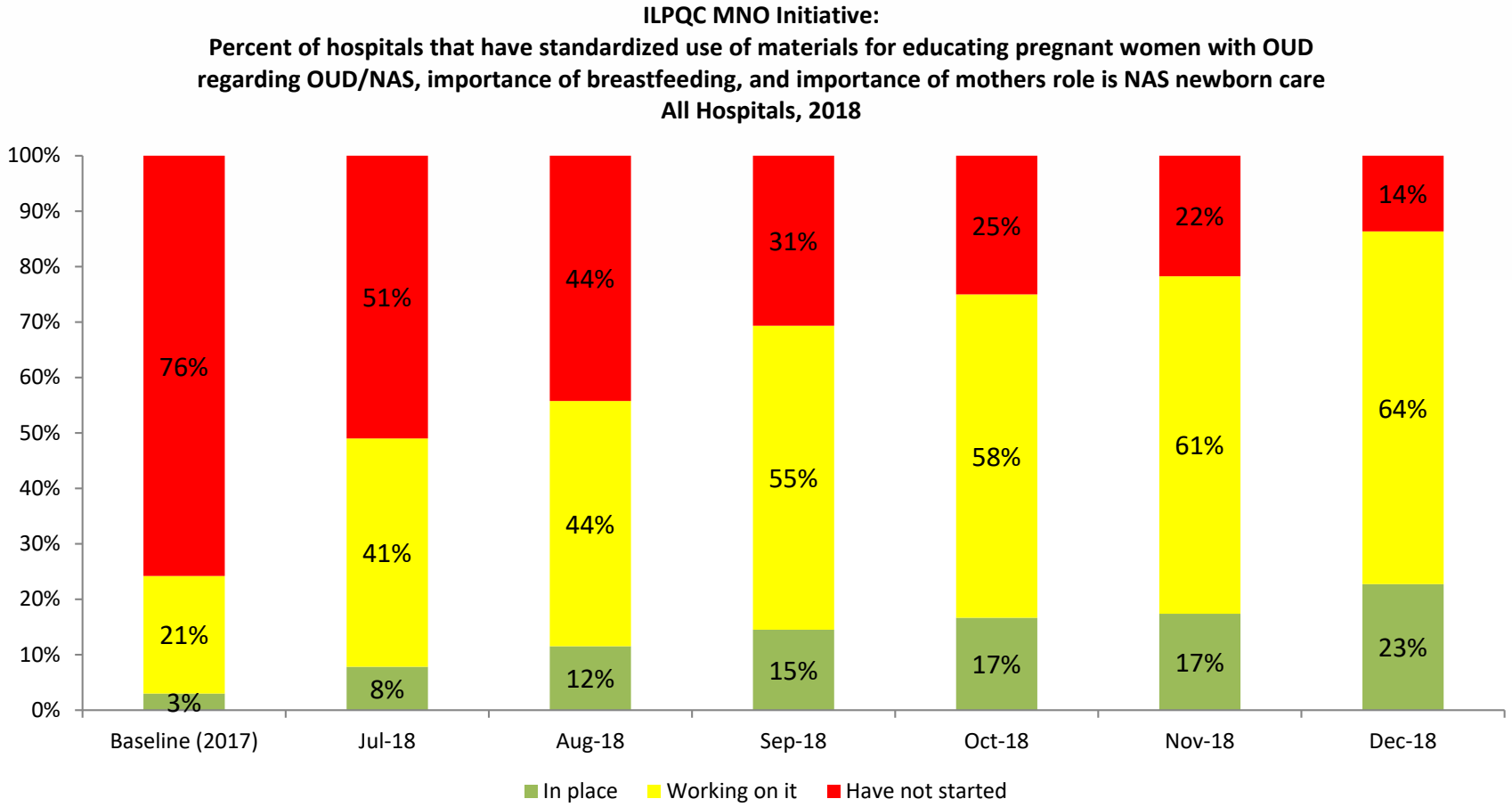


BENCHMARK = ≥ 80%

Screening & Linkage to Care: Mapping Community Resources (Structure Measure)



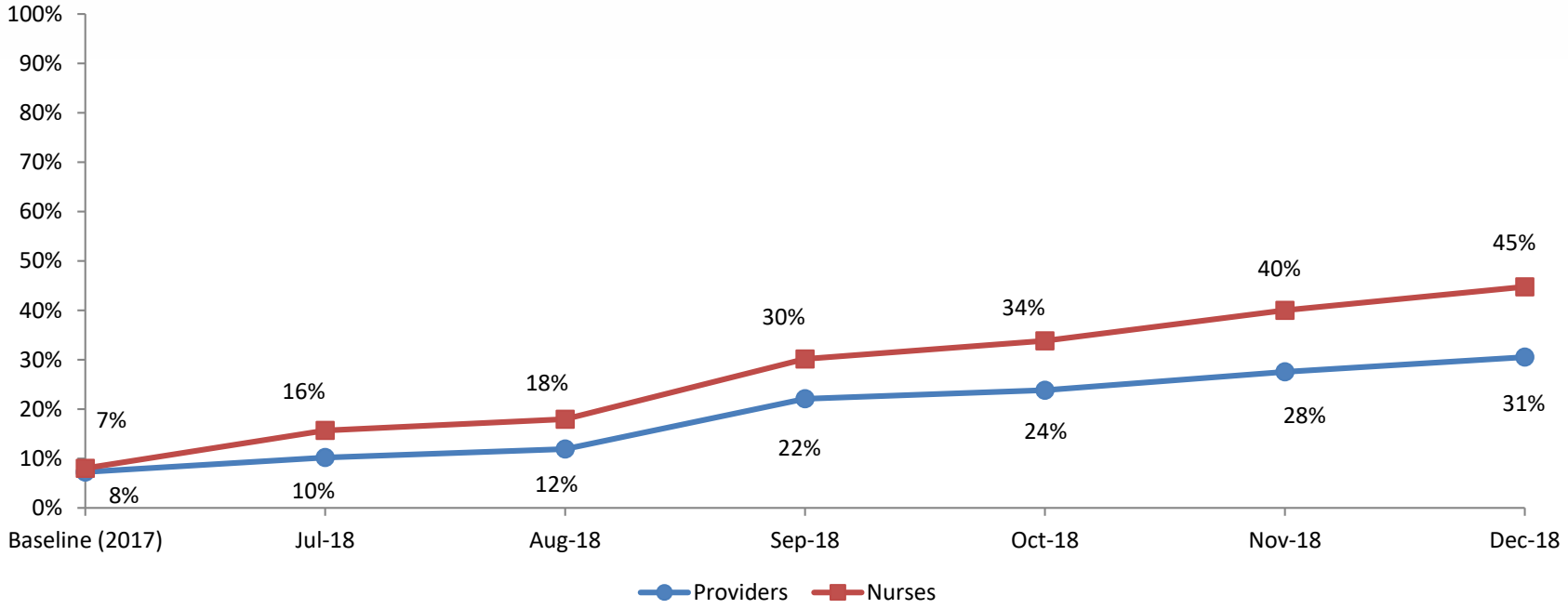
Optimizing Care: Standardized Education for Women with OUD (Structure Measure)



AIM: Increase proportion of women with OUD receiving OUD/NAS education prenatally or during delivery admission

Optimizing Care: Cumulative Provider & Nursing Education on OUD care protocols (Structure Measure)

ILPQC MNO Initiative:
Average cumulative proportion of providers and nurses educated on OUD care protocols (including stigma & bias)
All Hospitals, 2018



MNO in 2019

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Key Strategies

- Screening
- SBIRT
- Mapping
- Checklist
- Education

Covered in 2018

How do we begin to make progress?

Strategies to review in 2019

- Build trust / reduce stigma
- Improve patient navigation for MAT and support services
- Improve engaging providers in checklist / clinical care
- + Buprenorphine prescribing
- Standard system wide response for screen positive (OUD protocol)

Work towards goals in 2019

- Increase # of women screened & linked to care
- Increase # of women on MAT
- Increase # women with completed checklist
- Increase # women engaged in Opioid exposed newborn Care

ILPQC Immediate Postpartum LARC Initiative

Aims: Empower women with information and improved access to effective contraception before discharge home after delivery

to reduce short interval and unintended pregnancies linked with adverse MCH outcomes

Key Goals:

1) Increase % of women with prenatal comprehensive contraceptive counseling and documentation
2) Increase % of providers/ nurses trained to provide IPLARC
3) Increase % of hospitals who have completed key steps needed to provide IPLARc
4) Achieve GO LIVE goal to provide IPLARC for Wave 1 hospitals by March 2019

Consequences of Unplanned Births and Short Interval Pregnancy

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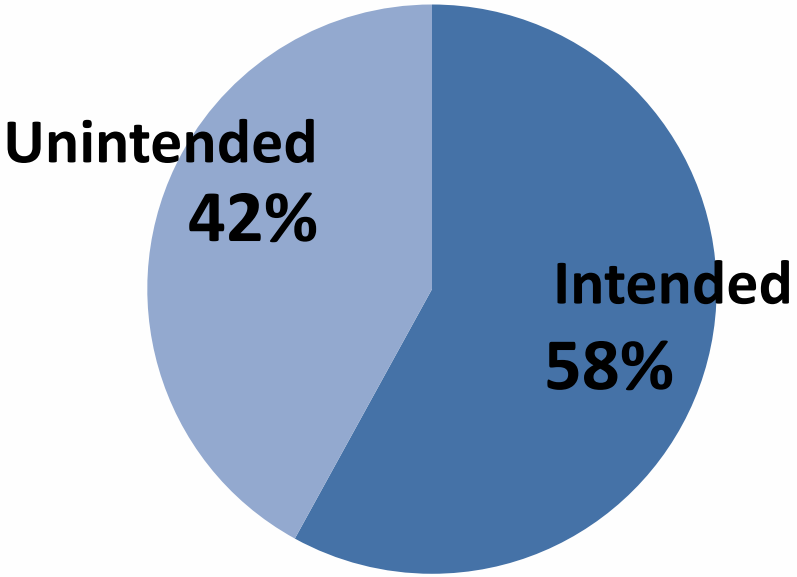
Of the 158,522 total births in IL in 2014:



50% of IL births covered by Medicaid

Consequences of Unplanned Pregnancies

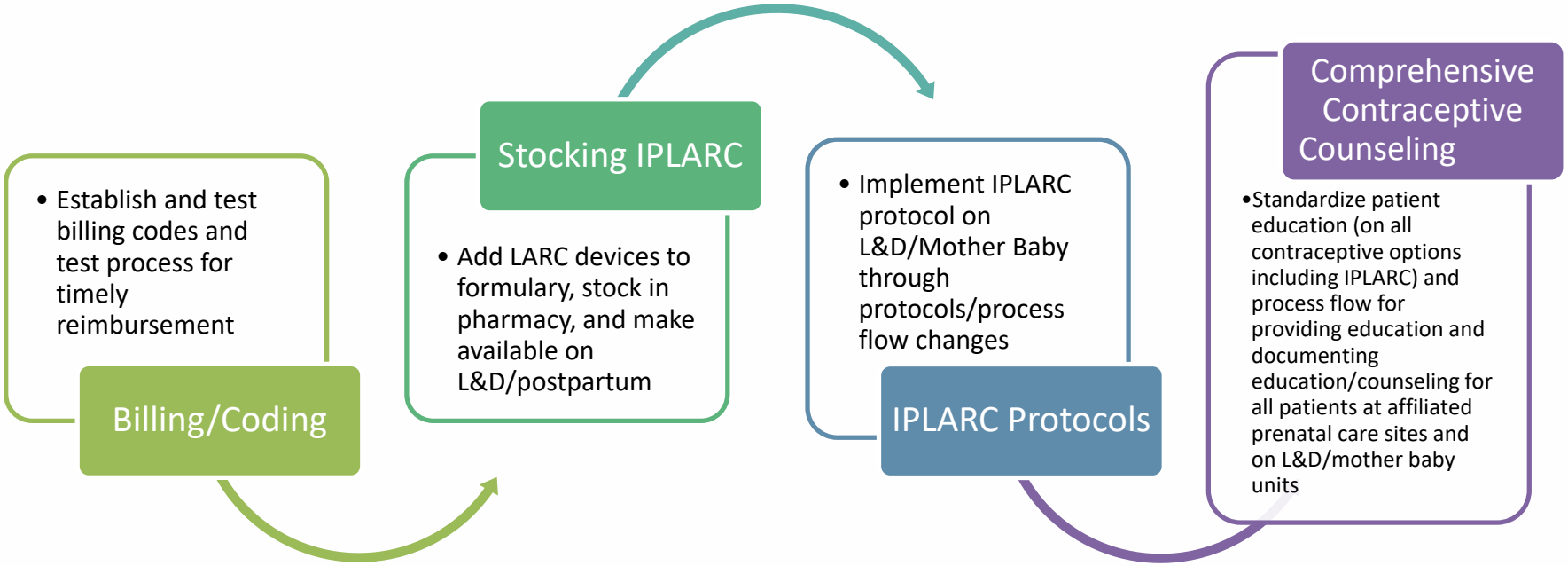
- Poor pregnancy outcomes
- Delayed initiation of prenatal care
- Lower breastfeeding rates
- Higher risk of maternal depression and potential future child maltreatment

Consequences of Short Interpregnancy Interval

Higher risk of poor maternal and infant outcomes: Preterm birth, low birthweight, preeclampsia

ILPQC IP LARC Initiative Goals

IPLARC Wave I work so far…



GO LIVE by March 2019

IPLARC on Formulary

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Percent of Hospitals with Inpatient **IUDs** Available on Hospital Formulary

Percent of Hospitals with Inpatient **Implants** Available on Hospital Formulary

IPLARC Wave II

ILPQC Illinois Perinatal Quality Collaborative

We want YOUR HOSPITAL to join Wave 2 of ILPQC's Immediate Postpartum LARC Initiative!

