

MISSOURI


MISSOURI ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

QUALITY IMPROVEMENT COLLABORATIVE
CARE FOR PREGNANT AND POSTPARTUM PEOPLE WITH SUBSTANCE USE DISORDER

ACKNOWLEDGEMENTS

“The Alliance for Innovation on Maternal Health (AIM) is the national, cross-sector commitment designed to lead in the development and implementation of patient safety bundles for the promotion of safe care for every U.S. birth. Founded in 2014 through a cooperative agreement funded by the Health Services Resources Administration (HRSA) and executed by the American College of Obstetricians and Gynecologists (ACOG), the AIM program provides expert technical support and capacity building to multidisciplinary state-based teams, most often perinatal quality collaboratives, leading targeted rapid-cycle quality improvement (QI) via implementation of patient safety bundles.

An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. Patient safety bundles are developed by expert multidisciplinary working groups, supported by the AIM staff at ACOG. Working groups include representatives appointed by professional member organizations, known experts and researchers specializing in the clinical topic, and patients with lived experience. The bundle development process includes design of measure and metrics for implementation and multiple levels of review from engaged stakeholders.”



Improving health care delivery for maternal and infant populations is a critical priority in Missouri. Missouri's AIM journey would not be possible without the collective vision, effort and collaboration of the Missouri Department of Health and Senior Services, Missouri Hospital Association, Missouri Maternal-Child Learning and Action Network, and March of Dimes Missouri. Additionally, multiple association and government agencies have committed support to reducing maternal morbidity and mortality, including the Missouri Section of ACOG; Missouri Chapter of the American Academy of Pediatrics; Missouri Department of Social Services MO HealthNet Division; Missouri Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses; and Nurse Practitioners in Women's Health Association. These partners successfully aligned efforts to bring AIM initiatives to Missouri in 2019. In addition, the Missouri Pregnancy-Associated Mortality Review Board serves as a leading data source to identify trends in maternal mortality. Reviews from the 2018 Missouri PAMR Report denote a continued worsening of substance use disorder in pregnant and postpartum persons.¹ The initiation of AIM's Care for Pregnant and Postpartum People with SUD patient safety bundle serves to ultimately reduce the rate of maternal mortality from this cause.

MHA leverages AIM patient safety bundles to support implementation of evidence-based practice and care delivery redesign for birthing units and providers throughout the state. This work also is supported through a subcontract with DHSS and the Centers for Disease Control and Prevention's Maternal Mortality Prevention grant #CS201333001, as funded by HRSA.

The MC LAN launched in 2018 and continues to be integral in driving momentum to improve maternal and infant health outcomes. Through peer-to-peer networking and passionate engagement, the current group of 58 subject matter experts provides guidance and oversight to deploy broad and sustainable evidence-based practices in Missouri. The vision of "Healthy Moms, Healthy Babies, Healthy Missouri" is a call to all stakeholders in women's and children's health care to assess current practices, collaborate and innovate to improve care, and close the gap on health care disparities.

Special thanks and recognition to the following members of the MC LAN for their contributions to this effort and for serving as the faculty slate for this quality improvement collaborative.

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MISSOURI'S CALL TO ACTION

The CPPPSUD patient safety bundle focuses on reducing severe maternal morbidity and mortality from SUD across the care continuum, and phases of pregnancy and postpartum through one year. SUD is a chronic disease with lasting effects for the mother, infant, family and community. Worsening rates of maternal SUD have been perpetuated by the global opioid epidemic, including non-evidence-based prescribing practices for this population, and further is impacted by the “pair of ACEs” — the combined effects of adverse traumatic life events and social determinants of health. According to the 2018 Missouri PAMR Report, 54% of pregnancy-related and 43% of pregnancy-associated but not related deaths were attributed to SUD. Mental health conditions overall were the primary underlying cause of pregnancy-related death with 63% occurring 43 to 365 days postpartum. Disparate health outcomes also are noted for Black birthing persons and for Medicaid recipients.¹

The call to action is now to implement improved care delivery models for pregnant and postpartum persons with SUD in Missouri.

