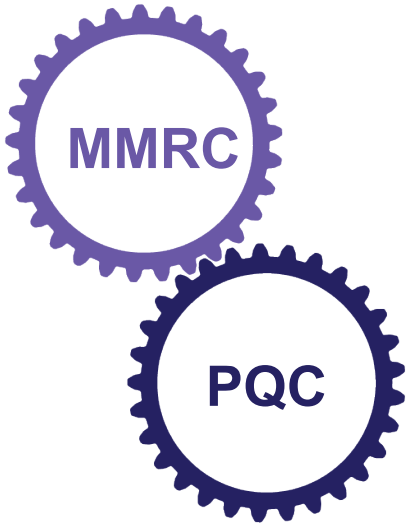


PA PQC

Pennsylvania Perinatal Quality Collaborative

Virtual Meeting

March 16, 2023

Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and the **American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team**. 1.00 hour is approved for this course.**

As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the **Association of Social Work Boards' (ASWB)** Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive **1.00 continuing education credit**.

Disclosures

No members of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity **have relevant financial relationships** with any entity producing, marketing, re-selling, or distributing health care goods or services, used on, or consumed by, patients to disclose.

Disclaimer

The information presented at this Center for Continuing Education in Health Sciences program **represents the views and opinions of the individual presenters**, and does not constitute the opinion or endorsement of, or promotion by, the UPMC Center for Continuing Education in the Health Sciences, UPMC / University of Pittsburgh Medical Center or Affiliates and University of Pittsburgh School of Medicine. Reasonable efforts have been taken intending for educational subject matter to be presented in a balanced, unbiased fashion and in compliance with regulatory requirements. However, each program attendee must always use his/her own personal and professional judgment when considering further application of this information, particularly as it may relate to patient diagnostic or treatment decisions including, without limitation, FDA-approved uses and any off-label uses.

Agenda

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

2. **QI Workshop: Key Interventions for Connecting Across the Continuum of Care** – Jennifer Condel, SCT(ASCP)MT, Manager, Lean Healthcare Strategy and Implementation, Jewish Healthcare Foundation