- Receive a IPLARC Wave 1 hospital mentor to provide guidance as your hospital implements IPLARC
- Access to IPLARC rapid-access DASHBOARDS!
- Learn about hot topics on monthly collaborative webinars, including billing & coding, stocking, etc.!
- *Opportunities to participate in IPLARC Alternative Strategies focusing on universal early postpartum follow up visits for maternal health and safety check and access to family planning

Upcoming IPLARC Training Opportunities

- We're working with ACOG to offer 3 IPLARC trainings in 2019:

Postpartum Contraceptive Access Initiative

Improving Postpartum Access to Care (IPAC)

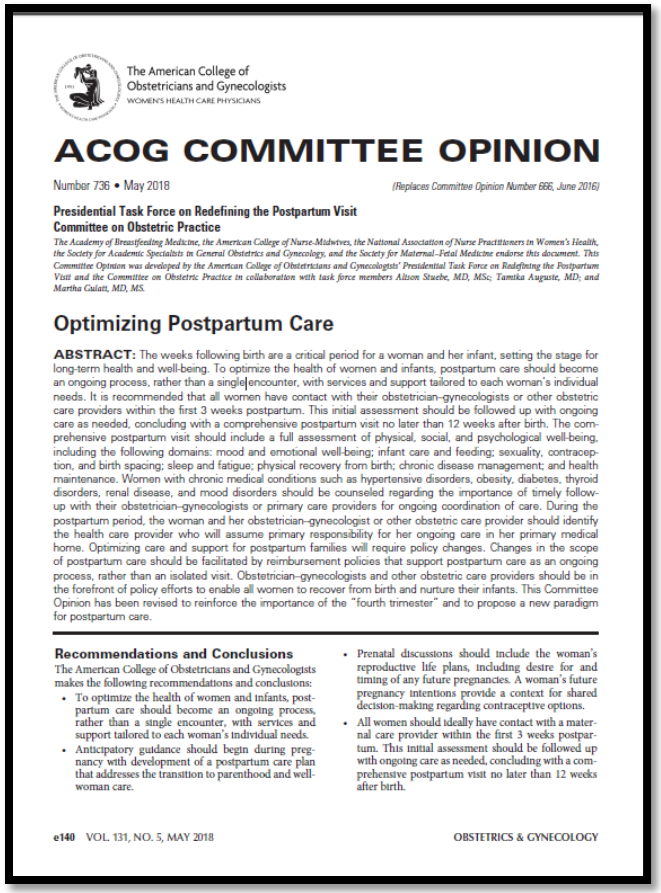
- Pathway for hospitals that do not provide contraception to participate in increasing access to early postpartum care
- Goal universal early postpartum visit at 2 wks
- ACOG committee opinion #736 and MMRC Report

Redefining Postpartum Care

Illinois Perinatal Quality Collaborative

ACOG Committee Opinion #736:

- To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter
- All women should ideally have contact with maternal care provider within the first 3 weeks postpartum
  - Blood pressure checks
  - Breastfeeding support
  - Mental health well-being
  - Contraception
- Initial assessment should be followed up with ongoing care as needed
- Conclude with a comprehensive postpartum visit NO LATER than 12 after birth



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 736 • May 2018 (Replaces Committee Opinion Number 666, June 2016)

Presidential Task Force on Redefining the Postpartum Visit
Committee on Obstetric Practice

The Academy of Breastfeeding Medicine, the American College of Nurse-Midwives, the National Association of Nurse Practitioners in Women's Health, the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal-Fetal Medicine endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice in collaboration with task force members Alison Stuebe, MD, MSc; Tamika Auguste, MD; and Martha Gulati, MD, MS.

Optimizing Postpartum Care

ABSTRACT: The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs. It is recommended that all women have contact with their obstetrician-gynecologists or other obstetric care providers within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their obstetrician-gynecologists or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her obstetrician-gynecologist or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit. Obstetrician–gynecologists and other obstetric care providers should be in the forefront of policy efforts to enable all women to recover from birth and nurture their infants. This Committee Opinion has been revised to reinforce the importance of the "fourth trimester" and to propose a new paradigm for postpartum care.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.
- Anticipatory guidance should begin during pregnancy with development of a postpartum care plan that addresses the transition to parenthood and well-woman care.
- Prenatal discussions should include the woman's reproductive life plans, including desire for and timing of any future pregnancies. A woman's future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.
- All women should ideally have contact with a maternal care provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.

e140 VOL. 131, NO. 5, MAY 2018 OBSTETRICS & GYNECOLOGY

ILPQC Maternal Hypertension Initiative

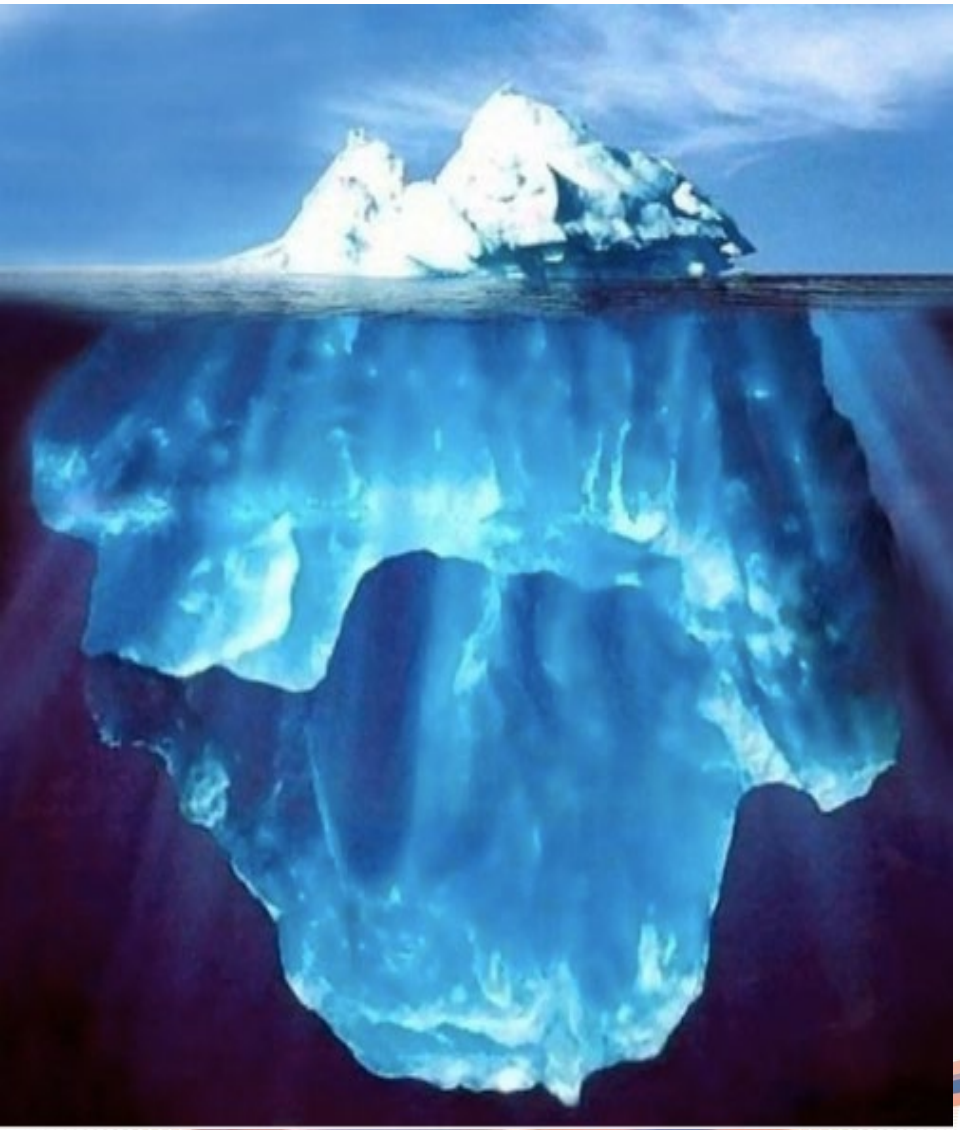
Aim: Reduce the rate of severe morbidities in women with severe preeclampsia, eclampsia, or preeclampsia superimposed on pre-existing hypertension by 20% by December 2017

Approach: 4 key goals

1. **Reduce time to treatment**
2. **Improve postpartum patient education**
3. **Improve postpartum patient follow up**
4. **Improve provider & RN debrief**

- 110 hospital teams - May 2016 kick off to December 2017
- 106 Hospitals submitted data for over 17,000 women who experienced severe maternal HTN across the initiative
- Sustainability started January 2018
- 86 teams have submitted sustainability data

Critical Pathways to Poor Outcomes



Maternal Death

Near Miss ICU Admission

Serious Morbidity

- Clinical Symptoms Not Recognized
- Delayed Diagnosis
- Delayed Treatment
- Assumption Delivery Fixes Problem
- Discharge without timely Follow-up

Project Aims

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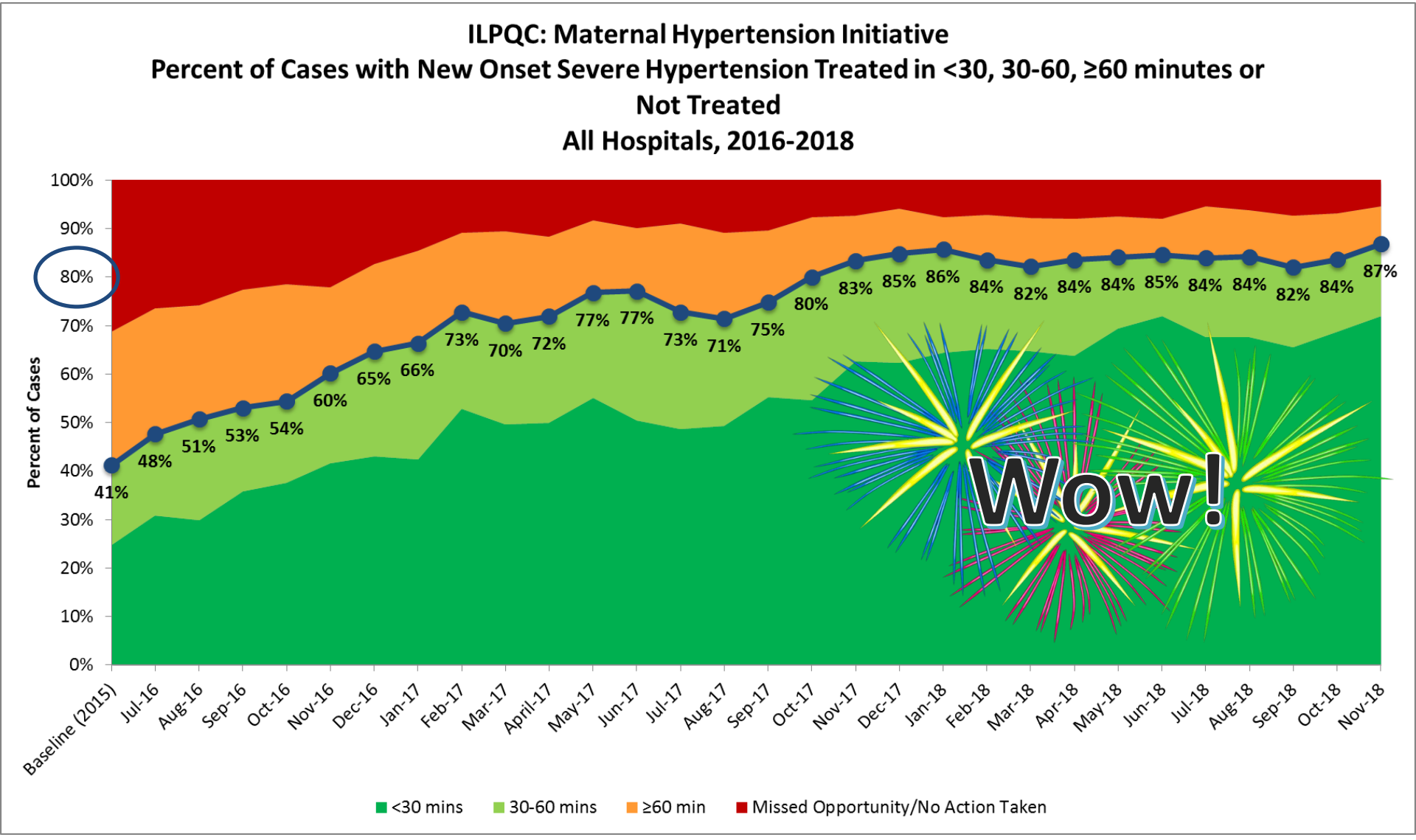
By December 2017, for all women with confirmed severe maternal HTN across participating hospitals:	Goal
Increase the proportion of women treated for severe HTN in < 60 minutes	≥ 80%
Increase the proportion of women receiving preeclampsia education at discharge	≥ 80%
Increase the proportion of women with follow-up appointments scheduled within 10 day of discharge	≥ 80%
Increase the proportion of cases with provider / nurse debriefs	≥ 50%
Reduce the rate of severe maternal morbidity (SMM)	↓20%

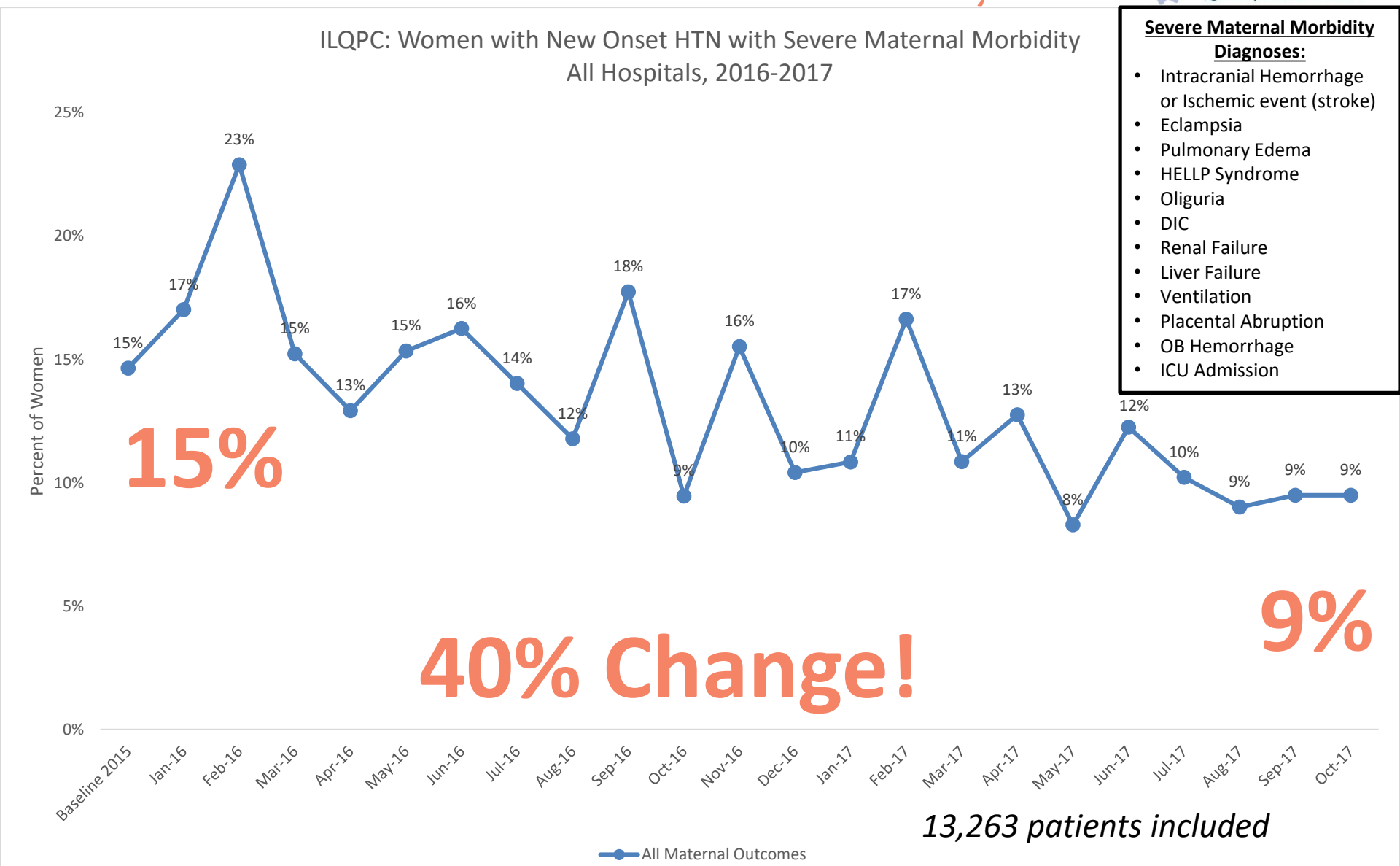
Maternal Hypertension Data: Time to Treatment

Illinois Perinatal Quality Collaborative



Maternal Hypertension Outcome Data: Severe Maternal Morbidity

Illinois Perinatal Quality Collaborative



Severe Maternal Morbidity Diagnoses:

- Intracranial Hemorrhage or Ischemic event (stroke)
- Eclampsia
- Pulmonary Edema
- HELLP Syndrome
- Oliguria
- DIC
- Renal Failure
- Liver Failure
- Ventilation
- Placental Abruption
- OB Hemorrhage
- ICU Admission

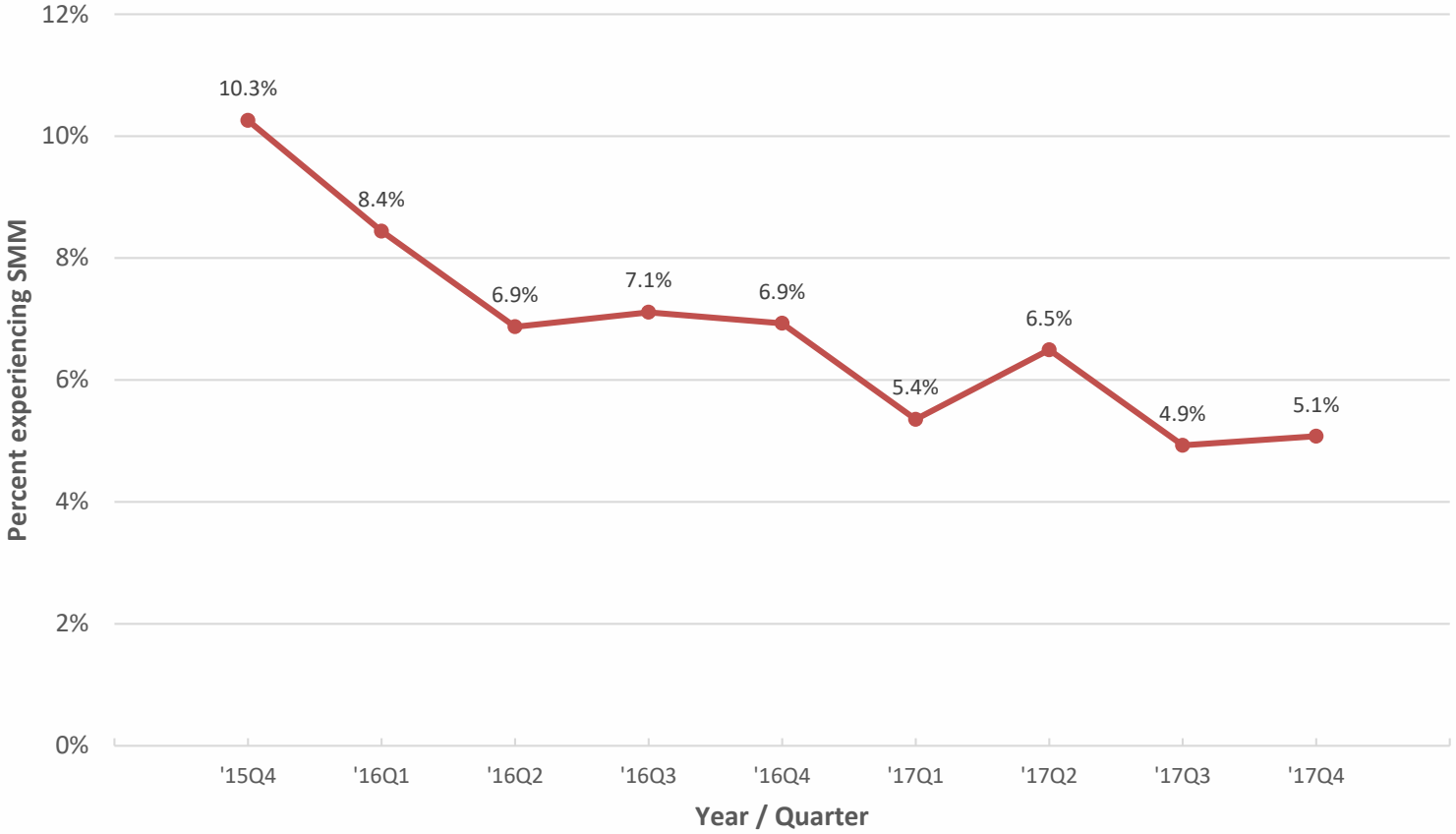
15%

9%

40% Change!

13,263 patients included

Severe Maternal Morbidity Rate Deliveries with Hypertension, Hospital Discharge Data, All Illinois Hospitals



Between 2015-Q4 and 2017-Q4, the SMM rate among women experiencing hypertension at delivery was cut in half.

ILPQC Support Strategies Hospital Teams Report Most Helpful

- ILPQC Hypertension Toolkit Binder
- Reviewing ILPQC Data Reports with Team
- AIM/ACOG Online E-Module Education
- May 2017 Face to Face Meeting
- Team Talks on monthly webinar

Additional QI Training Requested

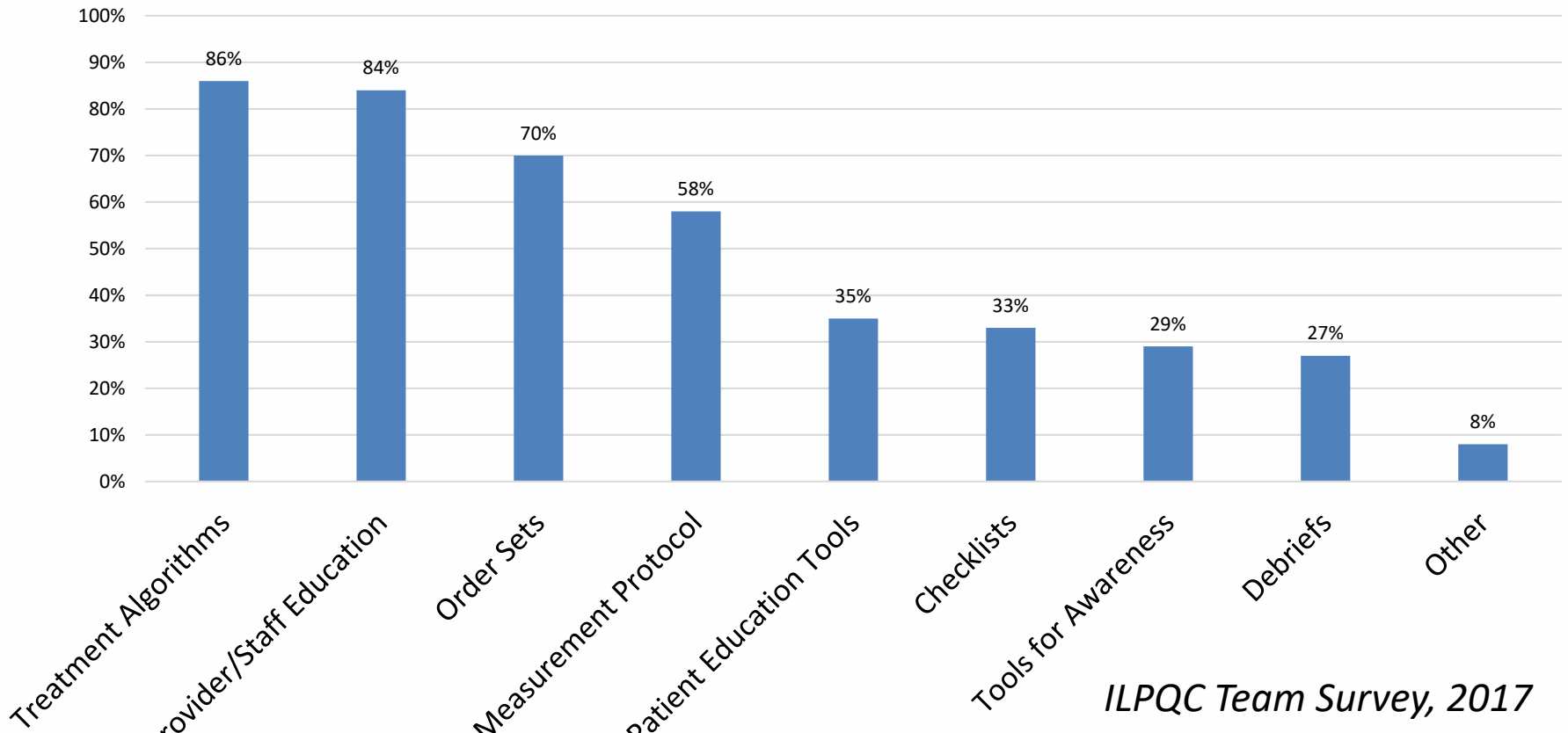
- Teamwork for Quality Improvement/TeamSTEPPS
- IHA's Model for Improvement

ILPQC Team Survey, 2017

Reducing Time To Treatment

Illinois Perinatal Quality Collaborative

Elements of Maternal Hypertensive Bundle Most Effective in Reducing Time to Treatment



ILPQC Team Survey, 2017

Achieving Initiative Goals with Team Recognition

ILPQC Quality Improvement Recognition Awards

GOLD

- ✓ Structure Measures
- \+
- ✓ <u>All 4</u> Process Measure goals met

SILVER

- ✓ Structure Measures
- \+
- ✓ <u>3 of the 4</u> Process Measure goals met

BRONZE

- ✓ Structure Measures
- \+
- ✓ <u>2 of the 4</u> Process Measure goals met

Award Criteria

Award Criteria for IL Maternal Hypertension Hospital Teams:

Structure Measures:

- Severe Maternal HTN Policies in place in all units (Implimentation Checklist question 1 A-C)
  - Standard protocols for early warning signs, updated diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia on L&D, Antepartum/Postpartum, Triage
- Provider & Nursing education: ≥80% of providers and nurses educated (AIM Quarterly Measures questions 2 A,B and 3 A,B)

Process Measures:

- Time to treatment ≤60 minutes: ≥80% of cases
- Debrief: ≥30% of cases
- Discharge education: ≥70% of cases
- Follow-up appointments scheduled within 10 days of discharge: ≥70% of cases

Hypertension Sustainability

- Compliance Monitoring
- New Hire Education
- Ongoing Staff/Provider Education

Compliance Monitoring in ILPQC Data System

- ❑Time to treatment severe HTN < 60 minutes
- ❑Magnesium provided
- ❑Early follow up for BP check within 7-10 days
- ❑Patient discharge education

"The Last Person You'd Expect to Die in Childbirth" Propublica/NPR May 12 2017

IL PQC Illinois Perinatal Quality Collaborative

https://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system

Quality Matters: every patient, every provider, every nurse, every unit every time.

Lauren Bloomstein: 33 year old healthy NICU nurse, wife, mom, severe HTN in labor, preeclampsia not diagnosed, severe HTN not treated, stroked and support withdrawn 20 hours after delivery.

Our Goals for 2019

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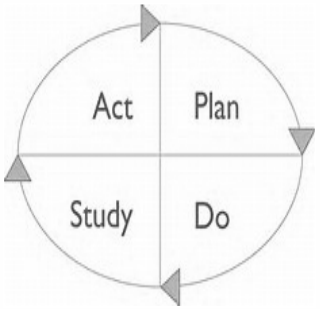
Ensure MNO & IPLARC initiative success for every hospital



Support strong hospital QI teams and expand QI capacity

Expand Immediate postpartum LARC for all IL hospitals

Support QI sustainability and compliance monitoring

Expand and engage stakeholders, patient/families, hospital teams for ongoing collaboration

Conclusion

- ILPQC is a collaborative of hospital teams working together to improve care and outcomes for IL moms and babies
- The collaborative is the teams of providers / nurses/patients and stakeholders who drive the initiatives with input from all
- ILPQC provides opportunities for collaborative learning, rapid response data and QI support
- Teams provide the magic of collaboration, belief in the importance of data, commitment to evidence based practice and the drive to do better together

Questions?

Email: info@ilpqc.org

Website: www.ilpqc.org

ILPQC
Illinois Perinatal Quality Collaborative

THANKS TO OUR SPONSORS

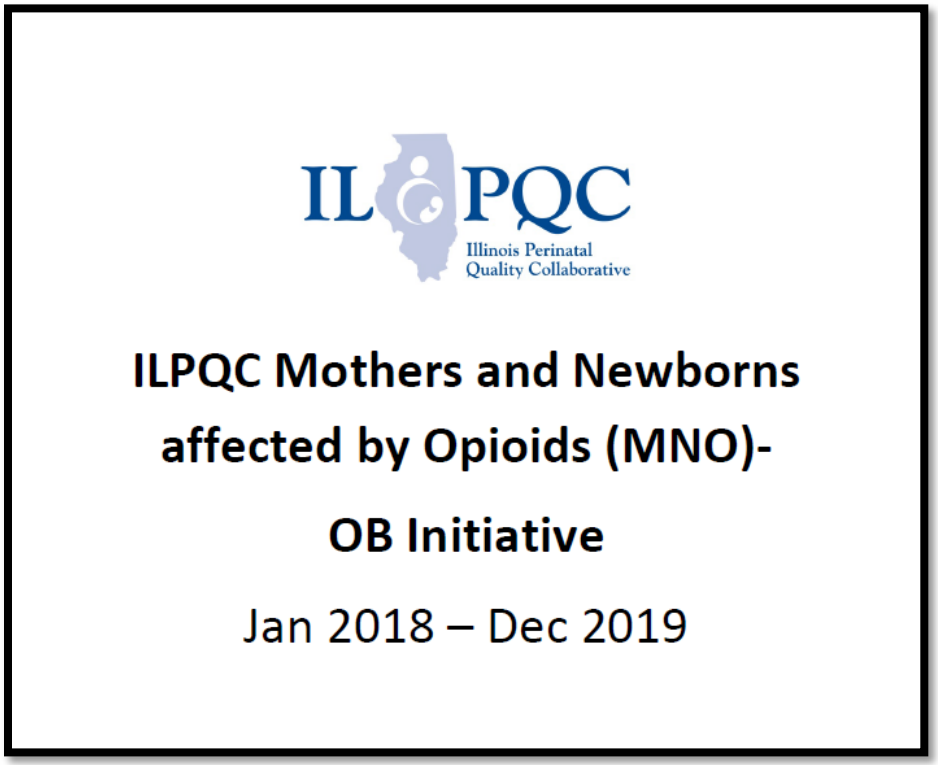
IDPH
Illinois Department of Public Health

CDC
Centers for Disease Control and Prevention

DHS
Illinois Department of Human Services

JB & MK PRITZKER
Family Foundation

Additional Slides



MNO-OB TOOLKIT

WEB VERSION AVAILABLE

WWW.ILPQC.ORG

OB Toolkit Sections

- Introduction
- Initiative Resources
- Mothers and Newborns Affected by Opioids Slide Set
- National Guidance: ACOG Committee Opinions

Screening & Linkage to Care

- Screening and assessment of pregnant women with OUD
- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- Improve Linkage to Addiction Care

Optimizing Clinical Care for Pregnant/Postpartum Women with OUD

- Example Protocols/Best Practice Recommendations/Checklists for Prenatal-Intrapartum-Postpartum Care of Women with OUD
- Counseling & Prescribing Naloxone/Narcan
- Additional Resources to Optimize Care of Women with OUD
- Education Materials for Pregnant Women with OUD

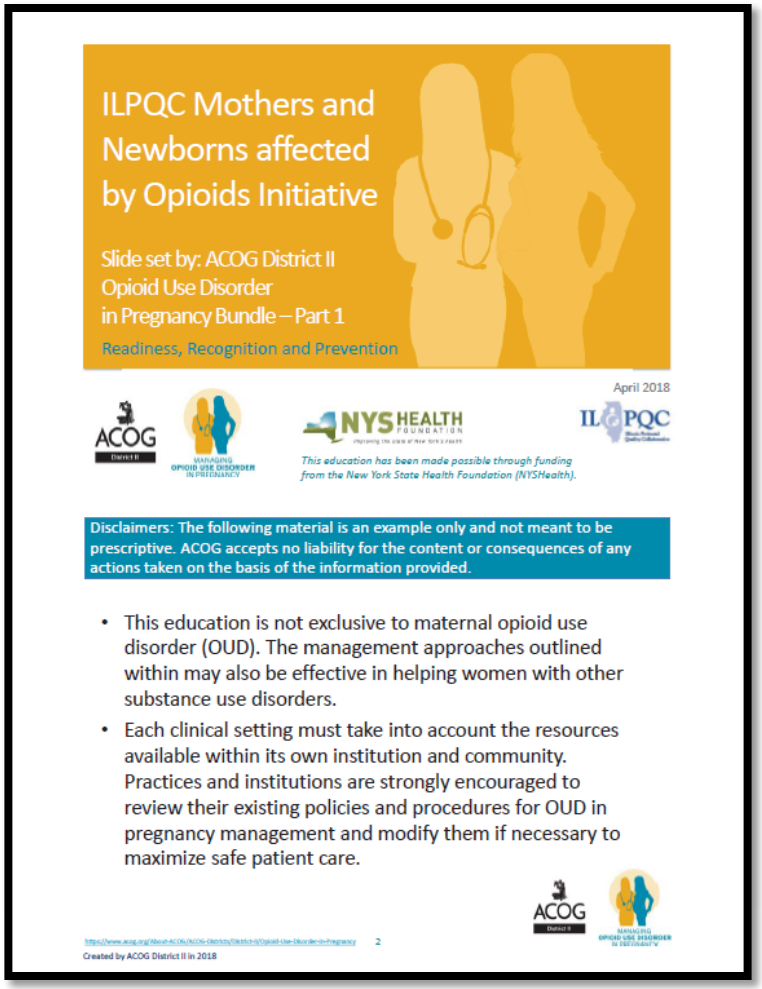
OB Toolkit Sections (cont.)