Much of the AIM CPPPSUD bundle serves to close the noted gaps in Missouri, as applied through the 3A's Framework — acceptability, availability and accessibility. Health care and social support providers must take steps to both recognize and mitigate their own stigma and implicit bias against persons with SUD and mental health diagnoses, both chronically referenced in multiple literature sources. System strategies also must be acted upon to address institutional racism. Decreasing stigma and bias serves to increase acceptability, providing respectful, inclusive and safe environments for patients to disclose misuse, and receive medical care and treatment resources. Policies and funding are needed to increase the availability and accessibility of care, as well. Missouri lacks mental health and SUD services in many parts of the state, especially those serving the perinatal population.² Through these changes, the model of care delivery must be changed from one that historically focuses on the infant's care and ignores the mother's medical and social needs. Moving to a mother-infant dyadic model of care will serve to promote healthier outcomes for both, while ensuring inclusion of the father, support person(s) and family. Initiation of family care plans (formerly known as plans of safe care) early in the prenatal period supports resource and care access, a warm handoff to Children's Division as required, and a greater opportunity to maintain the mother-infant dyad. Early patient engagement in medical and social care and resources increases opportunities to educate the patient, results in fewer conflicts in care needs at the time of birth, improves patient-provider relationships and produces better overall health outcomes.

GAPS IN MISSOURI

- lack of universal screening, brief intervention and referral to treatment (SBIRT) for pregnant and postpartum patients
 - » A validated process recommended by ACOG and the U.S. Preventive Services Task Force, the SBIRT process calls for universal screening of patients affected by SUD, assessment of interest and readiness for treatment, and treatment referral.
- availability and accessibility of providers to prescribe medication-assisted treatment and behavioral health counseling across various service types, as well as knowledge of available providers across the state
- use of evidence-based opioid prescribing practices, specifically during pregnancy and upon birth admission discharge
- lack of evidence-based pain management policies that recognize the unique needs of patients with SUD
- early initiation of family care plans during the prenatal phase
- stigma and implicit bias reduction training

SUMMARY

Health care providers and systems are well-positioned to support the mother-infant dyad affected by SUD. This support contributes to improved health outcomes and reduced health care costs. Opportunities to develop trusting relationships and support treatment occur throughout the prenatal, intrapartum and postpartum continuum. Through open, nonjudgmental communication, treatment initiation and ongoing support, mothers can reduce substance use, thereby reducing maternal SUD, neonatal abstinence syndrome and costs to society at large. The AIM CPPPSUD serves as a model of improvement to achieve these outcomes.

PROJECT OVERVIEW

PROJECT GOALS

Reduce severe maternal morbidity and mortality by:

- implementing evidence-based maternal safety bundles
- promoting safe maternal care for every Missouri birth
- engaging multidisciplinary partners at the national, state, hospital and community levels
- utilizing data-driven quality improvement strategies
- aligning existing safety efforts, as well as developing and collecting resources

TIMELINE

October 2021 through June 2024

Phase I: October 2021 – June 2022:

- form the team
- begin education and technical assistance
- review and develop applicable policies and procedures
- collect baseline data

Phase II: July – December 2022:

- implement selected screening tools
- develop resource networks
- develop an action plan to implement the early initiation of family care plans

Phase III: January – August 2023:

- implement strong referrals and care coordination
- improve stakeholder communication across the care continuum

Phase IV: August 2023 – January 2024:

- focus on sustainability planning
- reassess remaining care gaps and opportunities

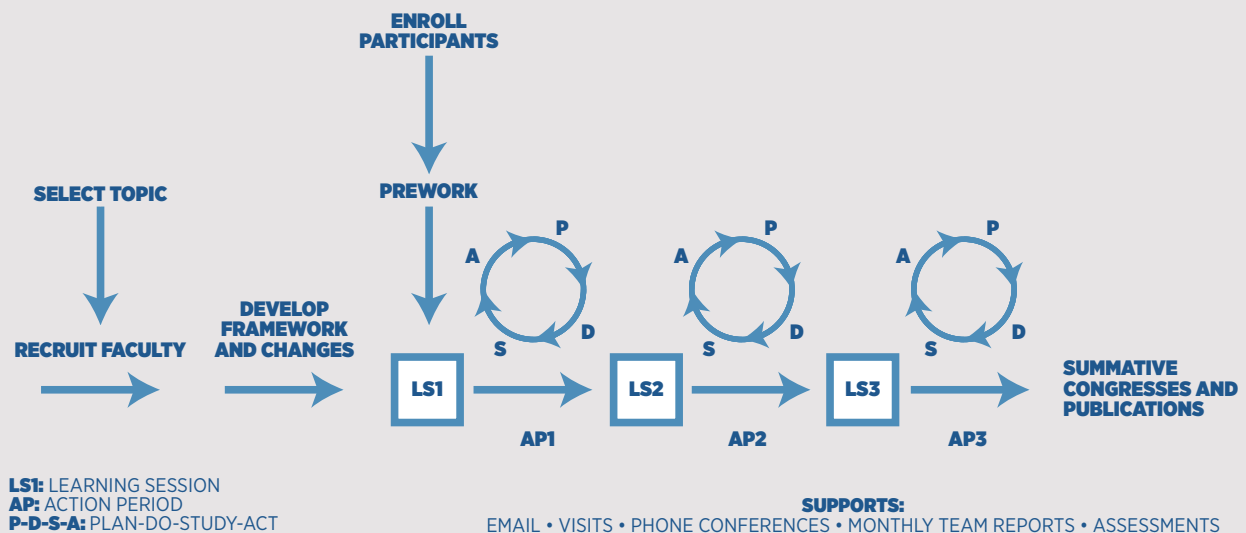
Phase V: June 2024:

- program evaluation and report out

METHODOLOGY

IHI's Breakthrough Series Model

The collaborative will use the Institute for Healthcare Improvement Breakthrough Series Model of Rapid Process Improvement designed to seek incremental changes toward an overarching improvement goal. Cycles of 90 days will be used with learning and action components.



To approach this bundle implementation during the 90-day cycles, participants are encouraged to use either the Plan, Do, Study, Act or the Lean Six Sigma DMAIC model of define, measure, analyze, implement and control. Resources and education on performance improvement science are included during the project webinars and through other recommended resources. Participants should approach the bundle with the goal of 100% implementation with minimal variation and may work through implementing the tasks in whichever order is feasible and beneficial to the organization, and the patients and families served.

Learning phases will include monthly office hours meetings and quarterly coaching calls with the following purposes.

- review and discuss data outcomes relative to the project
- provide a platform for shared learning, barrier mitigation and sharing of successes
- inform project participants of next interventions
- provide resources and opportunity for questions and answers

All project information and rationale for this AIM bundle selection is provided through an on-demand [webinar](#).



TEAM-BASED PROCESS IMPROVEMENT

Establish the team and identify roles and accountability.

Multidisciplinary teams should, at a minimum, include the following.

- » unit director/manager
- » staff nurse(s) and patient care tech(s)
- » physician/clinician champion
- » executive leadership champion
- » social worker
- » local division of family services representative
- » patient and/or family member
- » prenatal clinic representative
- » one to two community benefit organization representatives

Determine roles during an initial meeting.

- » Who is the team lead?
- » What are critical tasks and roles?
- » Who is supporting data collection?
- » Who will have peer discussions?
- » Who will lead staff education?
- » Who is the scribe and communication sender?

Define accountability and team expectations.

- » Determine the frequency and timing of team meetings.
- » Establish the format of meetings — in-person, huddles, virtual, etc.
- » Outline communication and expected work between team meetings.
- » Use the statement “who, what, by when?” to outline the expectations before the end of each team meeting and create momentum for action.

Complete a gap analysis based on the bundle tasks.

- » This task helps determine current bundle implementation within your area, as well as identifies “gaps” in the process and actions for the team.
- » While components and bundle tasks previously may have been implemented, it is important to measure and consider how reliable the process is and its impact on outcomes.

Complete a rapid process improvement workshop with the team.

- » The goal of an RPIW is to outline the process to ensure highly reliable task implementation.
- » The team should review the process for opportunities to increase efficiency and effectiveness.
- » Not sure if something is working or necessary? This is what you measure and how you intervene to improve the process.

Develop the action plan and timeline, and share it with the team.

- » Your plan will be individualized but will include all recommended and applicable tasks.
- » Track task completion within your organization, and plan to report it quarterly on the 30-60-90-day plan form or applicable organization PDSA/DMAIC form.

Complete the data collection plan (see data specifications sheet).

- » Review which metrics are reportable and how the organization will collect them monthly/quarterly as required. Required reportable AIM project data metrics are outlined in the data tool.
- » How will you share data with leadership, partners, staff, providers and patients throughout the project?

AIM BUNDLE COMPONENTS³

AIM patient safety bundles consist of five Rs — readiness, recognition and prevention, response, reporting and systems learning, and respectful care. The latter is integrated across the other four Rs.



Source: Alliance for Innovation on Maternal Health, 2021

Readiness — Every Event

Task #1: Provide education to pregnant and postpartum people related to SUD, naloxone use, harm reduction strategies and care of infants with in-utero substance exposure.

Task #2: Develop trauma-informed protocols and antiracist training to address health care team member biases and stigma related to SUDs.

Task #3: Provide clinical and nonclinical staff education on optimal care for pregnant and postpartum people with SUD, including federal, state and local notification guidelines for infants with in-utero substance exposure and comprehensive family care plan requirements.

Task #4: Engage appropriate partners to assist pregnant and postpartum people and families in the development of family care plans, beginning in the prenatal setting.

Task #5: Establish a multidisciplinary care team to provide coordinated clinical pathways for people experiencing SUDs.

Task #6: Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families for SDOH needs, behavioral health supports and SUD treatment.