3. **Discussion** – facilitated by Jennifer Condel, SCT(ASCP)MT

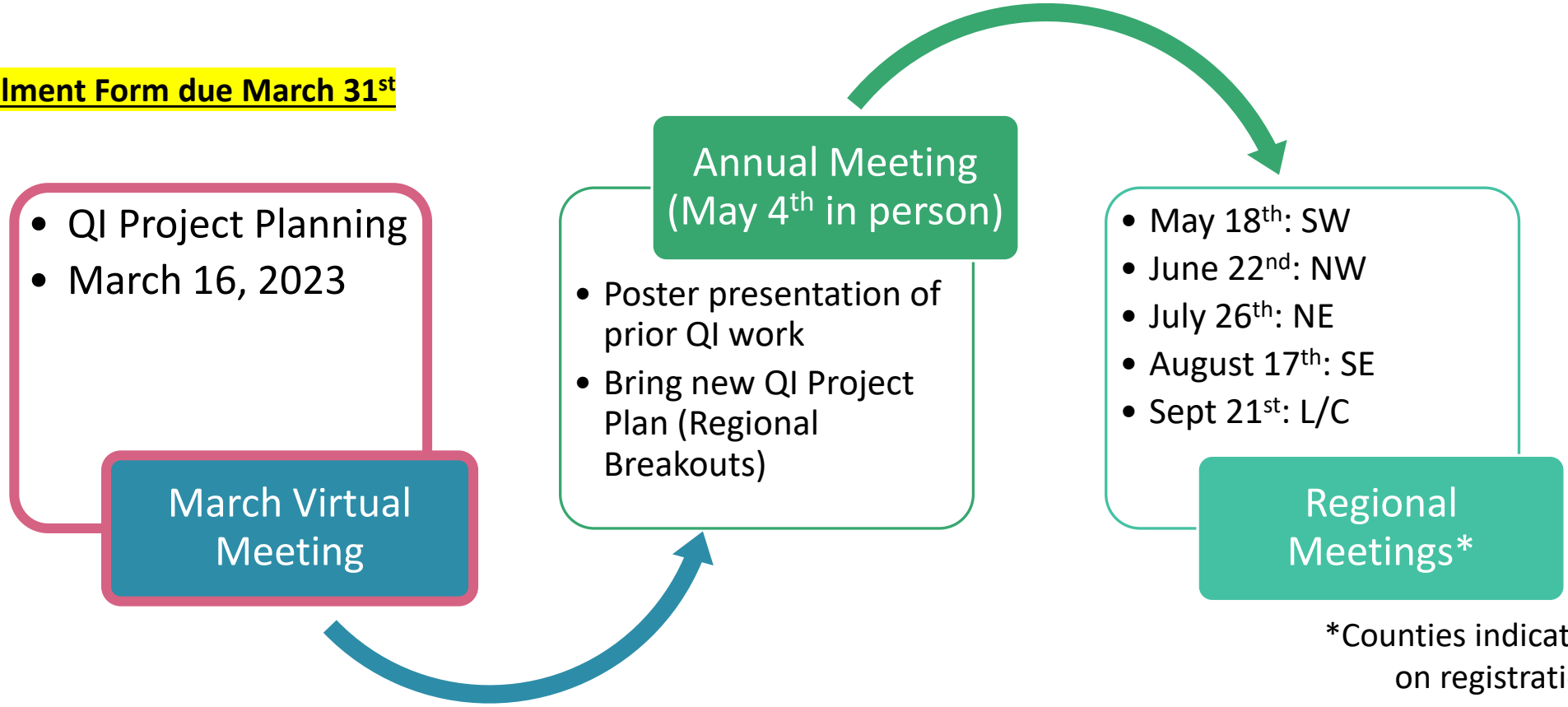
4. **Wrap-Up & Next Steps** – Sara Nelis, RN

