OB/GYN Webinar Series 2019-2020

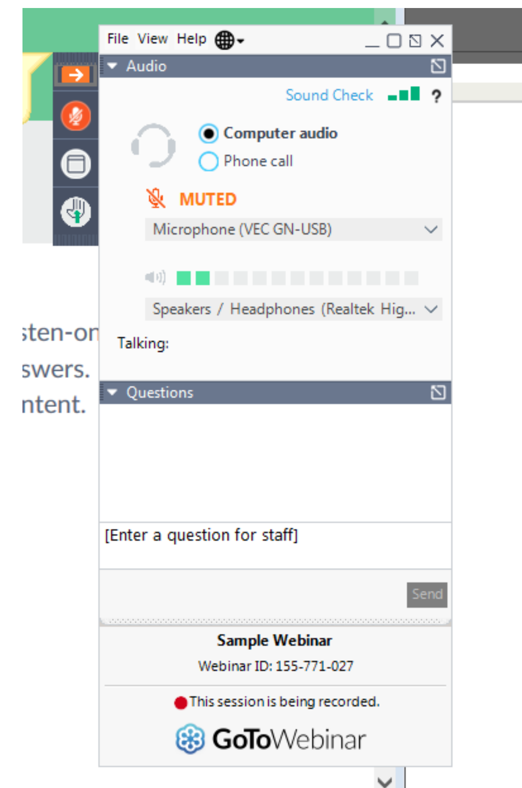
JCHAO Maternal Safety Standards & WIC Prenatal Provider Outreach

Thursday, April 9th, 12:00pm- 1pm EDT

Presented by:

Questions/Comments During the Webinar

Use the Question box in your webinar toolbar

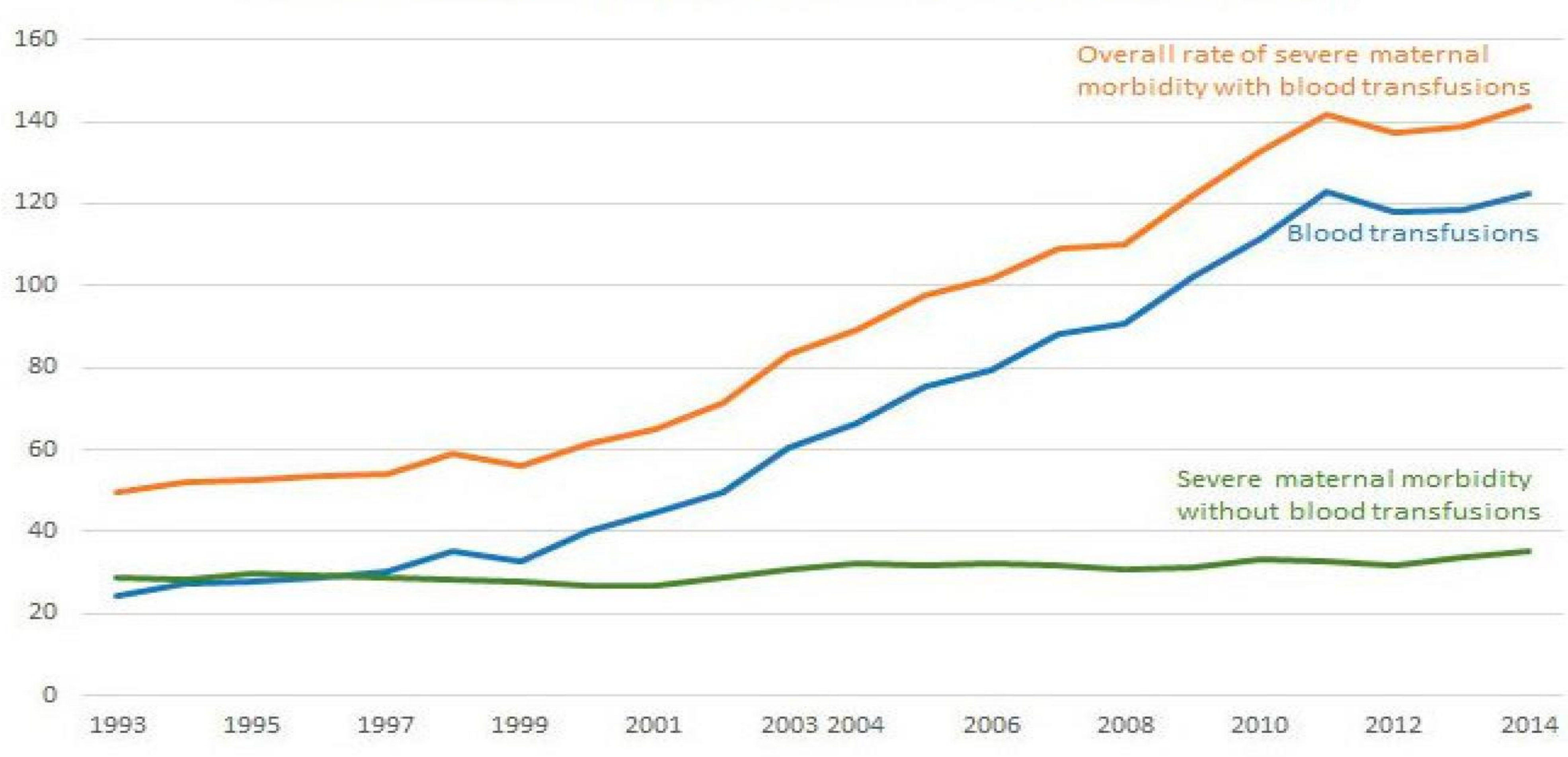


JCHAO Maternal Safety Standards: July 2020

Marjorie Meyer MD
Associate Professor
University of Vermont
University of Vermont Health Network

Death can happen up to a year after delivery.
33%
1 week to 1 year after delivery
31%
During pregnancy
36%
During delivery and up to 1 week afterward

Severe Maternal Morbidity, 1993–2014



Overall Severe Maternal Morbidities (SMM) and AIM measures, 2013-2015: PPH and HTN are the largest contributors to SMM in Northern New England