Prevention of OUD

- Patient and Provider Education for OUD Prevention
  - Patient education for all pregnant women
  - Provider/nursing/staff education on OUD
- Clinical guidelines/strategies to reduce opioid over prescribing postpartum
- Overview of new Illinois state law on ILPMP lookup

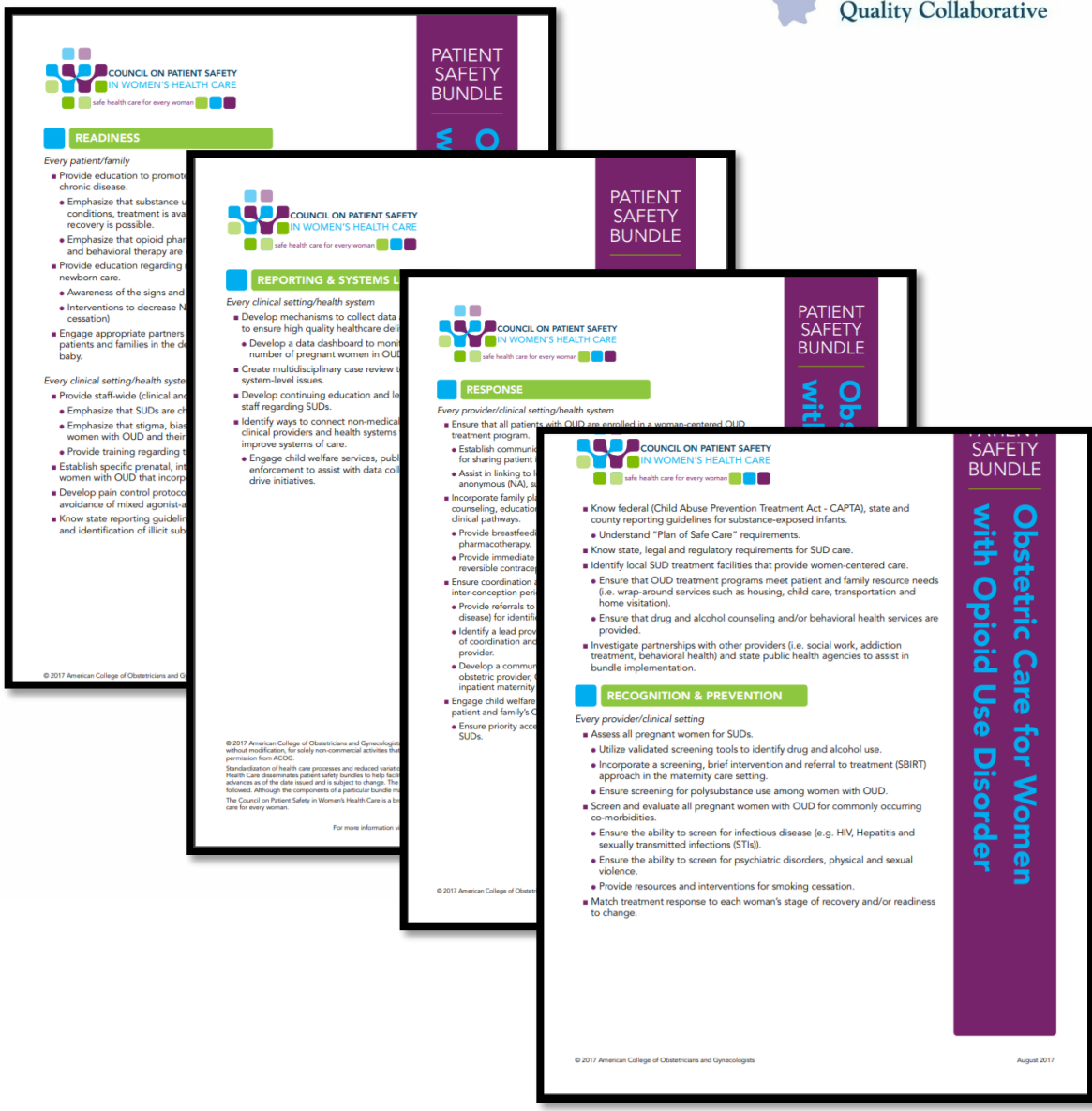
ILPQC MNO Slide Set

- ILPQC Mothers and Newborns affected by Opioids Initiative Slides set from ACOG District II*
- Tool to increase cumulative proportion of providers, nurses, and staff educated on OUD care protocols



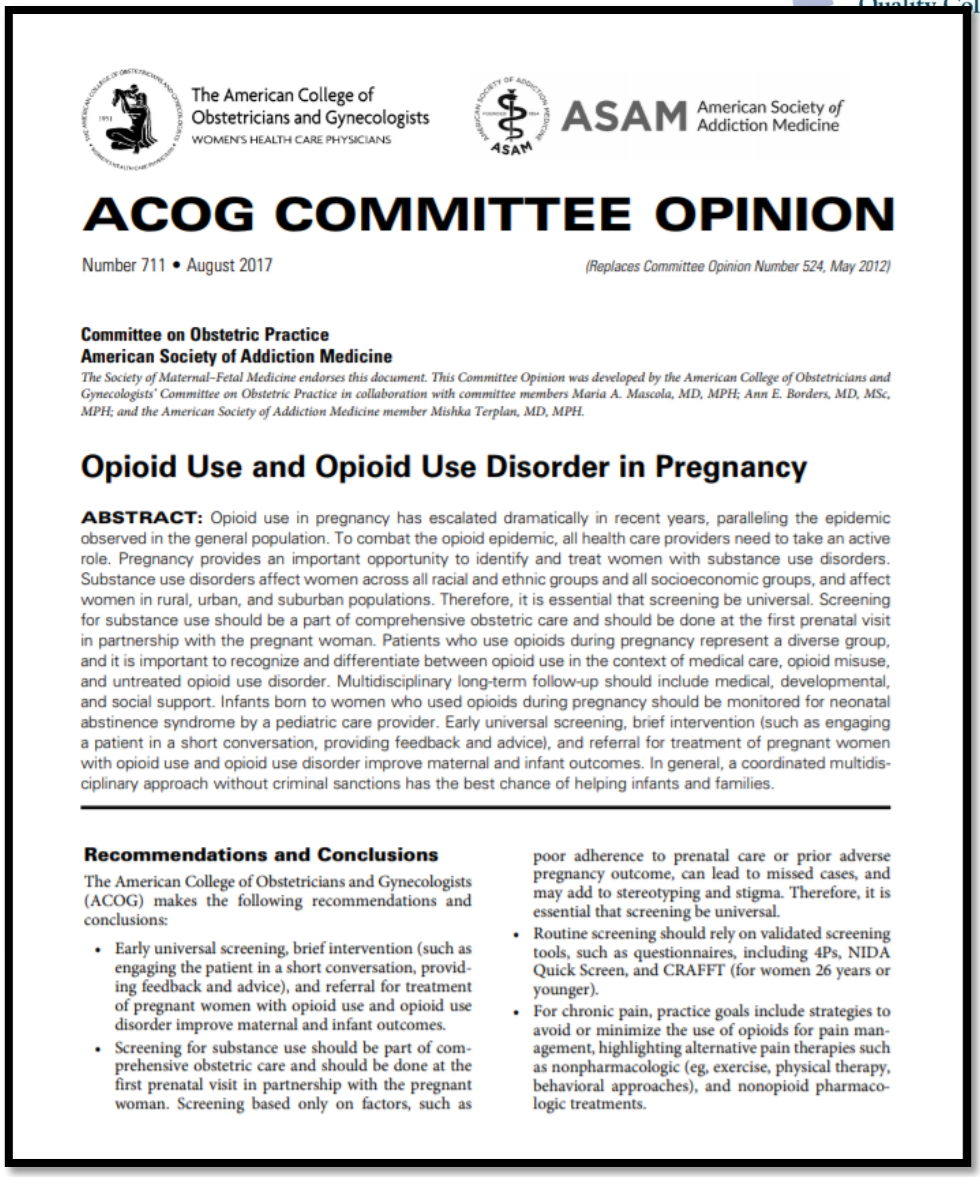
National Guidance: AIM Bundle

- Obstetric Care for Women with Opioid Use Disorder Bundle and Resources Listing*



ACOG Committee Opinion

- ACOG Committee Opinion #711: Opioid Use and Opioid Use Disorder in Pregnancy*



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

Number 711 • August 2017 *(Replaces Committee Opinion Number 524, May 2012)*

Committee on Obstetric Practice
American Society of Addiction Medicine

The Society of Maternal–Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Mascola, MD, MPH; Ann E. Borders, MD, MSc, MPH; and the American Society of Addiction Medicine member Mishka Terplan, MD, MPH.

Opioid Use and Opioid Use Disorder in Pregnancy

ABSTRACT: Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. To combat the opioid epidemic, all health care providers need to take an active role. Pregnancy provides an important opportunity to identify and treat women with substance use disorders. Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Therefore, it is essential that screening be universal. Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Patients who use opioids during pregnancy represent a diverse group, and it is important to recognize and differentiate between opioid use in the context of medical care, opioid misuse, and untreated opioid use disorder. Multidisciplinary long-term follow-up should include medical, developmental, and social support. Infants born to women who used opioids during pregnancy should be monitored for neonatal abstinence syndrome by a pediatric care provider. Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.

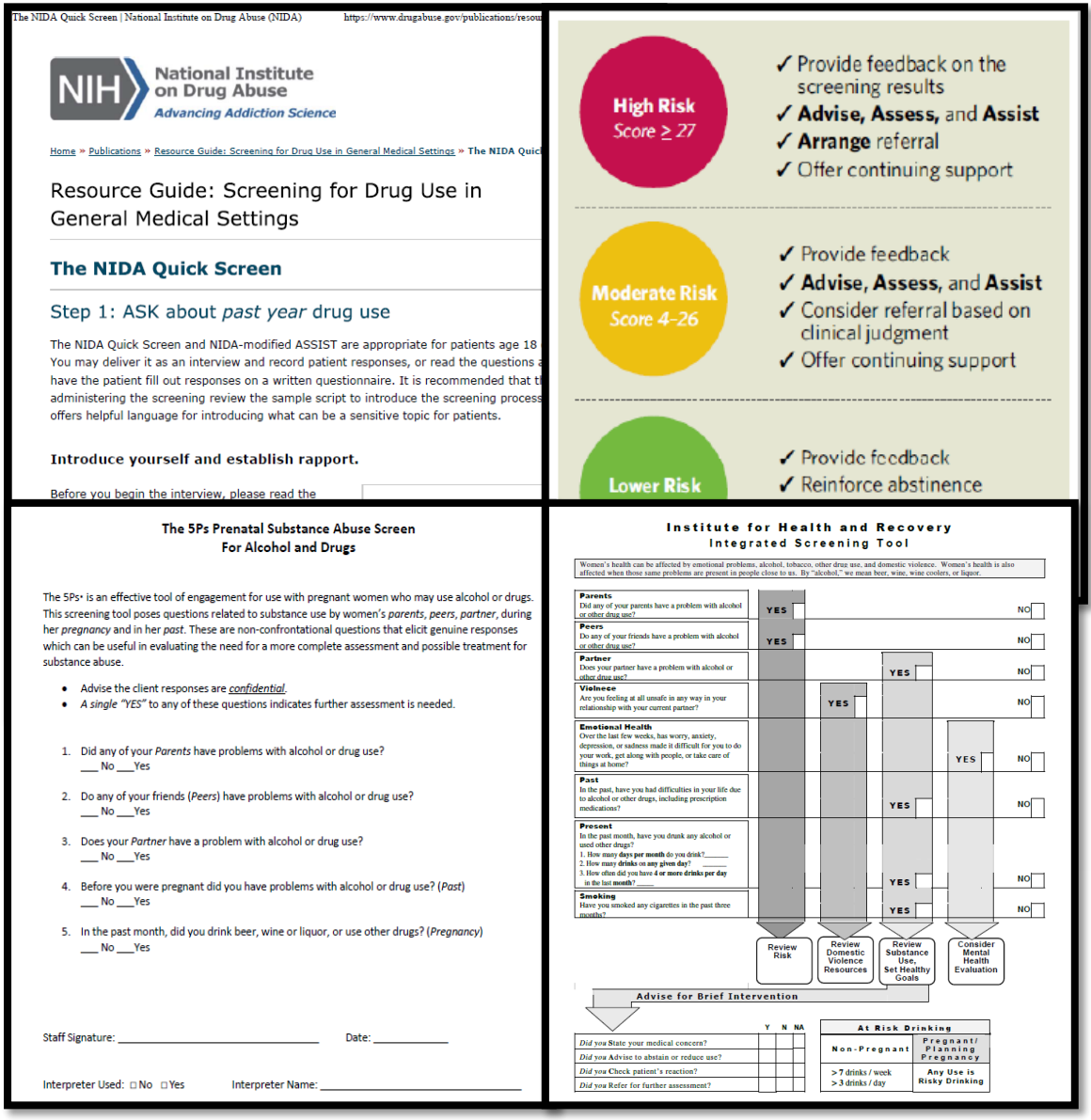
Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.
- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.
- Routine screening should rely on validated screening tools, such as questionnaires, including 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).
- For chronic pain, practice goals include strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (eg, exercise, physical therapy, behavioral approaches), and nonopioid pharmacologic treatments.