Quality Improvement: Project Planning

JENNIFER CONDEL, SCT(ASCP)MT
MANAGER, LEAN HEALTHCARE STRATEGY AND IMPLEMENTATION
JEWISH HEALTHCARE FOUNDATION

PA PQC Implementation Period: April 2023 – March 2024

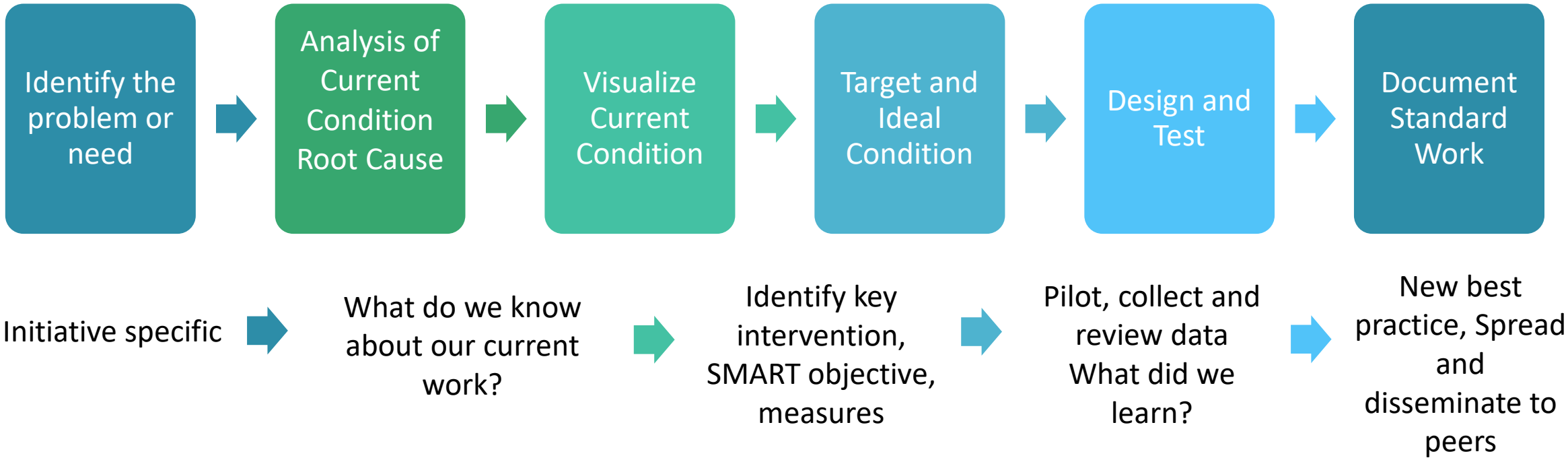
Annual Enrollment Form due March 31st



*Counties indicated by region on registration links

https://www.whamglobal.org/member-content/register-for-sessions

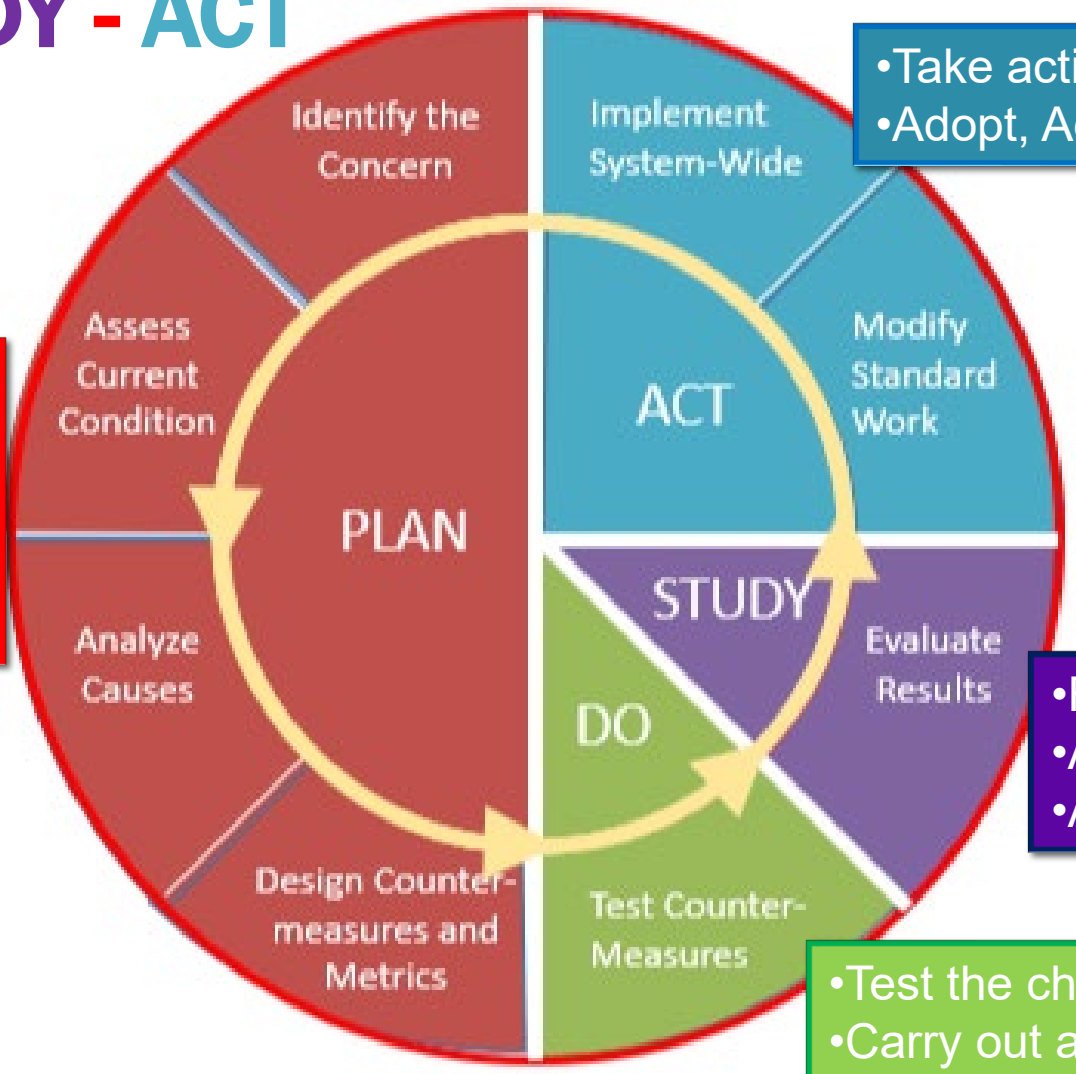
QI Project Plan Framework



An Organized Approach to Quality Improvement

PLAN - DO - STUDY - ACT

- Identify your goal
- Understand the **current state**
- Design experiment/interventions
- Identify metrics