	1		2		VT	
	Count	Rate per 10,000	Count	Rate per 10,000	Count	Rate per 10,000
Total delivery discharges	35,398	NA	35,692	N/A	16,285	N/A
Any SMM						
Any severe maternal morbidity (21 conditions)	420	118.7	541	151.6	322	197.7
Any severe maternal morbidity (excluding transfusion)	261	73.7	233	65.3	143	87.8
Severe hypertension						
Severe hypertension cases	761	215.0	811	227.2	372	228.4
SMM among severe hypertension cases	58	762.2	54	665.8	54	1,451.6
SMM (excluding transfusion) among severe hypertension cases	52	683.3	36	443.9	36	967.7
Severe hemorrhage						
Severe hemorrhage cases	2,808	793.3	2585	724.3	1,144	702.5
SMM among hemorrhage cases	261	929.5	417	1613.2	238	2,080.4
SMM (excluding transfusion) among hemorrhage cases	102	363.2	109	421.7	59	515.7

Contribution of HTN and PPH on SMM: 76% 87% 91%

SMM Count and Rate per 10,000, by Hospital Delivery Volume, 2013-2015

Volume category for 3-year period	Total Delivery Discharges			Any severe maternal morbidity (All 21 conditions)			Any severe maternal morbidity (excluding transfusion)		
	1	2	VT	1	2	VT	1	2	VT
Facilities with <1,000 deliveries	9,508	4,582	2,974	123	45	31	57	21	15
				129.4	98.2	104.2	59.9	45.8	50.4
Facilities with 1,000-1,999 deliveries	8,268	8,130	7,031	114	95	132	39	33	49
				137.9	116.9	187.7	47.2	40.6	69.7
Facilities with ≥2,000 deliveries	17,622	22,439	6,280	183	401	159	165	179	79
				103.8	178.7	253.2	93.6	79.8	125.8

SMM among Severe Hemorrhage Cases and Rate per 10,000, by Hospital Delivery Volume, 2013-2015

Volume category for 3-year period	Total Delivery Discharges			Total severe hemorrhage cases			Any SMM (All 21 conditions) among severe hemorrhage cases			SMM (excluding transfusion) among severe hemorrhage cases		
	1	2	VT	1	2	VT	1	2	VT	1	2	VT
Facilities with <1,000 deliveries	9,508	4,582	2,974	631	268	191	87	37	21	21	13	5
				663.7	584.9	642.2	1,378.8	1380.6	1,099.5	332.8	485.1	261.8
Facilities with 1,000-1,999 deliveries	8,268	8,130	7,031	564	528	407	92	75	101	17	13	18
				682.1	649.4	578.9	1,631.2	1420.5	2,481.6	301.4	246.2	442.3
Facilities with ≥2,000 deliveries	17,622	22,439	6,280	1,613	1789	546	82	305	116	64	83	36
				915.3	797.3	869.4	508.4	1704.9	2,124.5	396.8	463.9	659.3

SMM among Severe Hypertension Cases and Rate per 10,000, by Hospital Delivery Volume, 2013-2015

Volume category for 3-year period	Total Delivery Discharges			Total severe hypertension cases			Any SMM (All 21 conditions) among severe hypertension cases			Any SMM (excluding transfusion) among severe hypertension cases		
	1	2	VT	1	2	VT	1	2	VT	1	2	VT
Facilities with <1,000 deliveries	9,508	4,582	2,974	114	60	26	20	3	3	17	2	3
				119.9	130.9	87.4	1,754.4	500	1,153.8	1,491.2	333.3	1,153.8
Facilities with 1,000-1,999 deliveries	8,268	8,130	7,031	82	117	77	6	8	19	3	8	16
				99.2	143.9	109.5	731.7	683.8	2,467.5	365.9	683.8	2,077.9
Facilities with ≥2,000 deliveries	17,622	22,439	6,280	565	634	269	32	43	32	32	26	17
				320.6	282.5	428.3	566.4	678.2	1,189.6	566.4	410.1	632.0

PPH and HTN contribute to 80% or more of Severe Maternal Morbidity regardless of hospital size (Northern New England data)

Delivery Volume		**SMM related to dx**	**Total SMM**	**% of SMM related to disease**	**% of SMM related to PPH+HTN**
<1000	PPH	124	168	74%	
	HTN	23	168	14%	88%
1001-1999	PPH	167	209	80%	
	HTN	14	209	7%	87%
>2000	PPH	387	584	66%	
	HTN	75	584	13%	79%*

*tertiary care centers have more SMM related to other high risk diseases

PPH and HTN contribute to 80% or more of Severe Maternal Morbidity regardless of hospital size

PPH and HTN are the targets for intervention to reduce maternal morbidity and mortality nationally

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R3 Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission Issue 24, August 21, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

Effective July 1, 2020, 13 new elements of performance (EPs) will be applicable to Joint Commission-accredited hospitals. These new requirements are within the Provision of Care, Treatment, and Services (PC) chapter at PC.06.01.01 and PC.06.01.03 and are designed to improve the quality and safety of care provided to women during all stages of pregnancy and postpartum. The United States ranks 65th among industrialized nations in terms of maternal death.[1] Because of worsening maternal morbidity and mortality, The Joint Commission evaluated expert literature to determine what areas held the most potential impact. The literature review revealed that prevention, early recognition, and timely treatment for maternal hemorrhage and severe hypertension/preeclampsia had the highest impact in states working on decreasing maternal complications. This approach was supported by a technical advisory panel assembled by The Joint Commission, resulting in the development of EPs that focus on these complications.

Postpartum Hemorrhage: set of 7 JCHAO requirements

Provision of Care, Treatment, and Services chapter

Standard PC.06.01.01: Reduce the likelihood of harm related to maternal hemorrhage.