Example Screening Tools

- NIDA Quick Screen
- 5 P's Screening Tool & Follow-Up Questions*
- Institute for Health and Recovery Integrated Screening Tool*



The NIDA Quick Screen | National Institute on Drug Abuse (NIDA) https://www.drugabuse.gov/publications/resou

NIH National Institute on Drug Abuse
Advancing Addiction Science

Home » Publications » Resource Guide: Screening for Drug Use in General Medical Settings » The NIDA Quic

Resource Guide: Screening for Drug Use in General Medical Settings

The NIDA Quick Screen

Step 1: ASK about *past year* drug use

The NIDA Quick Screen and NIDA-modified ASSIST are appropriate for patients age 18
You may deliver it as an interview and record patient responses, or read the questions
have the patient fill out responses on a written questionnaire. It is recommended that t
administering the screening review the sample script to introduce the screening process
offers helpful language for introducing what can be a sensitive topic for patients.

Introduce yourself and establish rapport.

Before you begin the interview, please read the

High Risk Score ≥ 27
- ✓ Provide feedback on the screening results
- ✓ **Advise, Assess,** and **Assist**
- ✓ **Arrange** referral
- ✓ Offer continuing support

Moderate Risk Score 4-26
- ✓ Provide feedback
- ✓ **Advise, Assess,** and **Assist**
- ✓ Consider referral based on clinical judgment
- ✓ Offer continuing support

Lower Risk
- ✓ Provide feedback
- ✓ Reinforce abstinence

The 5Ps Prenatal Substance Abuse Screen For Alcohol and Drugs

The 5Ps• is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women's *parents*, *peers*, *partner*, during her *pregnancy* and in her *past*. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are *confidential*.
- *A single "YES"* to any of these questions indicates further assessment is needed.

1. Did any of your *Parents* have problems with alcohol or drug use?
   ___ No ___ Yes
2. Do any of your friends (*Peers*) have problems with alcohol or drug use?
   ___ No ___ Yes
3. Does your *Partner* have a problem with alcohol or drug use?
   ___ No ___ Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)
   ___ No ___ Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)
   ___ No ___ Yes

Staff Signature: _____ Date: _____

Interpreter Used: ☐ No ☐ Yes Interpreter Name: _____

Institute for Health and Recovery
Integrated Screening Tool

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women's health is also affected when those same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.

Parents Did any of your parents have a problem with alcohol or other drug use? YES NO
Peers Do any of your friends have a problem with alcohol or other drug use? YES NO
Partner Does your partner have a problem with alcohol or other drug use? YES NO
Violence Are you feeling at all unsafe in any way in your relationship with your current partner? YES NO
Emotional Health Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home? YES NO
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? YES NO
Present In the past month, have you drunk any alcohol or used other drugs?
1. How many **days per month** do you drink? _____
2. How many **drinks on any given day?** _____
3. How often did you have **4 or more drinks per day** in the last **month?** _____ YES NO
Smoking Have you smoked any cigarettes in the past three months? YES NO

Review Risk | Review Domestic Violence Resources | Review Substance Use, Set Healthy Goals | Consider Mental Health Evaluation

Advise for Brief Intervention

	Y	N	NA
Did you State your medical concern?			
Did you Advise to abstain or reduce use?			
Did you Check patient's reaction?			
Did you Refer for further assessment?			

At Risk Drinking

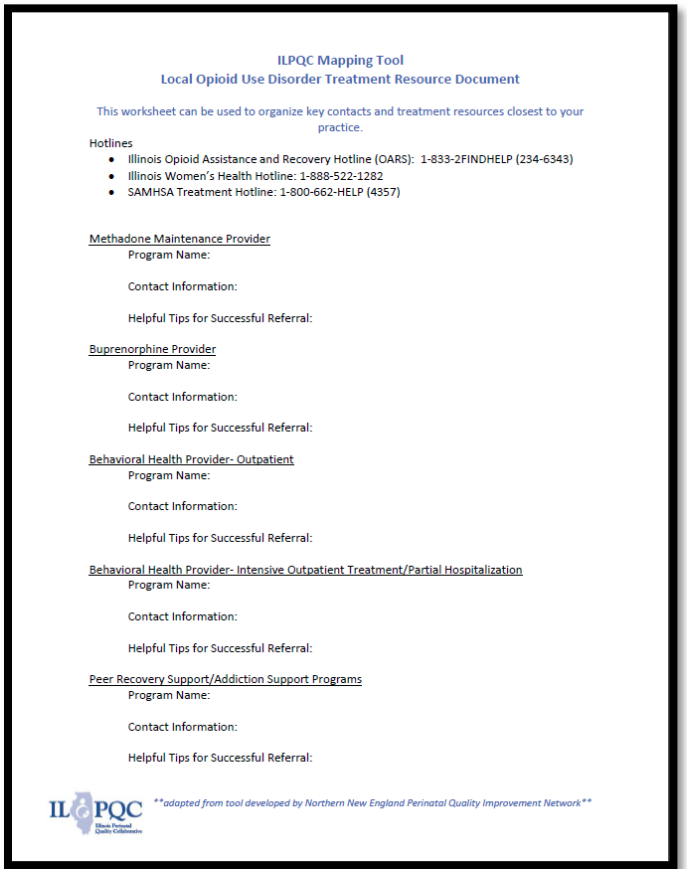
Non-Pregnant	Pregnant/ Planning Pregnancy
> 7 drinks / week > 3 drinks / day	Any Use is Risky Drinking

SBIRT

- Helping Women Get Treatment: Screening and diagnosis of OUD Overview*
- Screening for Substance Use using SBIRT Framework*
- Example process flow map for SBIRT at Initial OB Visit*
- Example protocol for Women who Endorse or Screen Positive for OUD
- Example Algorithm/Process Flow

Mapping Local Resources

- ILPQC Mapping Tool to map local resources*
- IDPH Opioid Use Treatment Resources for Pregnant Women with Medicaid in Illinois



ILPQC Mapping Tool
Local Opioid Use Disorder Treatment Resource Document

This worksheet can be used to organize key contacts and treatment resources closest to your practice.

Hotlines
- Illinois Opioid Assistance and Recovery Hotline (OARS): 1-833-2FINDHELP (234-6343)
- Illinois Women's Health Hotline: 1-888-522-1282
- SAMHSA Treatment Hotline: 1-800-662-HELP (4357)

Methadone Maintenance Provider
Program Name:
Contact Information:
Helpful Tips for Successful Referral:

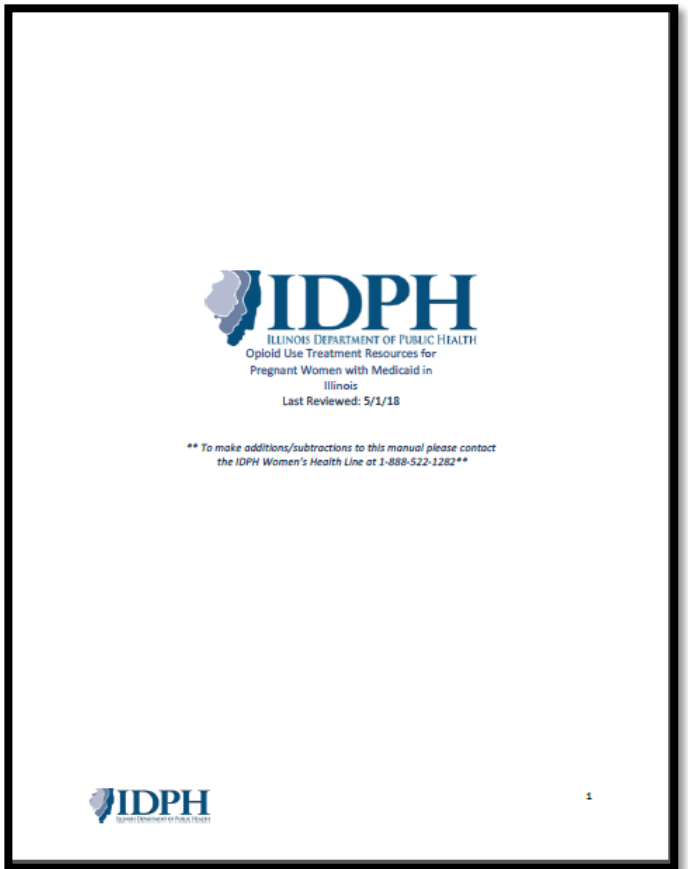
Buprenorphine Provider
Program Name:
Contact Information:
Helpful Tips for Successful Referral:

Behavioral Health Provider- Outpatient
Program Name:
Contact Information:
Helpful Tips for Successful Referral:

Behavioral Health Provider- Intensive Outpatient Treatment/Partial Hospitalization
Program Name:
Contact Information:
Helpful Tips for Successful Referral:

Peer Recovery Support/Addiction Support Programs
Program Name:
Contact Information:
Helpful Tips for Successful Referral:

IL PQC **adapted from tool developed by Northern New England Perinatal Quality Improvement Network**



IDPH
Illinois Department of Public Health
Opioid Use Treatment Resources for Pregnant Women with Medicaid in Illinois
Last Reviewed: 5/1/18

** To make additions/subtractions to this manual please contact the IDPH Women's Health Line at 1-888-522-1282**

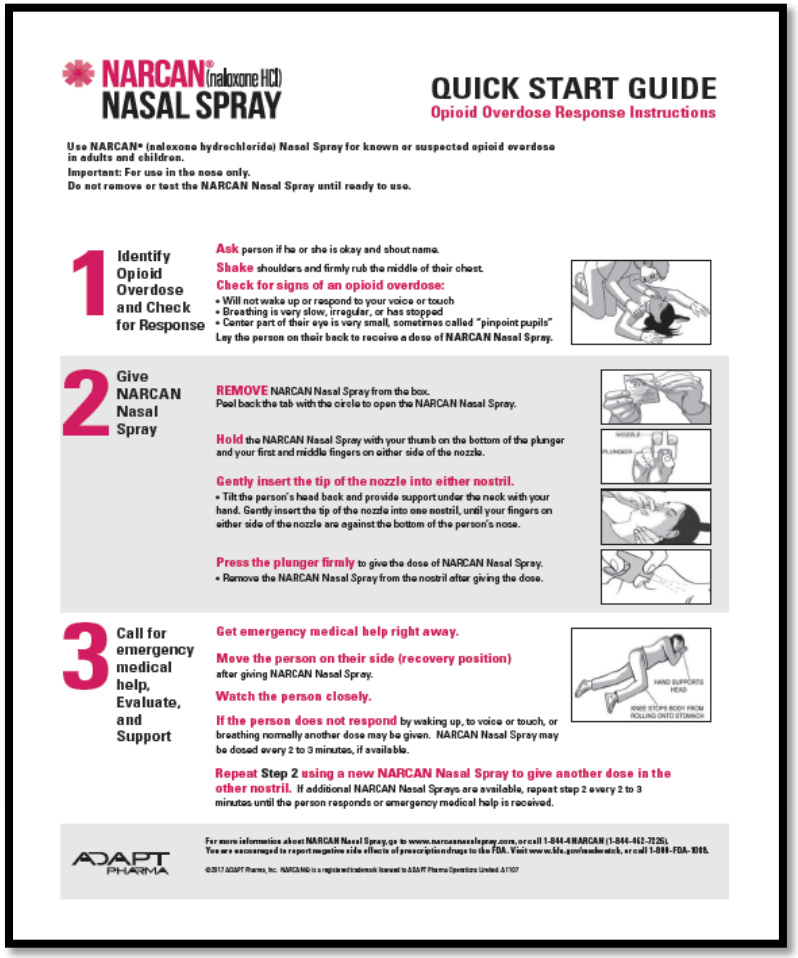
IDPH 1

Prenatal-Intrapartum-Postpartum Care

- Example Best Practice Recommendations for Prenatal/Intrapartum/Postpartum Care Complicated by Substance Use Disorders*
- Example Checklist for Providers for Prenatal/Intrapartum/Postpartum Care for Pregnant women with substance use disorders*
- Example Checklist to optimize prenatal care for women with OUD, Chart template

Counseling & Prescribing Naloxone/Narcan

- AMA Opioid Task Force Prescribing Naloxone One-Pager*
- Naloxone Rescue Kit Consultation Checklist*
- Narcan Nasal Spray- Quick Start Guide



NARCAN® (naloxone HCl) NASAL SPRAY

QUICK START GUIDE
Opioid Overdose Response Instructions

Use NARCAN® (naloxone hydrochloride) Nasal Spray for known or suspected opioid overdose in adults and children.
Important: For use in the nose only.
Do not remove or test the NARCAN Nasal Spray until ready to use.

1 Identify Opioid Overdose and Check for Response

Ask person if he or she is okay and shout name.
Shake shoulders and firmly rub the middle of their chest.
Check for signs of an opioid overdose:
- Will not wake up or respond to your voice or touch
- Breathing is very slow, irregular, or has stopped
- Center part of their eye is very small, sometimes called "pinpoint pupils"

Lay the person on their back to receive a dose of NARCAN Nasal Spray.

2 Give NARCAN Nasal Spray

REMOVE NARCAN Nasal Spray from the box.
Peel back the tab with the circle to open the NARCAN Nasal Spray.

Hold the NARCAN Nasal Spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

Gently insert the tip of the nozzle into either nostril.
- Tilt the person's head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into one nostril, until your fingers on either side of the nozzle are against the bottom of the person's nose.

Press the plunger firmly to give the dose of NARCAN Nasal Spray.
- Remove the NARCAN Nasal Spray from the nostril after giving the dose.

3 Call for emergency medical help, Evaluate, and Support

Get emergency medical help right away.

Move the person on their side (recovery position) after giving NARCAN Nasal Spray.

Watch the person closely.

If the person does not respond by waking up, to voice or touch, or breathing normally another dose may be given. NARCAN Nasal Spray may be dosed every 2 to 3 minutes, if available.

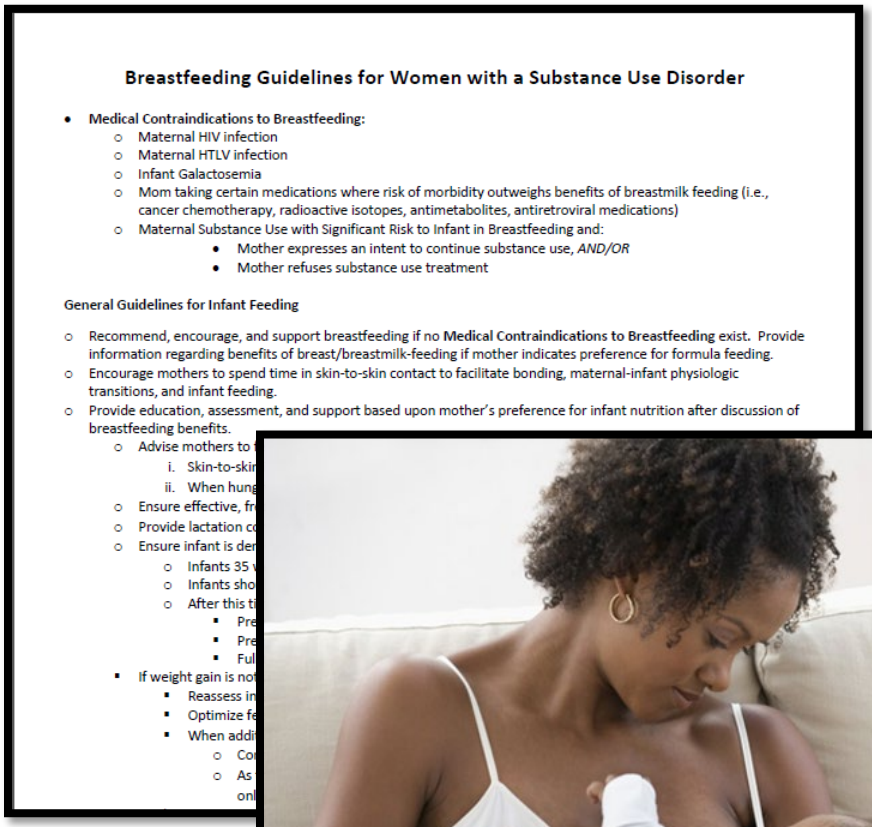
Repeat Step 2 using a new NARCAN Nasal Spray to give another dose in the other nostril. If additional NARCAN Nasal Sprays are available, repeat step 2 every 2 to 3 minutes until the person responds or emergency medical help is received.