- Predict results



- Take action based on what you learned
- Adopt, Adapt, Abandon

- Review the test
- Analyze results
- Assess learnings

- Test the change
- Carry out a small-scale experiment
- Collect data

Reducing waste while increasing value.

PDSA Thinking:
The Foundation of Quality Improvement

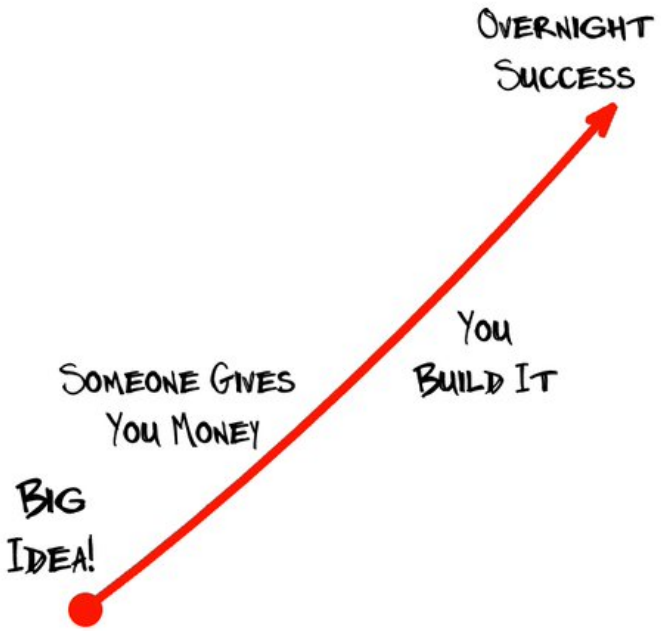
An approach and shared language to **standardizing** problem solving

A way of **engaging and organizing teams** to continuously identify and act upon opportunities for improvement

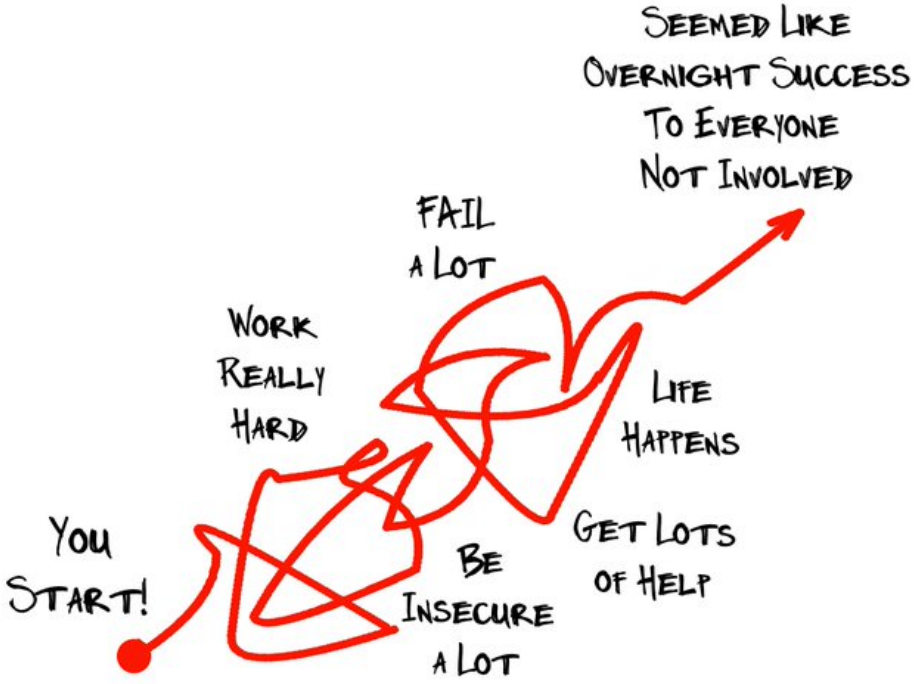
Applied to process changes as well as behavior changes, and to problems big and small