Requirement	EP 1: Complete an assessment using an evidence-based tool for determining maternal hemorrhage risk on admission to labor and delivery and on admission to postpartum. (See also PC.01.02.01, EPs 1 and 2; PC.01.02.03, EP 3; RC.02.01.01, EP 2)

- **AWHONN Postpartum Hemorrhage Risk Assessment tool**
- **Admission: current**
- **At start of second stage: in the works but not JCHAO required**
- **On transfer to postpartum unit: JCHAO required: will add and use same score**

Risk Assessment for PPH

- **Admission**
- **Start of second stage (or after 1-2 hour)**
- **On transfer to PP unit**

POSTPARTUM HEMORRHAGE (PPH) RISK ASSESSMENT TABLE • 1.0

CLINICIAN GUIDELINES:

- Each box ❑ represents ONE risk factor. Treat patients with 2 or more medium risk factors as high risk.
- Prenatal risk assessment is beyond the scope of this document, however performing a prenatal hemorrhage risk assessment and planning is highly recommended. Early identification and management preparation for patients with special considerations such as placental previa/accreta, bleeding disorder, or those who decline blood products will assist in better outcomes.
- Adjust blood bank orders based on the patient's most recent risk category. When a patient is identified to be at high risk for hemorrhage verify that the blood can be available on the unit within 30 minutes of a medical order.
- Plan appropriately for patient and facility factors that may affect how quickly the blood is delivered to the patient. For example,
  - Patient issues: Pre-existing red cell antibody
  - Facility issues: Any problems at your facility related to the blood supply and obtaining blood

RISK CATEGORY: ADMISSION			
	Low Risk	**Medium Risk** (2 or More Medium Risk Factors Advance Patient to High Risk Status)	**High Risk**
	❑ No previous uterine incision	❑ Induction of labor (with oxytocin) or Cervical ripening	❑ Has 2 or More Medium Risk Factors
	❑ Singleton pregnancy	❑ Multiple gestation	❑ Active bleeding more than "bloody show"
	❑ ≤4 Previous vaginal births	❑ >4 Previous vaginal births	❑ Suspected placenta accreta or percreta
		❑ Prior cesearean birth or prior uterine incision	❑ Placenta previa, low lying placenta
	❑ No known bleeding disorder	❑ Large uterine fibroids	❑ Known coagulopathy
	❑ No history of PPH	❑ History of one previous PPH	❑ History of more than one previous PPH
		❑ Family history in first degree relatives who experienced PPH (known or unknown etiology with possible coagulopathy)	❑ Hematocrit <30 AND other risk factors
		❑ Chorioamnionitis	❑ Platelets <100,000/mm3
		❑ Fetal demise	
		❑ Estimated fetal weight greater than 4 kg	
		❑ Morbid obesity (body mass index [BMI] >35)	
		❑ Polyhydramnios	
Anticipatory Interventions Monitor patient for any change in risk factors at admission and implement anticipatory interventions as indicated.			
❑ **Blood Bank Order:** Change blood bank orders as needed if risk category changes	❑ **Clot Only (Type and Hold)**	❑ **Obtain Type and Screen**	❑ **Obtain Type and Cross (See Clinical Guidelines)**
		❑ Notify appropriate personnel such as the Provider (OB MD/CNM), Anesthesia, Blood Bank, Charge Nurse, Clinical Nurse Specialist	❑ Notify appropriate personnel such as the Provider (OB MD/CNM), Anesthesia, Blood Bank, Charge Nurse, Clinical Nurse Specialist
			❑ Consider delivering at a facility with the appropriate level of care capable of managing a high risk mother

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The Postpartum Hemorrhage (PPH) Risk Assessment Table is exemplary and does not include all possible patient complaints or conditions. The PPH Risk Assessment Table is designed to guide clinical decision-making but does not replace clinical judgment.

UVM Medical Center OB Hemorrhage Protocol

STAGE 0: All Births: Prevention & Recognition of OB Hemorrhage

Hemorrhage Risk Factor Assessment

- ☐ On Admission
- ☐ Ongoing Risk Factor Assessment during Labor, estimate EBL prior to delivery if significant

Active Management of Third Stage

- ☐ Oxytocin infusion following delivery of infant: 30 units oxytocin/500ml solution, titrate infusion rate to uterine tone (10u IM if no IV)
- ☐ Fundal massage with controlled cord traction for placental delivery
- ☐ Uterine tone assessment and **vigorous fundal massage** for at least 15 seconds after delivery of placenta

Ongoing Evaluation of Blood Loss and Ongoing Evaluation of Vital Signs

- ☐ EBL/QBL estimation using formal methods as appropriate--visual comparisons or weight of blood soaked materials (**1gm = 1ml**)

IF: Cumulative Blood Loss > 500 ml for vaginal birth or > 1000 ml for C/S OR
Increased bleeding during recovery or postpartum OR
Vital Sign changes: HR > 110, BP < 85/45, O2 sat < 95% or >15% change from baseline,
THEN: Proceed to STAGE 1

Stage 1: OB Hemorrhage

Cumulative Blood Loss > 1000 ml , and <1500ml OR
Increased bleeding during recovery or postpartum OR
Vital Sign changes: HR > 110, BP < 85/45, O2 sat < 95% or >15% change from baseline

MOBILIZE	ACT	THINK
Primary nurse: ☐ Notify resident team, OB attending, L&D charge nurse and anesthesia resident **Primary nurse, Physician or CNM**: ☐ Activate OB Hemorrhage Protocol ☐ Bring Hemorrhage Cart to room ☐ Document: OB Hemorrhage Record ☐OB Attending to page OB anesthesia attending for consult in patient room	**Primary nurse**: ☐ Establish IV access if not present and labs if not drawn, at least 18 gauge IV x 1 ☐ Increase IV fluid rate (LR preferred) and increase oxytocin rate (500 mL/hour of 30 units/500mL solution); Titrate oxytocin infusion to uterine tone ☐ Administer Hemabate 250 mcg IM/IMM OR methergine 200mcg IM ☐Consider TXA- slow IV push over 10 minutes **caution use of TXA with DIC ☐ Vital Signs, including O2 sat & level of consciousness (LOC) q5 minutes ☐ Administer oxygen to maintain O2 sats at >95% ☐ Empty bladder: straight cath or place Foley ☐ Keep patient warm **Physician or midwife:** ☐ Continue vigorous fundal massage ☐ Rule out non-atony etiology, at c/s inspect broad ligament, posterior uterus ☐ Type and Crossmatch for 2 units Red Blood Cells STAT (if not already done) **2nd Nurse (or OB Charge Nurse):** ☐ Weigh materials, calculate and **record** cumulative blood loss q 5-15 minutes	**Consider potential etiology:** • Uterine atony • Trauma/Laceration • Retained placenta • Amniotic Fluid Embolism • Uterine Inversion • Coagulopathy • Placenta Accreta • Uterine Rupture **? Contraindications to methergeine→HTN or to Hemabate→asthma** **Once stabilized:** Modified Postpartum management with increased surveillance

IF: Continued bleeding or vital sign instability AND <1500 ml cumulative blood loss
THEN: Proceed to STAGE 2