ADAPT PHARMA

For more information about NARCAN Nasal Spray, go to www.narcannasalspray.com, or call 1-844-4-NARCAN (1-844-462-7226).
You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Other Resources to Optimize Care for Women with OUD

- Breastfeeding Guidelines for Women with a Substance Use Disorder*



Breastfeeding Guidelines for Women with a Substance Use Disorder

- **Medical Contraindications to Breastfeeding:**
  - Maternal HIV infection
  - Maternal HTLV infection
  - Infant Galactosemia
  - Mom taking certain medications where risk of morbidity outweighs benefits of breastmilk feeding (i.e., cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications)
  - Maternal Substance Use with Significant Risk to Infant in Breastfeeding and:
    - Mother expresses an intent to continue substance use, *AND/OR*
    - Mother refuses substance use treatment

General Guidelines for Infant Feeding

- Recommend, encourage, and support breastfeeding if no **Medical Contraindications to Breastfeeding** exist. Provide information regarding benefits of breast/breastmilk-feeding if mother indicates preference for formula feeding.
- Encourage mothers to spend time in skin-to-skin contact to facilitate bonding, maternal-infant physiologic transitions, and infant feeding.
- Provide education, assessment, and support based upon mother's preference for infant nutrition after discussion of breastfeeding benefits.
  - Advise mothers to f
    - i. Skin-to-skin
    - ii. When hung
  - Ensure effective, fr
  - Provide lactation co
  - Ensure infant is der
    - Infants 35 w
    - Infants sho
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      - Ful
  - If weight gain is not
    - Reassess in
    - Optimize fe
    - When addi
      - Co
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        onl

Education Materials for Pregnant Women with OUD

IL PQC Illinois Perinatal Quality Collaborative

- Pregnancy and MAT one-pager
- Are you in treatment or recovery
- NAS What you need to know one-pager
- NAS Booklet

State of Illinois
Illinois Department of Public Health

Prescription Pain Medicine, Opioids, and Pregnancy:
What All Pregnant Women Need to Know

What are opioids?

Opioids are a class of drugs that includes prescription pain relievers such as oxycodone and hydrocodone, the illegal drug heroin, and dangerous synthetic opioids such as fentanyl, carfentanil, and other analogues. Opioids work in the brain to reduce pain and can also produce feelings of relaxation and euphoria.

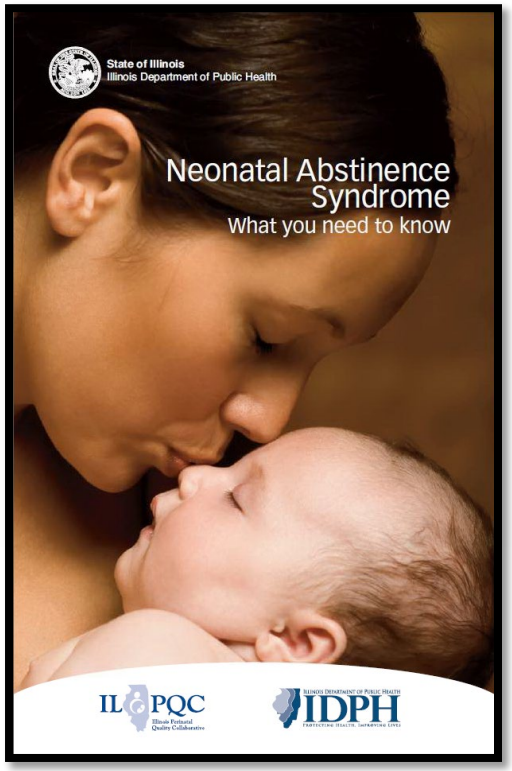
Prescribed opioids include:

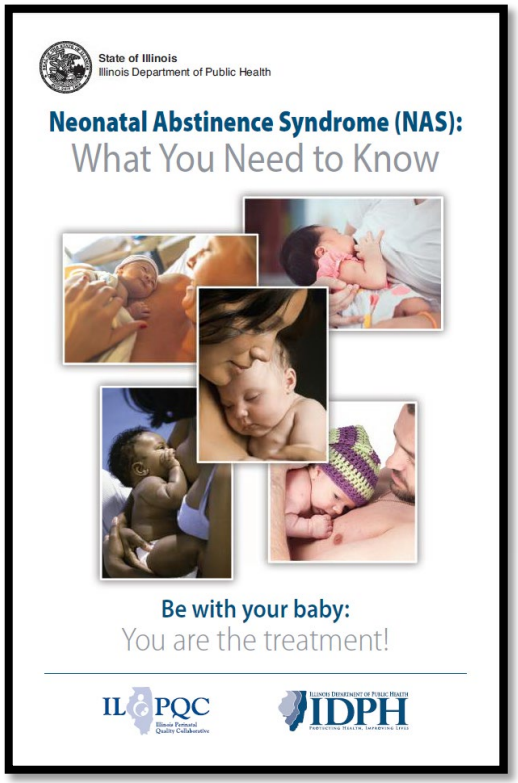
- Buprenorphine (Belbuca, Buprenex, Butrans)
- Codeine
- Fentanyl (Actiq, Duragesic, Sublimaze)
- Hydrocodone (Lorcet, Lortab, Norco, Vicodin)
- Hydromophone (Dalaudid, Exalgo)
- Meperidine (Demerol)
- Methandone (Dolophine, Methadose)
- Morphine (Astramorph, Avinza, Duramorph, Roxanol)
- Oxycodone (OxyContin, Percodan, Percocet)
- Oxymorphone (Opana)
- Tramadol (ConZip, Ryzolt, Ultram)

Your doctor may prescribe an opioid for you if you've had surgery, dental work, an injury, or after you deliver your baby. Prescription opioids are important pain medications that can provide relief for acute or chronic pain. Unfortunately, they can also be prescribed inappropriately and misused. Misuse or chronic use of prescription opioids increases the risk of developing opioid use disorder (OUD) and may lead to overdose. If you take opioids during pregnancy they can also cause serious problems for your baby.

What is opioid use disorder?

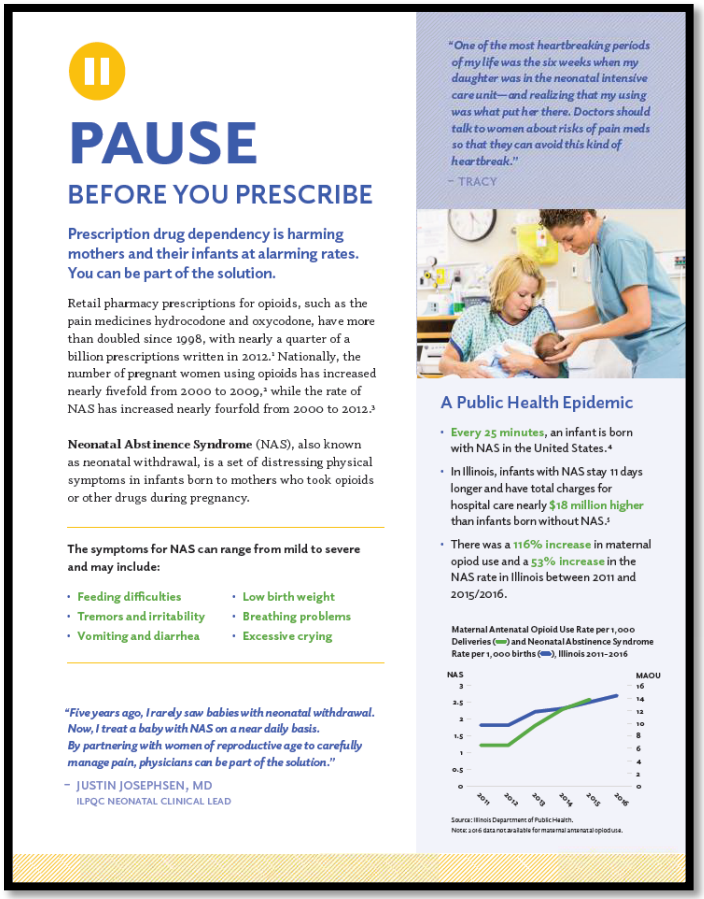
Opioid can be dangerous and addictive. Symptoms of opioid use disorder include developing a need for higher doses in order to feel the same effect; using more than the amount of the drug that is prescribed; taking non-prescribed opioids such as heroin; having work, school, of family problems caused by your opioid use; feeling a strong urge or desire ("craving") to use the drug; and experiencing painful withdrawal symptoms if you abruptly stop taking opioids. Taking higher doses of opioids or using opioids for extended periods of time increases the risk of developing OUD.





Patient and Provider Education for OUD Prevention

- Pain Medication, Opioids and Pregnancy ILPQC Handout*
- Pause Before You Prescribe- ILPQC Handout*



PAUSE

BEFORE YOU PRESCRIBE

Prescription drug dependency is harming mothers and their infants at alarming rates. You can be part of the solution.

Retail pharmacy prescriptions for opioids, such as the pain medicines hydrocodone and oxycodone, have more than doubled since 1998, with nearly a quarter of a billion prescriptions written in 2012.[1] Nationally, the number of pregnant women using opioids has increased nearly fivefold from 2000 to 2009,[2] while the rate of NAS has increased nearly fourfold from 2000 to 2012.[3]

Neonatal Abstinence Syndrome (NAS), also known as neonatal withdrawal, is a set of distressing physical symptoms in infants born to mothers who took opioids or other drugs during pregnancy.

The symptoms for NAS can range from mild to severe and may include:

- Feeding difficulties
- Tremors and irritability
- Vomiting and diarrhea
- Low birth weight
- Breathing problems
- Excessive crying

"Five years ago, I rarely saw babies with neonatal withdrawal. Now, I treat a baby with NAS on a near daily basis. By partnering with women of reproductive age to carefully manage pain, physicians can be part of the solution."

– JUSTIN JOSEPHSEN, MD
ILPQC NEONATAL CLINICAL LEAD

"One of the most heartbreaking periods of my life was the six weeks when my daughter was in the neonatal intensive care unit—and realizing that my using was what put her there. Doctors should talk to women about risks of pain meds so that they can avoid this kind of heartbreak."

– TRACY

A Public Health Epidemic

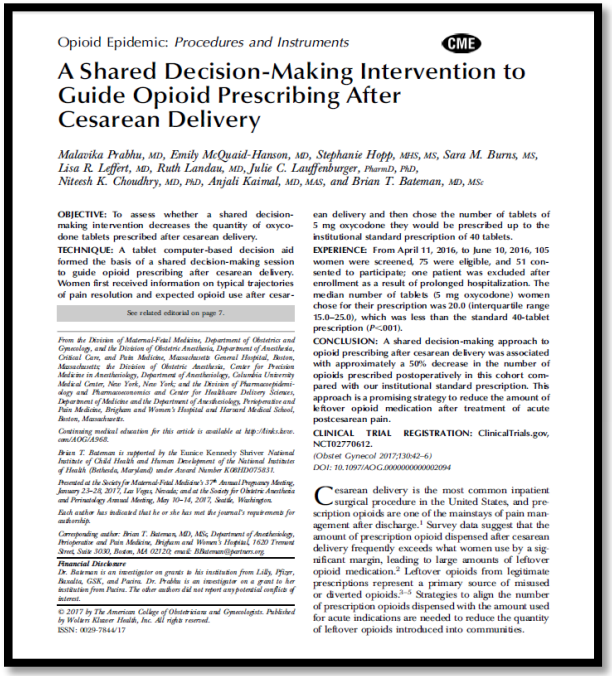
- Every 25 minutes, an infant is born with NAS in the United States.[4]
- In Illinois, infants with NAS stay 11 days longer and have total charges for hospital care nearly $18 million higher than infants born without NAS.[5]
- There was a 116% increase in maternal opiod use and a 53% increase in the NAS rate in Illinois between 2011 and 2015/2016.

Maternal Antenatal Opioid Use Rate per 1,000 Deliveries (MAOU) and Neonatal Abstinence Syndrome Rate per 1,000 births (NAS), Illinois 2011–2016

Source: Illinois Department of Public Health.
Note: 2016 data not available for maternal antenatal opioid use.

Reduce Opioid Over Prescribing Postpartum

- A Shared Decision-Making Intervention to Guide Opioid Prescribing After Cesarean Delivery –article and PowerPoint tool*
- Example Enhanced Recovery after Surgery (ERAS) Pathway for Cesarean*



Opioid Epidemic: *Procedures and Instruments* CME

A Shared Decision-Making Intervention to Guide Opioid Prescribing After Cesarean Delivery

Malavika Prabhu, MD, Emily McQuaid-Hanson, MD, Stephanie Hopp, MHS, MS, Sara M. Burns, MS, Lisa R. Leffert, MD, Ruth Landau, MD, Julie C. Lauffenburger, PharmD, PhD, Niteesh K. Choudhry, MD, PhD, Anjali Kaimal, MD, MAS, and Brian T. Bateman, MD, MSc

OBJECTIVE: To assess whether a shared decision-making intervention decreases the quantity of oxycodone tablets prescribed after cesarean delivery.

TECHNIQUE: A tablet computer-based decision aid formed the basis of a shared decision-making session to guide opioid prescribing after cesarean delivery. Women first received information on typical trajectories of pain resolution and expected opioid use after cesarean delivery and then chose the number of tablets of 5 mg oxycodone they would be prescribed up to the institutional standard prescription of 40 tablets.

See related editorial on page 7.

EXPERIENCE: From April 11, 2016, to June 10, 2016, 105 women were screened, 75 were eligible, and 51 consented to participate; one patient was excluded after enrollment as a result of prolonged hospitalization. The median number of tablets (5 mg oxycodone) women chose for their prescription was 20.0 (interquartile range 15.0–25.0), which was less than the standard 40-tablet prescription ($P<.001$).

CONCLUSION: A shared decision-making approach to opioid prescribing after cesarean delivery was associated with approximately a 50% decrease in the number of opioids prescribed postoperatively in this cohort compared with our institutional standard prescription. This approach is a promising strategy to reduce the amount of leftover opioid medication after treatment of acute postcesarean pain.

CLINICAL TRIAL REGISTRATION: ClinicalTrials.gov, NCT02770612.

(Obstet Gynecol 2017;130:42–6)
DOI: 10.1097/AOG.0000000000002094

Cesarean delivery is the most common inpatient surgical procedure in the United States, and prescription opioids are one of the mainstays of pain management after discharge.[1] Survey data suggest that the amount of prescription opioid dispensed after cesarean delivery frequently exceeds what women use by a significant margin, leading to large amounts of leftover opioid medication.[2] Leftover opioids from legitimate prescriptions represent a primary source of misused or diverted opioids.[3–5] Strategies to align the number of prescription opioids dispensed with the amount used for acute indications are needed to reduce the quantity of leftover opioids introduced into communities.