Supports **deep examination** of problems

Quality Improvement is an enterprise-wide, 24/7 commitment



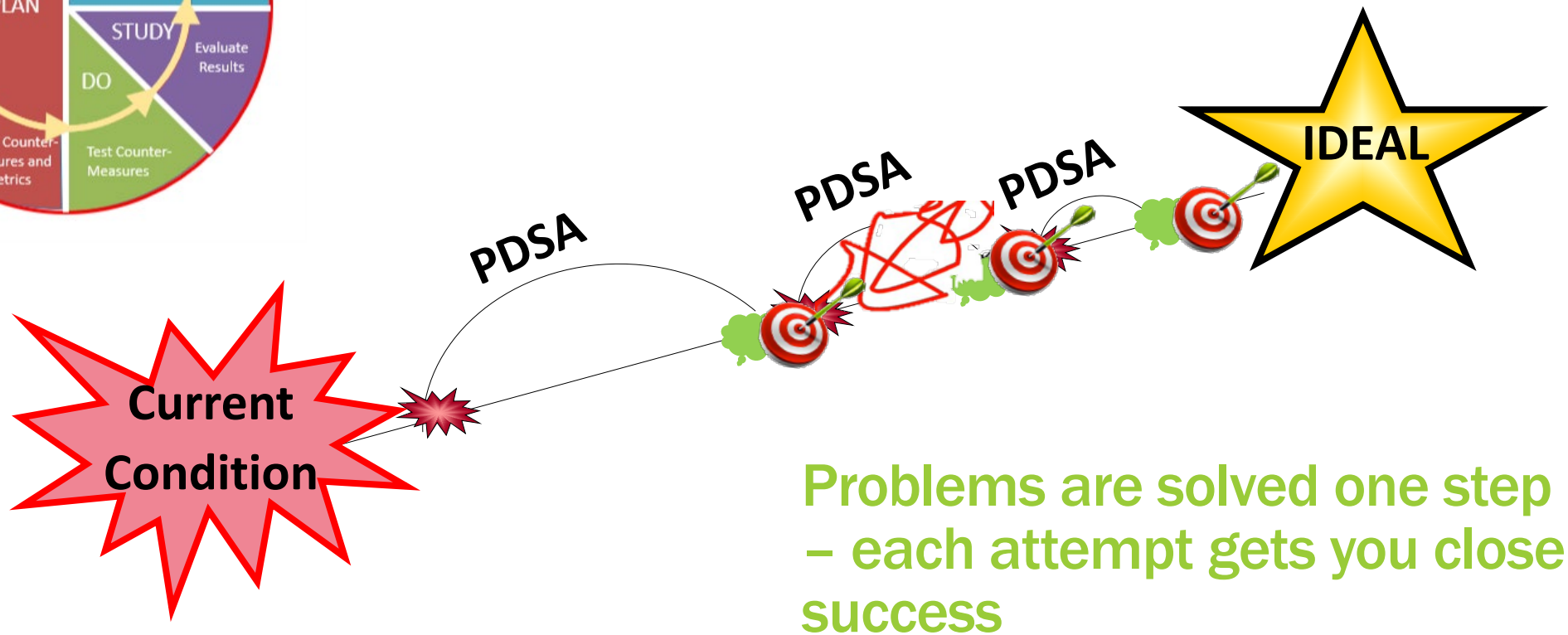
WHAT PEOPLE THINK IT LOOKS LIKE . . .