Stage 2: OB Hemorrhage

Continued bleeding OR Continued Vital Sign Instability AND Cumulative Blood Loss < 1500 ml

MOBILIZE	ACT	THINK
Physician or CNM: ☐ Consider moving to OR (L&D or Main OR) ☐ If on postpartum unit, move to L&D ☐ Consider notifying: 2nd OB attending, blood bank, GYN Onc, IR, main OR charge nurse **Primary nurse (or delegate):** ☐ Notify OB attending (if not present), anesthesia attending **Charge nurse:** ☐ Assign single person to communicate with blood bank ☐ Call social worker or assign other family support person	**OB Physician/Anesthsiologist:** ☐ Additional uterotonic medications: Methergine 0.2 mg IM (if no HTN) and/or Misoprostol 800 mcg PR or 400-600 mcg SL o Continue repeat dosing of Hemabate q 15 min (75% respond to 1st dose) ☐Give TXA- slow IV push over 10 minutes **caution use of TXA with DIC **Do not delay other interventions while waiting for response to medications** ☐ Bimanual uterine massage ☐ Order 2 units PRBCs and bring to the bedside, consider thawing 2u FFP (takes 30 min), use if transfusing >2 units PRBCs ☐ Order labs STAT (CBC, Coags w/fibrinogen, consider ABG, Ca/lytes) ☐ **Transfuse PRBCs based on clinical signs, do not wait** for lab results ☐ Consider appropriateness of: Bakri Balloon, D&C, Laparotomy or IR -If IR considered, call to alert them to the possibility ASAP **Primary nurse**: ☐ Establish 2nd large bore IV (at least 18g); Maintain adequate fluid volume with LR and adequate uterine tone with oxytocin infusion ☐ Assess and announce Vital Signs q5 min ☐ Set up blood administration set and blood warmer for transfusion ☐ Administer meds, blood products and draw labs, as ordered ☐ Keep patient warm **Second nurse (or charge nurse):** ☐ Obtain Hemorrhage cart (if not already done) ☐ Place Foley (if not already done) ☐ Continue quantifying EBL by weighing, document on OB Hemorrhage Record and *verbalize* EBL q 5-10 minutes ☐ Obtain blood products from the Blood Bank ☐ Assist with move to OR (if indicated)	**Sequentially advance through interventions** based on etiology: **Atony:** **-Bakri Balloon** **-Uterine hemostatic suture** (B-Lynch, O'Leary) **-Uterine Artery Ligation** **Trauma** (vaginal, cervical or uterine): -Visualize and repair **Retained placenta**:D&C **Uterine Inversion**: Anesthesia and uterine relaxant for manual reduction **Amniotic Fluid Embolism**: Aggressive respiratory, vasopressor and blood product support **If vital signs are worse than estimated blood loss**: DIC, possible uterine rupture or broad ligament tear with internal bleeding → **move to laparotomy** **Once stabilized:** Modified Postpartum management with increased surveillance

Re-Evaluate Bleeding and Vital Signs:
IF: cumulative Blood Loss > 1500 ml OR > 2u PRBCs given OR Vital Sign Instability OR suspicion for DIC:
THEN: Proceed to STAGE 3

Stage 3: OB Hemorrhage

Continued Bleeding with:

Total Blood Loss > 1500 ml OR > 2 units PRBCs given OR VS instability OR suspicion for DIC

MOBILIZE	ACT	THINK
Nurse or Physician: ☐ **Move to OR** if not already there ☐ Activate Massive Transfusion Protocol (MTP) (if appropriate) **Charge Nurse or designee:** ☐ Consider notifying: GYN surgeon ☐ Consider notifying: ICU attending ☐ Consider notifying: 2nd Anesthesiologist ☐ Call social worker or assign other family support person if not already done ☐ Call-in OR staff as needed ☐ Reassign staff as needed ☐ Continue OB Hemorrhage Record (In OR, anesthesiologist will assess and document VS) ☐ Notify ANC or Rapid Response nurse as needed for additional support	**Team leader** (OB physician + OB anesthesiologist) ☐ **Order Massive Transfusion (MTP)** (RBCs + FFP + 1u PLTS—see note in right column ☐ Repeat CBC, BMP, PT/aPTT, Fibrinogen, ABG STAT q30-60 min ☐ Dose or Re-dose with standard surgical prophylactic antibiotics ☐TXA if not already given or greater than 30 minutes from first dose (max 2 doses)- **caution use of TXA with DIC **Anesthesiologist** (as indicated): ☐ Arterial blood gases ☐ Central hemodynamic monitoring ☐ CVP or PA line ☐ Arterial line ☐ Vasopressor support ☐ Intubation **Primary nurse:** ☐ Announce VS and cumulative measured blood loss q 5-10 minutes ☐ Apply upper body warming blanket if feasible ☐ Use fluid warmer and/or rapid infuser for fluid & blood product administration ☐ Apply sequential compression stockings to lower extremities ☐ Circulate in OR **Second nurse and/or anesthesiologist:** ☐ Continue to administer meds, blood products and draw labs, as ordered **Third Nurse (or charge nurse):** ☐ Recorder	• **Interventions based on etiology not yet completed** • **Prevent hypothermia, acidemia** • **Selective Embolization (IR)** • **Bakri Balloon placement** **Conservative or Definitive Surgery:** • Uterine Artery Ligation • Uterine Hemostatic Suture • Hysterectomy **For Resuscitation: Aggressively Transfuse <u>Based on Vital Signs, Blood Loss</u>** **HIGH RATIO of FFP to PRBCs- 4:4:1 PRBCs: FFP: Platelets *Use UVMMC blood bank MTP protocol as guide** **Once Stabilized:** Modified Postpartum Management; consider ICU transfer

Postpartum Hemorrhage: set of 7 JCHAO requirements

Provision of Care, Treatment, and Services chapter

Standard PC.06.01.01: Reduce the likelihood of harm related to maternal hemorrhage.