From the Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, and the Division of Obstetric Anesthesia, Department of Anesthesia, Critical Care, and Pain Medicine, Massachusetts General Hospital, Boston, Massachusetts; the Division of Obstetric Anesthesia, Center for Precision Medicine in Anesthesiology, Department of Anesthesiology, Columbia University Medical Center, New York, New York; and the Division of Pharmacoepidemiology and Pharmacoeconomics and Center for Healthcare Delivery Sciences, Department of Medicine and the Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston, Massachusetts.

Continuing medical education for this article is available at http://links.lww.com/AOG/A568.

Brian T. Bateman is supported by the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health (Bethesda, Maryland) under Award Number K08HD075831.

Presented at the Society for Maternal-Fetal Medicine's 37th Annual Pregnancy Meeting, January 23–28, 2017, Las Vegas, Nevada; and at the Society for Obstetric Anesthesia and Perinatology Annual Meeting, May 10–14, 2017, Seattle, Washington.

Each author has indicated that he or she has met the journal's requirements for authorship.

Corresponding author: Brian T. Bateman, MD, MSc, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital, 1620 Tremont Street, Suite 3030, Boston, MA 02120; email: BBateman@partners.org.

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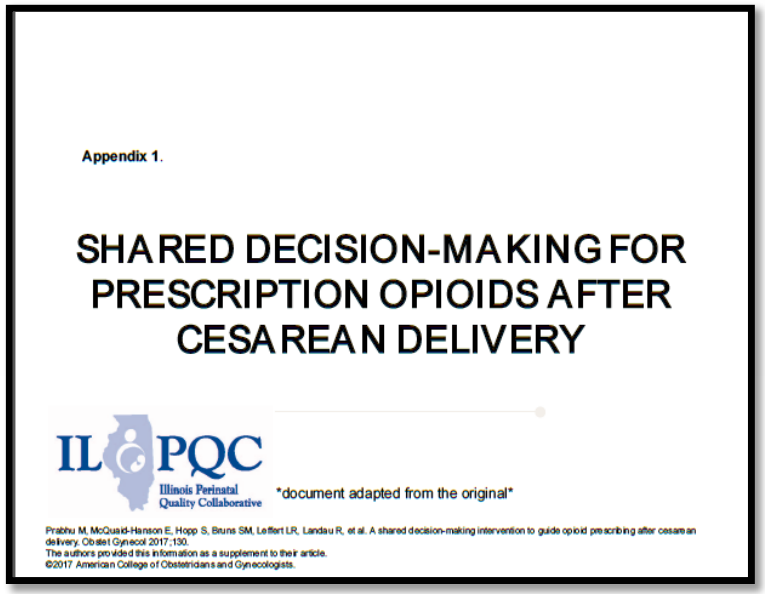


Appendix 1.

SHARED DECISION-MAKING FOR PRESCRIPTION OPIOIDS AFTER CESAREAN DELIVERY

IL PQC Illinois Perinatal Quality Collaborative

document adapted from the original

Prabhu M, McQuaid-Hanson E, Hopp S, Bruns SM, Leffert LR, Landau R, et al. A shared decision-making intervention to guide opioid prescribing after cesarean delivery. Obstet Gynecol 2017;130.

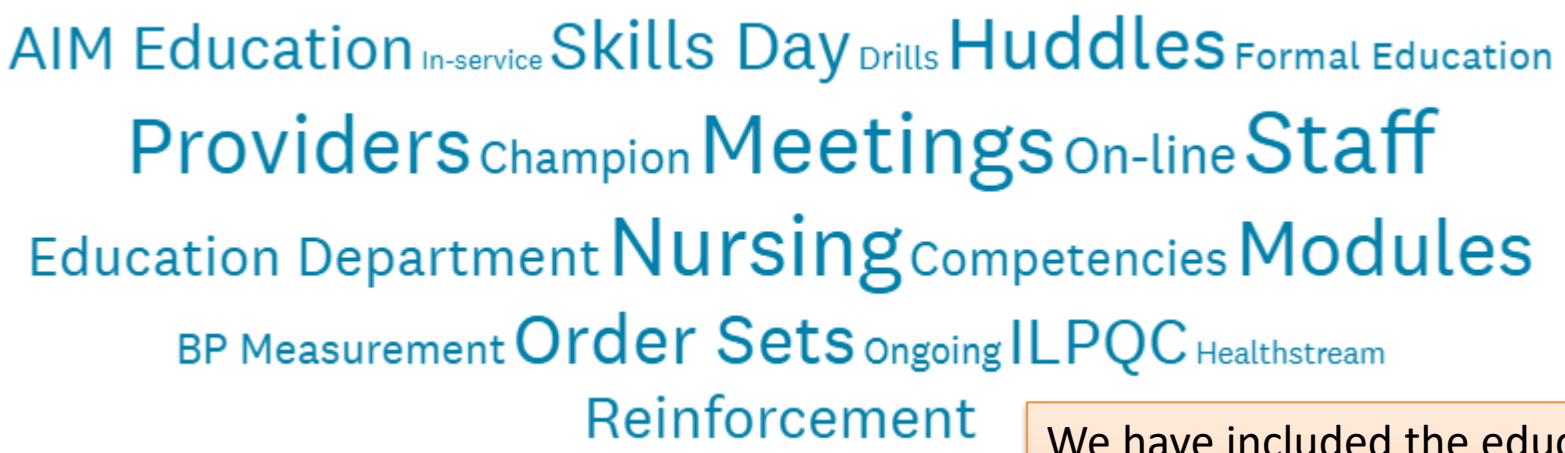
The authors provided this information as a supplement to their article.

Offer Responsive QI Services to Hospital Teams 2018

- HTN – *112 teams*
  - 4 sustainability webinars
  - 1 QI topic call on sustainability plans
- IPLARC – *17 wave 1 teams*
  - 8 webinars
  - 3 QI topic calls
  - 2 state wide IPLARC provider trainings (Springfield, Chicago)
- MNO – *100 OB teams, 88 Neo teams*
  - *OB*: 11 webinars, 2 QI topic calls (+3 scheduled)
  - *Neo:* 8 webinars, 2 QI topic calls
  - 3 Buprenorphine provider trainings (Springfield, Champagne, Chicago) with 70 OB providers trained
- OB Advisory Workgroup – 10 webinars
- Neo Advisory Workgroup – 8 webinars

Effective Steps to Implement Education Program

ILPQC Team Survey, 2017



We used consistent reminders after education in huddles and unit meetings and audited charts.

We have included the education into our computer modules and have made it an annual requirement. We have also included maternal hypertension simulations

We identified RN and MD champions for the whole hospital along with unit champions and have the support of nursing administration

We incorporated HTN education as part of nursing skills day yearly. All new staff and physicians will be educated using the comprehensive slide set.

Barriers to Implementing Education Program

ILPQC Team Survey, 2017

ED participation and buy in

It's hard to engage private practice physicians and get buy in from them to attend education

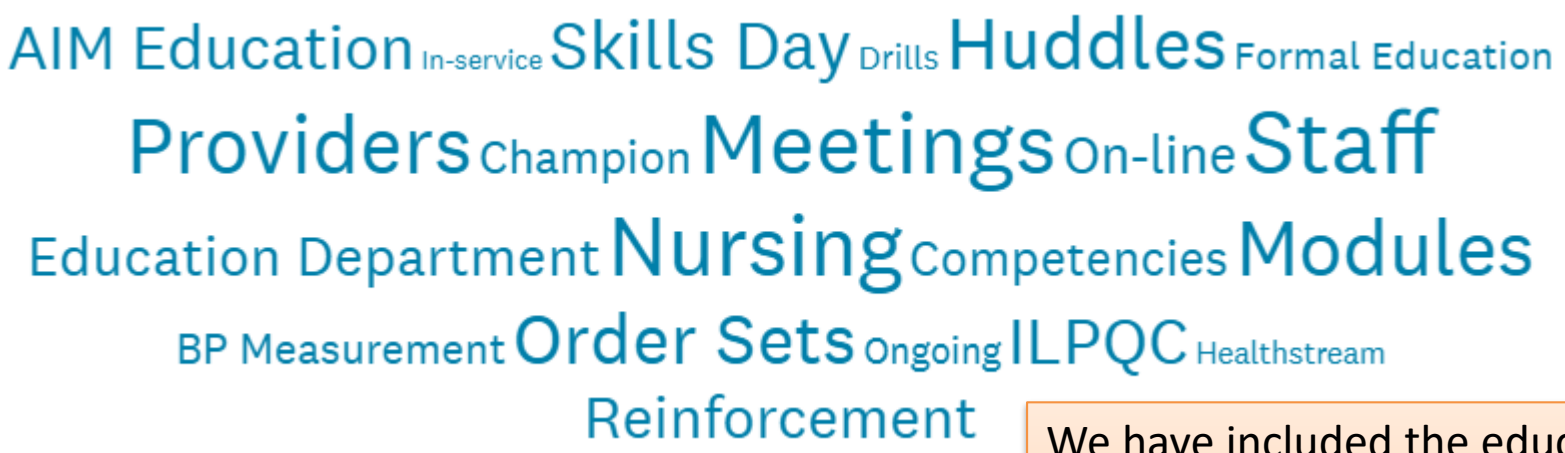
Provider buy in has been the biggest barrier. Many providers are still not on board with the protocol despite education and policy changes.

Time to accomplish simulations and ongoing time for educational offerings is a barrier

Our initial roll out was very successful but sometimes it's difficult to keep up with new hires

Effective Steps to Implement Education Program

ILPQC Team Survey, 2017



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Effective Steps to Implement Standard Protocols

ILPQC Team Survey, 2017

We reiterate what the goal is at physician OB department meetings and work closely with OB chair to promote an overall culture of safety where the chain of command is used and event reporting is done to determine trends.

We have updated policies and created a protocol for management of severe HTN that is posted in all rooms with other visual aides.

We use common order set for all units. ED knows that they have the full support of the OB unit and can call at anytime for us to facilitate the treatment of possible patient

Barriers to Implementing Standard Protocols

ILPQC Team Survey, 2017

We had a delay in making order sets available because we needed various committee approvals and the IT build.

We have lack of support/buy in from private physicians. Resistance from some who do not want to follow protocol-want to do things their own way

It's hard to develop mechanisms to trigger the memory of providers and staff for a condition they are rarely exposed to in practice.

We experience high turnover in the ED and face resistance to treat BPs in the ED.

IPLARC on Formulary

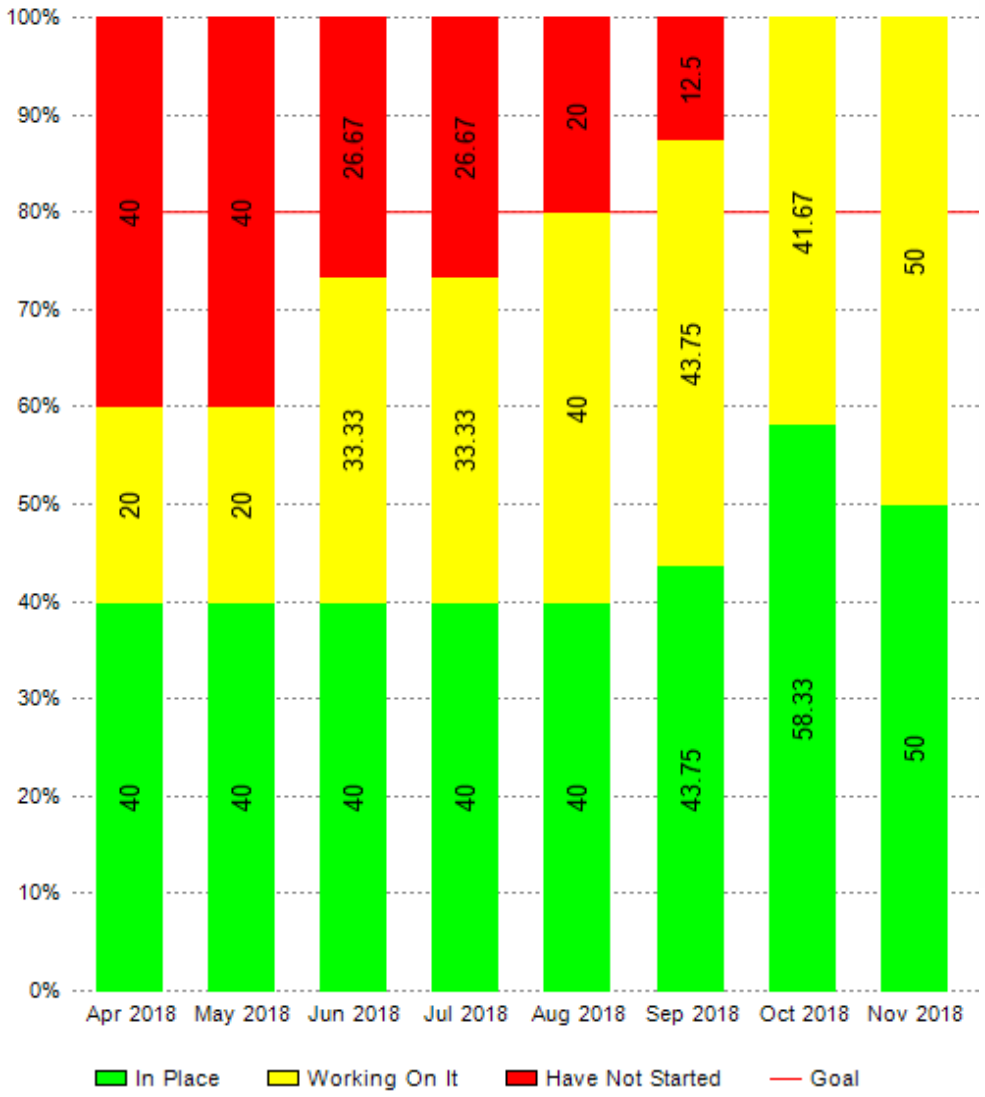
Illinois Perinatal Quality Collaborative