WHAT IT REALLY LOOKS LIKE . . .

Matt Gubba @MattGubba Jul 7, 2016

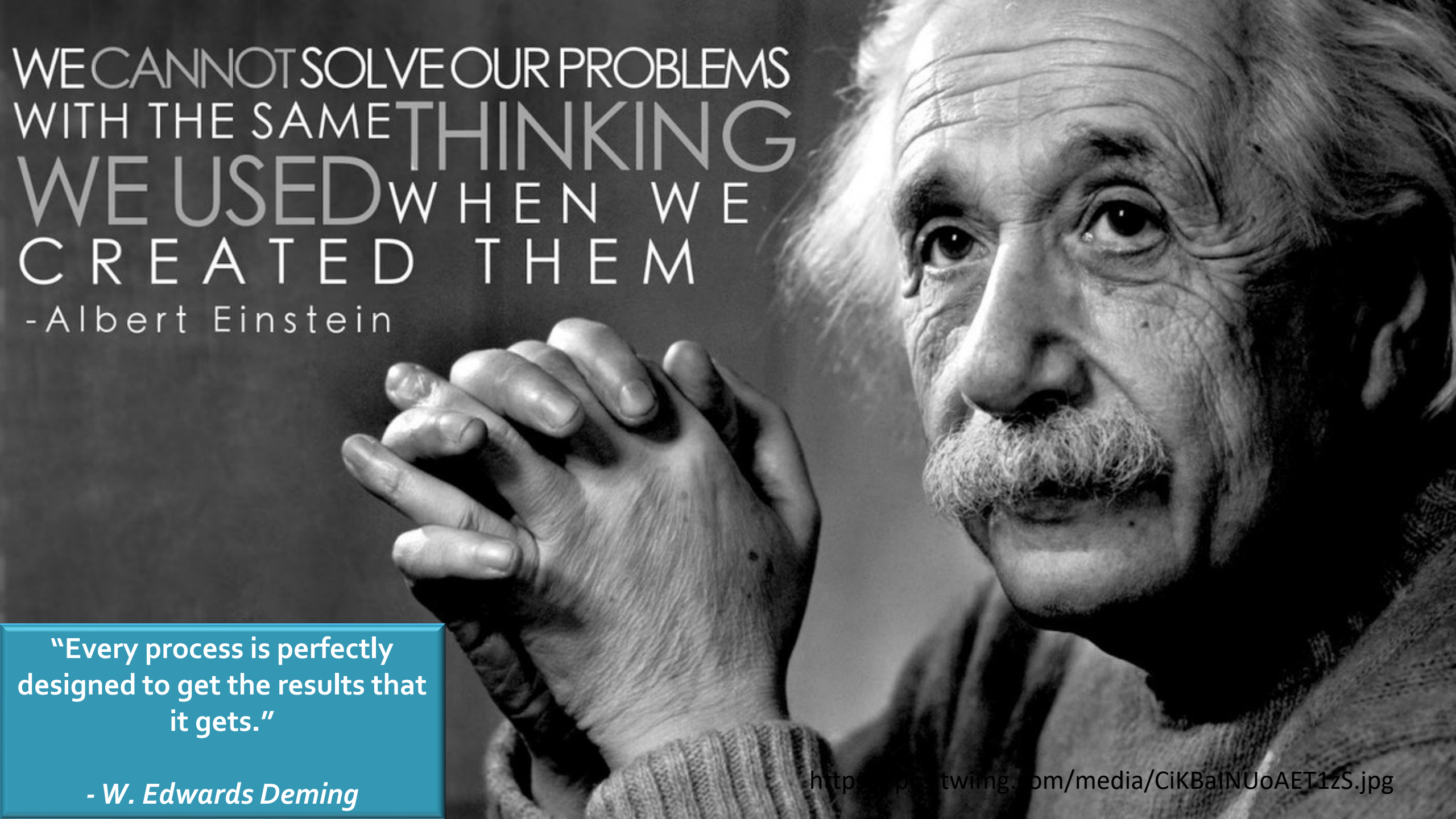
PDSA Thinking is Iterative and Continuous



Problems are solved one step at a time – each attempt gets you closer to success

Key Interventions for Connecting Across the Continuum of Care

APRIL 2023 – MARCH 2024 IMPLEMENTATION PERIOD THEME



"Every process is perfectly designed to get the results that it gets."