Requirement	EP 2: Develop written evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that includes the following: • The use of an evidence-based tool that includes an algorithm for identification and treatment of hemorrhage • The use of an evidence-based set of emergency response medication(s) that are immediately available on the obstetric unit • Required response team members and their roles in the event of severe hemorrhage • How the response team and procedures are activated • Blood bank plan and response for emergency release of blood products and how to initiate the organization's massive transfusion procedures • Guidance on when to consult additional experts and consider transfer to a higher level of care • Guidance on how to communicate with patients and families during and after the event • Criteria for when a team debrief is required immediately after a case of severe hemorrhage *Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, anesthesiology, nursing, laboratory, and blood bank.*

<u>Multidisciplinary Guidelines</u> (not a policy) had to specify:

- **how MTP is activated**
- **Blood bank plan**
- **What criteria are used to call for help**
- **Who will keep families informed**
- **When we will debrief (when >4u PRBC used since that is counted as a severe maternal morbidity measurement) or any ICU admission**

Postpartum Hemorrhage: set of 7 JCHAO requirements

Requirement	EP 3: Each obstetric unit has a standardized, secured, dedicated hemorrhage supply kit that must be stocked per the organization's defined process and, at a minimum, contains the following: • Emergency hemorrhage supplies as determined by the organization • The organization's approved procedures for severe hemorrhage response	Kit with meds
Requirement	EP 4: Provide role-specific education to all staff and providers who treat pregnant and postpartum patients about the organization's hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the processes or procedures occur, or every two years.	Education
Requirement	EP 5: Conduct drills at least annually to determine system issues as part of on-going quality improvement efforts. Drills include representation from each discipline identified in the organization's hemorrhage response procedure and include a team debrief after the drill.	Drills
Requirement	EP 6: Review hemorrhage cases that meet criteria established by the organization to evaluate the effectiveness of the care, treatment, and services provided by the hemorrhage response team during the event.	Review/QAI
Requirement	EP 7: Provide education to patients (and their families including the designated support person whenever possible). At a minimum, education includes: • Signs and symptoms of postpartum hemorrhage during hospitalization that alert the patient to seek immediate care • Signs and symptoms of postpartum hemorrhage that alert the patient to seek immediate care	Pt education

Must include anesthesiology and Emergency Department: all must be multidisciplinary

Need to develop a Continuing Education Curriculum for RNs and OB providers

AWHONN has handouts for discharge re: PPH and HTN

Preeclampsia/Severe hypertension: set of 6 JCHAO requirements

Standard PC.06.01.03: Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia.

Requirement	EP 1: Develop written evidence-based procedures for measuring and remeasuring blood pressure. These procedures include criteria that identify patients with severely elevated blood pressure.

CMQCC PREECLAMPSIA TOOLKIT
PREECLAMPSIA CARE GUIDELINES
CDPH-MCAH Approved: 12/20/13

PATIENT CARE AND TREATMENT RECOMMENDATIONS
ACCURATE BLOOD PRESSURE MEASUREMENT

Kristi Gabel, RNC-OB, C-EFM, MSN, CNS, Sutter Roseville Medical Center

Standardization of bp measurement is essential

- Position
- Cuff size
- NOT: left lateral decubitus

(yes, we know it makes it better)

Table 1: Steps for Obtaining Accurate Blood Pressure Measurements[3]

Step 1: Prepare equipment	a. Mercury sphygmomanometer is gold standard, can use validated equivalent automated equipment b. Check cuff for any defaults c. Obtain correct size cuff: width of bladder 40% of circumference and encircle 80% of arm (See Figure 1)
Step 2: Prepare the patient:	a. Use a sitting or semi-reclining position with back supported and arm at heart level b. Patient to sit quietly for 5 minutes prior to measurement c. Bare upper arm of any restrictive clothing d. Patients feet should be flat, not dangling from examination table or bed, and her legs uncrossed e. Assess any recent (within previous 30 minutes) consumption of caffeine or nicotine. If blood pressures are at the level that requires treatment, consumption of nicotine or caffeine should not lead to delays in instituting appropriate anti-hypertensive therapies
Step 3: Take measurement	a. Support patients arm at heart level, seated in semi-fowlers position b. For ausculatory measurement: use first audible sound (Kortokoff I) as systolic pressure and use disappearance of sound (Kortokoff V) as diastolic pressure c. Read to the nearest 2 mm Hg d. Instruct the patient not to talk e. At least one additional readings should be taken within 15 minutes f. Use the highest reading g. If greater than or equal to 140/90, repeat within 15 minutes and if still elevated, further evaluation for preeclampsia is warranted. **Do not reposition patient to either side to obtain a lower BP. This will give you a false reading.**
Step 4: Record Measurement	Document BP, patient position, and arm in which taken

Adapted from Peters RM (2008) High blood pressure in pregnancy. Nursing for Women's Health, Oct/Nov, pp. 410-422. Photo courtesy of and printed with permission by Kristi Gabel, RNC-OB, C-EFM, MSN, CNS, Sutter Roseville Medical Center 2013.

Preeclampsia/Severe hypertension: set of 6 JCHAO requirements

Requirement	EP 2: Develop written evidence-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes the following: • The use of an evidence-based set of emergency response medications that are stocked and immediately available on the obstetric unit • The use of seizure prophylaxis • Guidance on when to consult additional experts and consider transfer to a higher level of care • Guidance on when to use continuous fetal monitoring • Guidance on when to consider emergent delivery • Criteria for when a team debrief is required *Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, emergency department, anesthesiology, nursing, laboratory, and pharmacy.*

Kit with meds

Mg indications

Consult/Transfer

Fetal assessment

Delivery

Debrief

<u>Guidelines (not a policy):</u>

- Emergency meds stocked and available on the unit (we developed a kit for the Pyxis)
- Who will get seizure prophylaxis (we said severe disease, not otherwise contraindicated)
- When to call experts
- We said delivery as clinically indicated by maternal or fgetal status
- We said debrief for any ICU admission

Preeclampsia/Severe hypertension: set of 6 JCHAO requirements

Requirement	EP 3: Provide role-specific education to all staff and providers who treat pregnant/ postpartum patients about the hospital's evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years. *Note: The emergency department is often where patients with symptoms or signs of severe hypertension present for care after delivery. For this reason, education should be provided to staff and providers in emergency departments regardless of the hospital's ability to provide labor and delivery services.*

- **Include anesthesiology and emergency physicians as well as all providers that treat pregnant women**
- **Will develop material for providers to do with credentialing (q2 yrs)**
- **RNs will have educational sessions**

Preeclampsia/Severe hypertension: set of 6 JCHAO requirements

Requirement	EP 4: Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Severe hypertension/preeclampsia drills include a team debrief.