Recognition & Prevention — Every Patient

Task #1: Screen all pregnant and postpartum people for SUDs using validated self-reported screening tools and methodologies during prenatal care and during the delivery admission.

Task #2: Screen each pregnant and postpartum person for medical and behavioral health needs, and provide linkage to community services and resources.

Task #3: Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans, and provide linkage to resources.



Response — Every Event

Task #1: Assist pregnant and postpartum people with SUD to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive in an intersectional manner, and discuss readiness to begin treatment, as well as referral for treatment with warm handoff and close follow-up.

Task #2: Establish specific prenatal, intrapartum and postpartum care pathways that facilitate coordination among multiple providers during pregnancy and the year that follows.

Task #3: Offer comprehensive reproductive life planning discussions and resources.

Reporting and Systems Learning — Every Unit

Task #1: Identify and monitor data related to SUD treatment, care outcomes and process metrics for pregnant and postpartum people with disaggregation by race, ethnicity and payer as able.

Task #2: Convene inpatient and outpatient providers and community stakeholders, including those with lived experience in an ongoing way, to share successful strategies and identify opportunities to improve outcomes and system-level issues.

Respectful, Equitable and Supportive Care — Every Unit, Provider and Team Member

Task #1: Engage in open, transparent and empathetic communication with pregnant and postpartum people and their identified support person(s) to understand diagnosis, options and treatment plans.

Task #2: Integrate pregnant and postpartum persons as part of the multidisciplinary care team to establish trust and ensure informed, shared decision-making that incorporates the pregnant and postpartum person's values and goals.

Task #3: Respect the pregnant and postpartum person's right of refusal in accordance with their values and goals.

RECOMMENDED RESOURCES

Bundle Resources

AIM: [Care of the Pregnant and Postpartum Person with Substance Use Disorder](#)

AIM: [CPPPSUD Element Implementation Details](#)

ACOG: [ACOG District II Safe Motherhood Initiative](#)

ACOG: [Clinical Guidance: Opioid Use and Opioid Use Disorder in Pregnancy](#)

NIH: [Eat, Sleep, Console Approach: A Family-Centered Model for the Treatment of NAS](#)

SAMHSA: [A Collaborative Approach to the Treatment of Pregnant Women with OUD](#)

SAMHSA: [Concept of Trauma and Guidance for a Trauma-Informed Approach](#)

Screening Toolkits

IRETA: [Clinical Research on SBIRT and Integrative Healthcare at an FQHC](#)

SAMHSA: [Screening, Brief Intervention and Referral to Treatment](#)

SAMHSA: [White Paper on SBIRT in Behavioral Health Care](#)

OUD/SUD Treatment Resources

DMH: [Medication-Assisted Treatment](#)

OUD/SUD Clinical Guidance

CDC: [Treatment for OUD Before, During and After Pregnancy](#)

SAMHSA: [Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants](#)

SAMHSA: [Implementing Tobacco Cessation Programs in SUD Treatment Settings](#)

SAMHSA: [National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)

General Pain and OUD Pain Management Guidelines

NIH: [Frequency of Opioid Dispensing After Vaginal Delivery](#)

SAMHSA: [Clinical Guidance, Peripartum Pain Relief pg. 58](#)

Billing Mechanisms

DSS: MO Healthnet [Billing Instructions for SBIRT Services](#)

NASHP: [State Options for Promoting Recovery Among Pregnant and Parenting Women with Opioid or Substance Use Disorder](#)

SAMHSA: [Coding for Screening and Brief Intervention Reimbursement](#)

Patient Event Debriefs

PSQH: [Debriefing for Patient Safety](#)

Other State Resources

AHCCCS: [State Pilot Grant Program for Treatment of Pregnant and Postpartum Women](#)

ILPQC: [Mother and Newborns Affected by Opioids, OB Initiative](#)

Stigma/Bias Resources

ASTHO: [Stigma Reinforces Barriers to Care for Pregnant and Postpartum Women with SUD](#)

NIH: [Your Words Matter – Language Showing Compassion and Care for Women, Infants, Families and Communities Impacted by SUD](#)

March of Dimes: [Beyond Labels: Do Your Part to Reduce Stigma Around SUD and Pregnancy](#)



CORD

SUGGESTED CITATION AND REFERENCES

SUGGESTED CITATION

Williams, A. (2021). *Missouri AIM: Care for Pregnant and Postpartum People with Substance Use Disorder*. Missouri Hospital Association.

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- ² The Uplift Connection. (2021). Missouri's Perinatal SUD Resource Map Survey. Retrieved from <https://www.theupliftconnection.org/sud-resources>
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