Percent of Hospitals with Inpatient **IUDs** Available on Hospital Formulary

Percent of Hospitals with Inpatient **Implants** Available on Hospital Formulary

IPLARC on L&D/ Postpartum

Percent of Hospitals with LARC Devices on L&D or Postpartum Unit

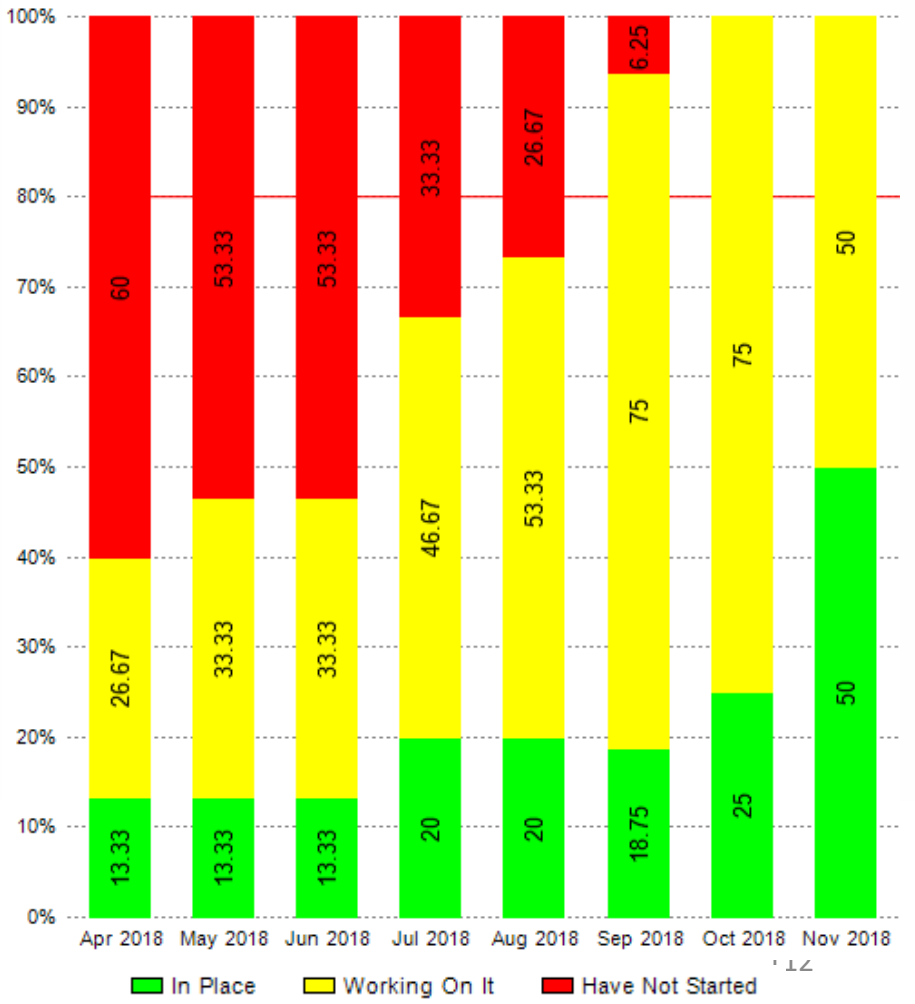


IPLARC Protocols in Place

Illinois Perinatal Quality Collaborative

Percent of Hospitals with Immediate Postpartum Protocols in Place and Process Flows in Place for IUDS

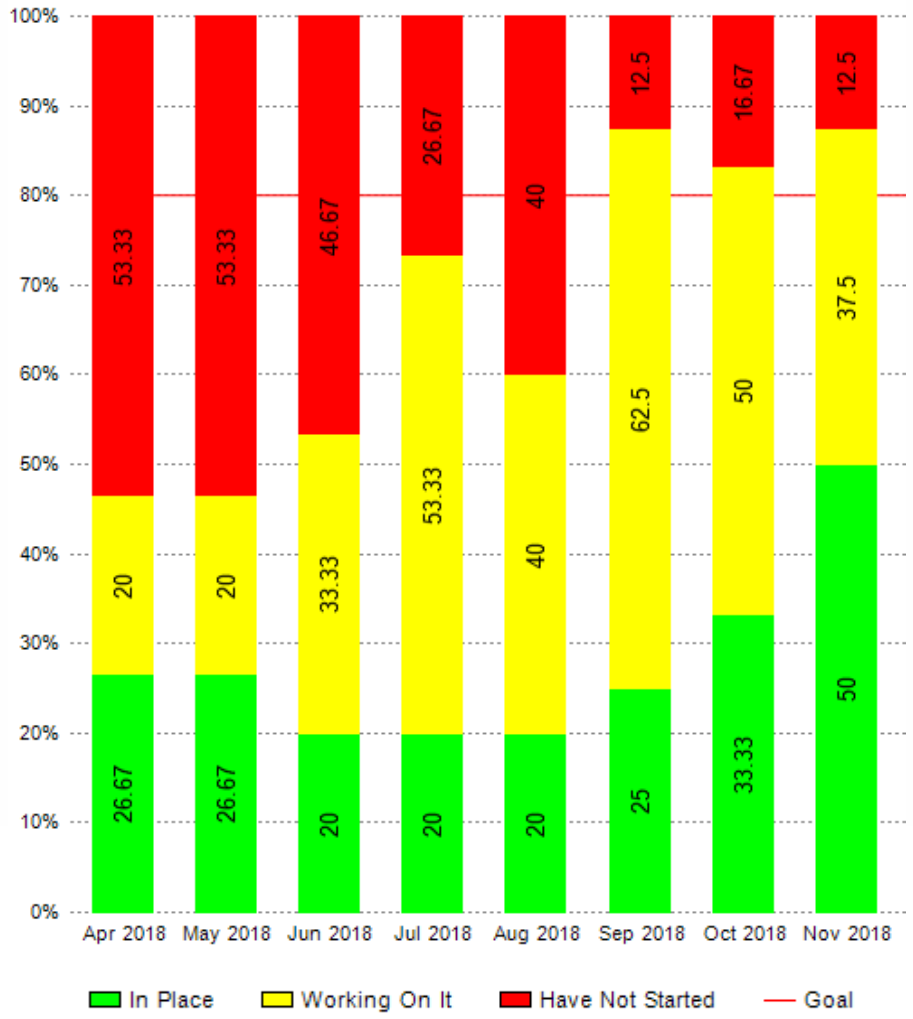
Percent of Hospitals with Immediate Postpartum Protocols in Place and Process Flows in Place for Implants



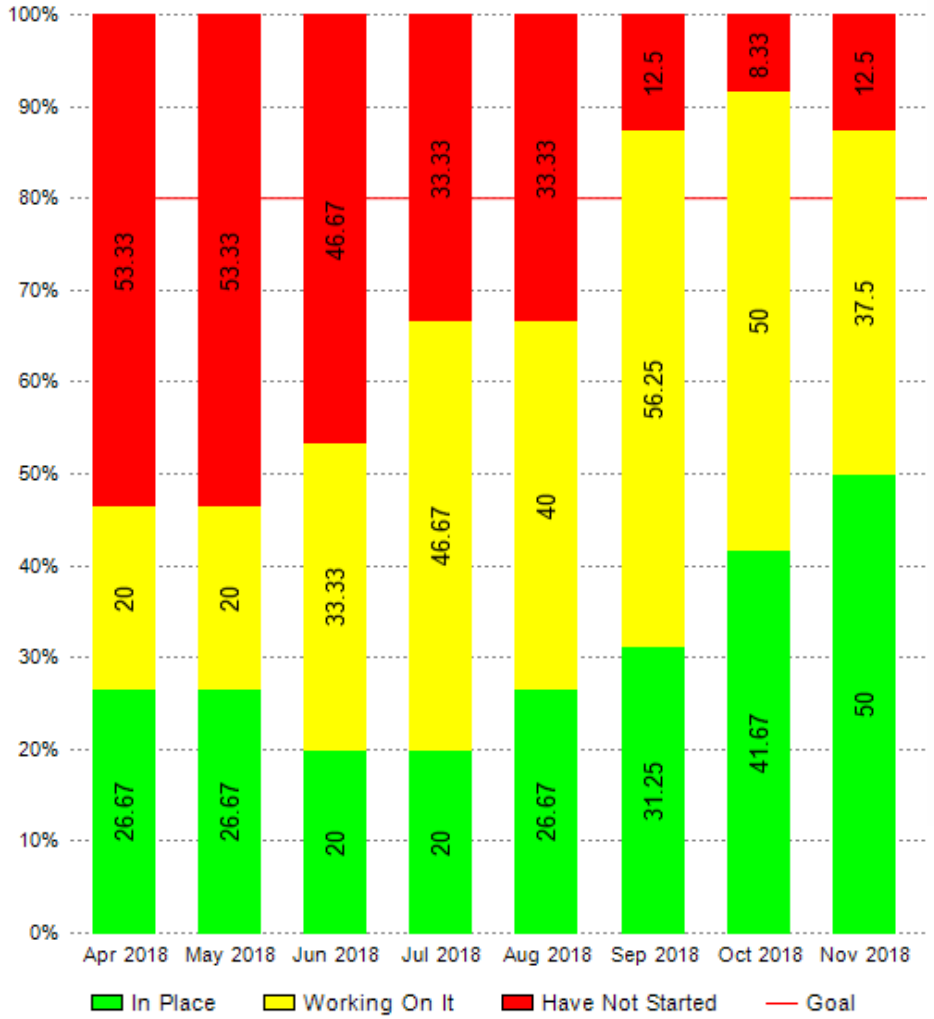
IPLARC Billing Codes

Illinois Perinatal Quality Collaborative

Percent of Hospitals with Billing Codes Implemented for **IUDs**

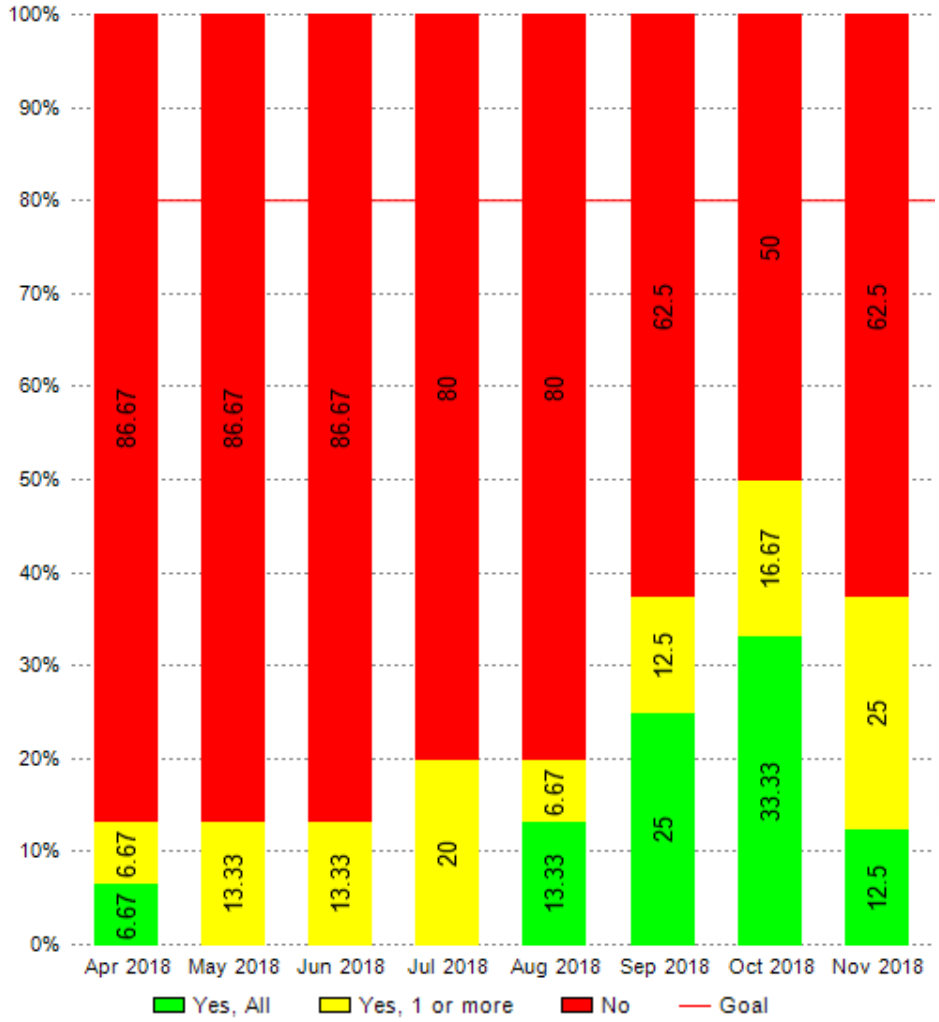


Percent of Hospitals with Billing Codes Implemented for **Implants**



IPLARC Standardized Patient Education at Prenatal Sites

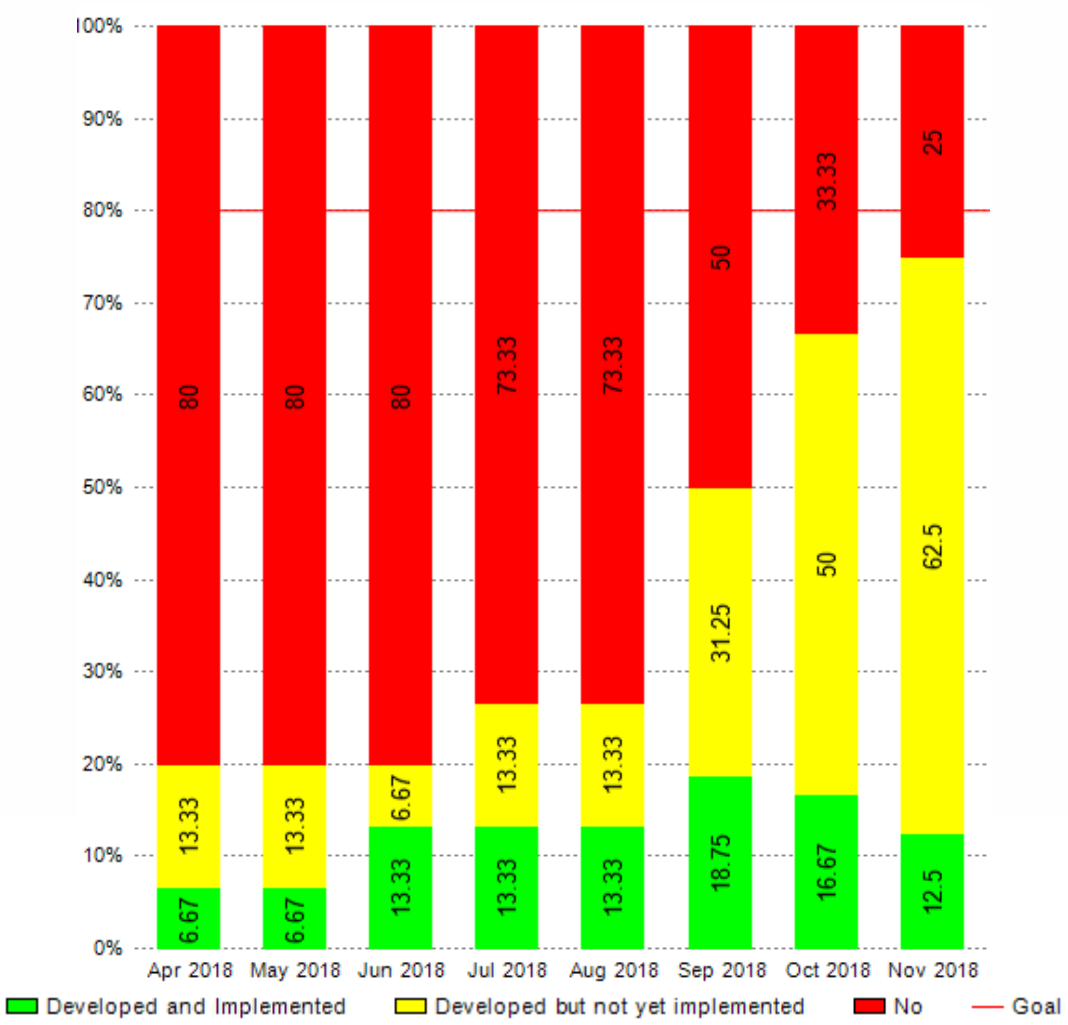
Percent of Hospitals that have Provided Standardized Education Materials and Counseling Protocols to Affiliated Prenatal Care Sites



IPLARC Inpatient Patient Education & Counseling Protocols

Illinois Perinatal Quality Collaborative

Percent of Hospitals with Standardized Education Materials and Counseling Protocols during Delivery Admission



IT/EMR Revisions In Place

Percent of Hospitals with IT/EMR Revisions for Tracking and Documentation of Immediate Postpartum LARC