- Drills should be annually
- Include the ED and anesthesiology

Requirement	EP 5: Review severe hypertension/preeclampsia cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided to the patient during the event.

- Determine criteria for review
- We decided on ICU admission
- Might consider any pt that presents in the ED as well for QAI and education

Preeclampsia/Severe hypertension: set of 6 JCHAO requirements

Requirement	EP 6: Provide printed education to patients (and their families including the designated support person whenever possible). At a minimum, education includes: • Signs and symptoms of severe hypertension/preeclampsia during hospitalization that alert the patient to seek immediate care • Signs and symptoms of severe hypertension/preeclampsia after discharge that alert the patient to seek immediate care • When to schedule a post-discharge follow-up appointment

- We use Injoy
- AWHONN has good discharge handout which we will use as well

PPH and HTN account for >80% of Severe Maternal Morbidity regarless of hospital size
PPH and HTN are the targets for intervention to reduce maternal morbidity and mortality nationally

Postpartum Hemorrhage: set of 7 JCHAO requirements

Preeclampsia/Severe hypertension: set of 6 JCHAO requirements

- **JCHAO will expect you to have guidelines/policies that address these**
- **Critical Access Hospitalss may no be required to follow these but they make good sense given the contribution to severe maternal morbidity even in small hospitals where these events are rare**

WIC Prenatal Provider Outreach

April 9, 2020

VCHIP Webinar

Amy Malinowski, RD and Jen Woodard, MS, RD

Agenda

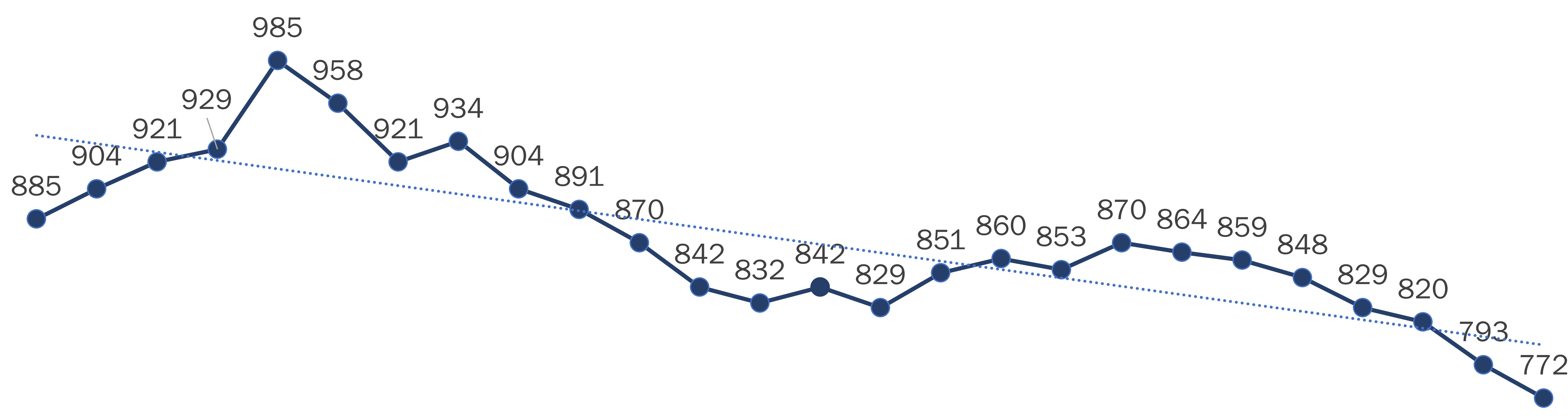
- Recent WIC Data and Research
- Ways to Partner
- WIC’s Response to COVID-19
- New and Planned Outreach/Referral Materials

Why WIC?

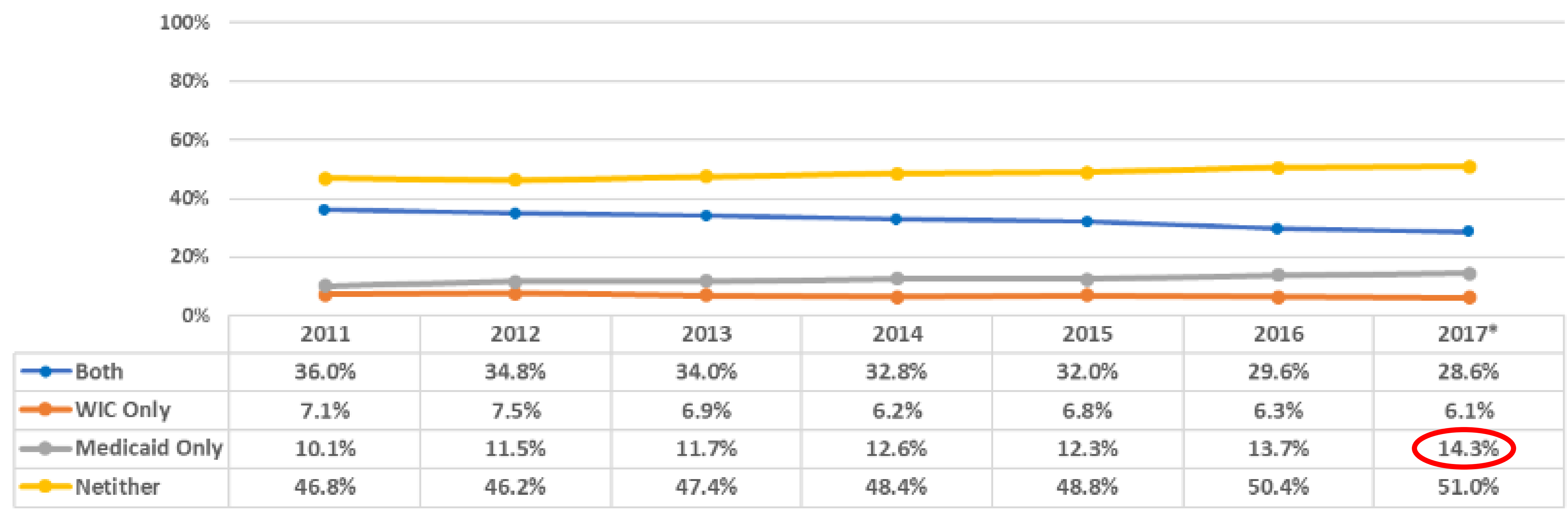
- Nutrition Education, Foods, Referrals
- Breastfeeding Support
- Improved Health Outcomes; WIC participation associated with:
  - Lower infant mortality
  - Reduced rate of LBW and VLBW infants
  - Longer pregnancies, fewer premature births
  - More likely to receive prenatal care
  - Prenatal and postpartum: higher Hgb, less obesity, higher birthweight at subsequent pregnancy than those who participating only prenatally
- Cost Savings: Every dollar spent on pregnant women in WIC produces **$1.92 to $4.21** in Medicaid savings for newborns and their mothers.

Active Pregnant WIC Participants

January 2018 - February 2020

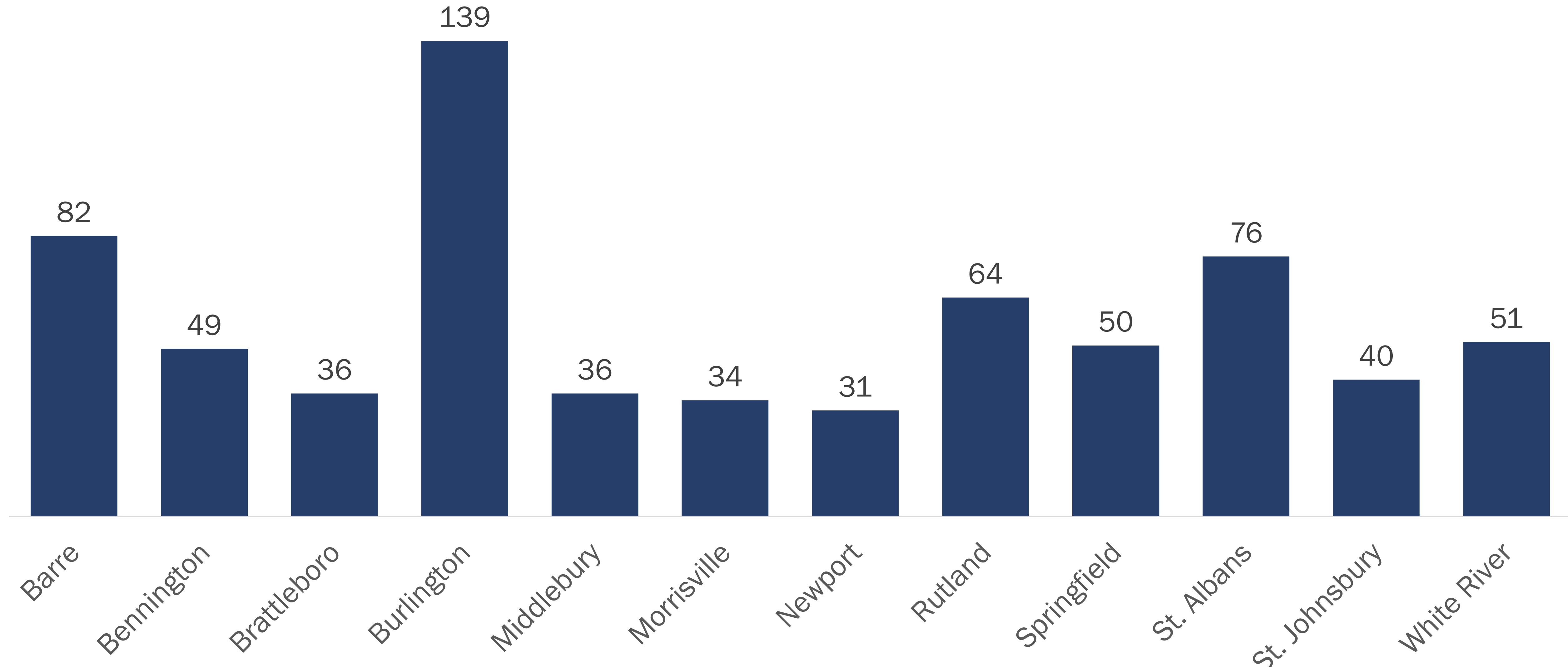


WIC Data, January 2018 - February 2020



	2011	2012	2013	2014	2015	2016	2017*
Both	36.0%	34.8%	34.0%	32.8%	32.0%	29.6%	28.6%
WIC Only	7.1%	7.5%	6.9%	6.2%	6.8%	6.3%	6.1%
Medicaid Only	10.1%	11.5%	11.7%	12.6%	12.3%	13.7%	14.3%
Netither	46.8%	46.2%	47.4%	48.4%	48.8%	50.4%	51.0%

** 2017 Vermont Vital Statistics are preliminary data.*



Vital Statistics, 2018, *preliminary data

Response to COVID-19

- Between March 16 and March 31 – **3.9%** increase in participation, **444** participants (across categories)
- We are maintaining WIC Operations:
  - All WIC appointments held by phone
  - Nutrition and Breastfeeding Support available by phone
  - Temporarily expanded WIC food options to make shopping easier
  - Working with stores to ensure contract infant formula is available. We encourage families to check at customer service if the infant formula shelf is empty.
  - Communication of these changes to WIC families by text, through our participant newsletter, Facebook posts, and our website which is updated regularly: www.healthvermont.gov/wic

WIC's Ask of Providers

- Refer patients to WIC as part of initial prenatal visit
- Assess ongoing WIC participation and use of benefits
- Ask about WIC at follow-up appointments and refer again as needed

New WIC Referral Resources

New WIC Referral Re

GET A HEALTHY START WITH WIC

REFER TO WIC

WIC provides nutrition counseling, breastfeeding support and healthy foods free for Vermont families who qualify.

PREGNANT OR POSTPARTUM

Name:____________________

Date of birth:________________

Address:____

Phone:____________________

Email:________________________________

CHILD(REN) UNDER 5

Name(s):______________________

Date(s) of birth:__________________

Permission to text: Yes / No

Medical Provider: Please complete the following information

Practice Name:______________________ Phone:__________________

☐ **The above-mentioned patient(s) agree to have WIC contact them to determine WIC eligibility.**

Apply at your local WIC clinic, text **VTWIC** to **855-11**, or start your application online at healthvermont.gov/wic

Vermont Department of Health
Burlington WIC Program
108 Cherry Street, Suite 102
Burlington, VT 05402
802-863-7323 or Toll-free 888-253-8803
Fax 802-863-7571

This institution is an equal opportunity provider.

YOU GOT THIS.

Text VTWIC to 855-11 or apply at healthvermont.gov/wic

Text VTWIC to 855-11 or start your application online at healthvermont.gov/wic

Vermont WIC is:

- Nutrition Counseling
- Breastfeeding Support
- Healthy Foods

All services are free for Vermont families who qualify
From pregnancy through age 5 – You got this.
We're here to help.

This institution is an equal opportunity provider.

WASH IT simply rinse your sticky clean with soap and water, let it air dry, and restick it to your mobile device!

SIGN UP FOR VT WIC – IT'S EASY!

TEXT

VTWIC to

855-11

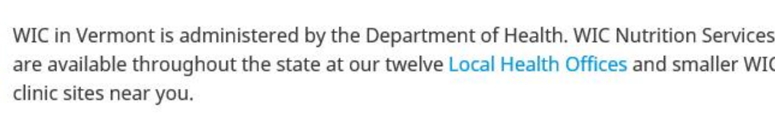
WIC Online “Application”

lytowic

HOME / CHILDREN, YOUTH & FAMILIES / WIC /

HEALTHY RELATIONSHIPS
FAMILY PLANNING & PREGNANCY
INFANTS & YOUNG CHILDREN
CHILDREN WITH SPECIAL HEALTH NEEDS
SCHOOL HEALTH
ADOLESCENT HEALTH
HEALTH CARE FOR CHILDREN & YOUTH
WIC

APPLY TO WIC



SIGN UP TODAY! or text VTWIC to 855-11 to sign up!

Standard message & data rates ma

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Vermont WIC Online Application

Apply for Vermont WIC Online

Page description:
Start your application today. Follow these steps:

1. Complete and submit this form.
2. After you submit this form, someone from your local WIC office will contact you to find out if you qualify. If you do, they will set up a WIC appointment.
3. Attend your appointment to enroll in WIC.

It's that easy!

healthvermont.gov/children-youth-families/wic/resources-health-professionals

CHILDREN, YOUTH & FAMILIES

HEALTHY RELATIONSHIPS

FAMILY PLANNING & PREGNANCY

INFANTS & YOUNG CHILDREN

CHILDREN WITH SPECIAL HEALTH NEEDS

SCHOOL HEALTH

ADOLESCENT HEALTH

HEALTH CARE FOR CHILDREN & YOUTH

WIC

PLANS & REPORTS

CONTACT:

Maternal & Child Health Division
108 Cherry Street
Burlington, VT 05401
Phone: 802-863-7333

QUICK LINKS | ALERTS | GET HELP NOW | HOW HEALTHY ARE WE? | SEARCH

When you're in central Vermont, stop by our Barre Office of Local Health and check out this inspiring show of art b... https://t.co/6kObafLIT7
Read More

HOME / CHILDREN, YOUTH & FAMILIES / WIC /

VERMONT WIC RESOURCES FOR HEALTH PROFESSIONALS

"Those living in food insecure households consume fewer servings of fruits, vegetables, and whole grains, and more sugar, fat, and salt. These dietary shortfalls are linked to chronic diseases, including diabetes, cardiovascular disease, and cancer. Given their vulnerability, the elderly and children suffer the greatest impact." (USDA Food & Nutrition Service)

Through good nutrition, WIC helps ensure optimal health outcomes for pregnant people, new parents, and families with infants and young children. As Vermont's premier public health nutrition program, WIC's nutrition education, breastfeeding support, and healthy foods support thousands of parents, infants and children every year to eat well, learn about good nutrition and stay healthy. WIC and health professionals work together to help Vermont's families get the support they need during critical periods of growth and development, giving children the best possible start in life. Find out more about the many benefits of WIC, how to help families apply and learn about WIC's role in improving lifetime health for parents, their infants, and young children.

PROVIDER UPDATE: VT WIC FORMULA

› Medical Documentation Requirements for Medical Formula and WIC Foods

› WIC Mother/Baby Breastfeeding Support

› WIC Resources for Health Professionals

› Birth and Beyond: 10 Steps to Empower Mothers and Nurture Babies Training Resources

National WIC Patient Outreach Material –

7 MILLION WOMEN, INFANTS, AND CHILDREN GET WIC BENEFITS. ARE YOU ELIGIBLE?

WHAT IS WIC?

WIC is the nation's most successful public health nutrition program. We provide healthy food, nutrition education, and community support to income-eligible pregnant women, moms of infants, and children up to 5 years old. With WIC, you:

- get healthy food and tips on how to prepare it.
- meet other moms as well as nutrition and breastfeeding experts for help and support.
- find out about other local services such as dental care and immunizations.

WHO IS ELIGIBLE?

- Pregnant women
- Mothers of babies up to 6 months old
- Mothers who are breastfeeding babies up to 12 months old
- Kids up to 5 years old

HOW CAN I FIND OUT MORE?

CALL

VISIT

WE'RE HERE FOR YOU

Did you know WIC offers the following?

HEALTHY FOOD + NUTRITION TIPS

We help you feed your kids nutritious meals. We provide:

- monthly vouchers to buy healthy food.
- tips on how to shop for healthy food, how to cook it, and how to encourage your kids to eat it.
- a larger food package if you breastfeed exclusively to help you stay healthy.

A COMMUNITY OF SUPPORT

We offer a network of experts and peers for education and guidance:

- nutritionists to help you and your kids eat well
- breastfeeding specialists to help you breastfeed successfully
- other moms for sharing experiences and for moral support

REFERRALS

We introduce you to care beyond WIC, including:

- healthcare professionals such as pediatricians and dentists
- immunization services
- other social services

WIC is administered by the United States Department of Agriculture (USDA). The USDA, WIC, and organizations or institutions administering WIC are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity. Submit complaints by letter or form AD-3027 (available at 866-632-9992) to: USDA, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; by fax: (202) 690-7442; or by email at program.intake@usda.gov. © 2016 National WIC Association. "WIC" is a registered trademark of the U.S. Department of Agriculture. All rights reserved.

Opt in to receive at nwa.meredithcustomsolutions.com

Questions?

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Your patients can reach us at:

WIC@vermont.gov

Thank you!