- W. Edwards Deming

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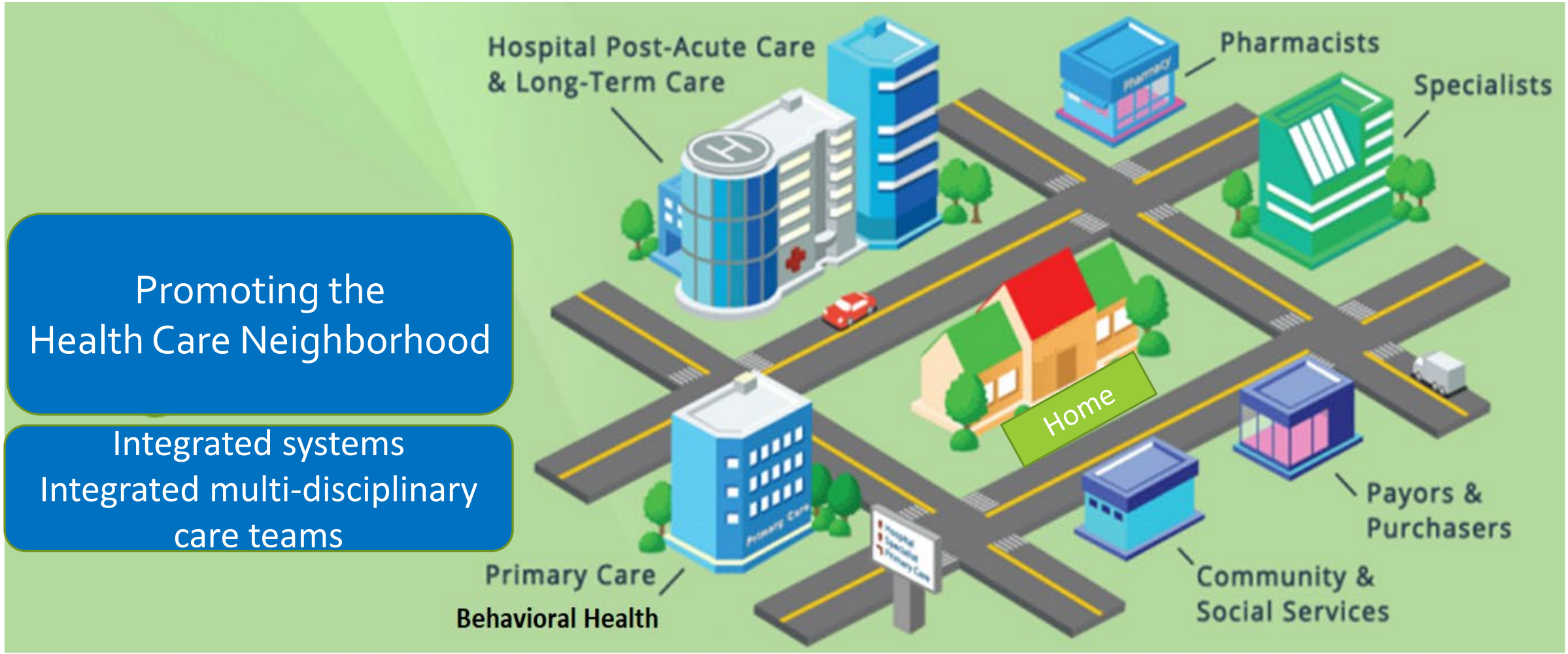
Continuum of Care Requires Systems Thinking

Promoting the Health Care Neighborhood

Integrated systems
Integrated multi-disciplinary care teams



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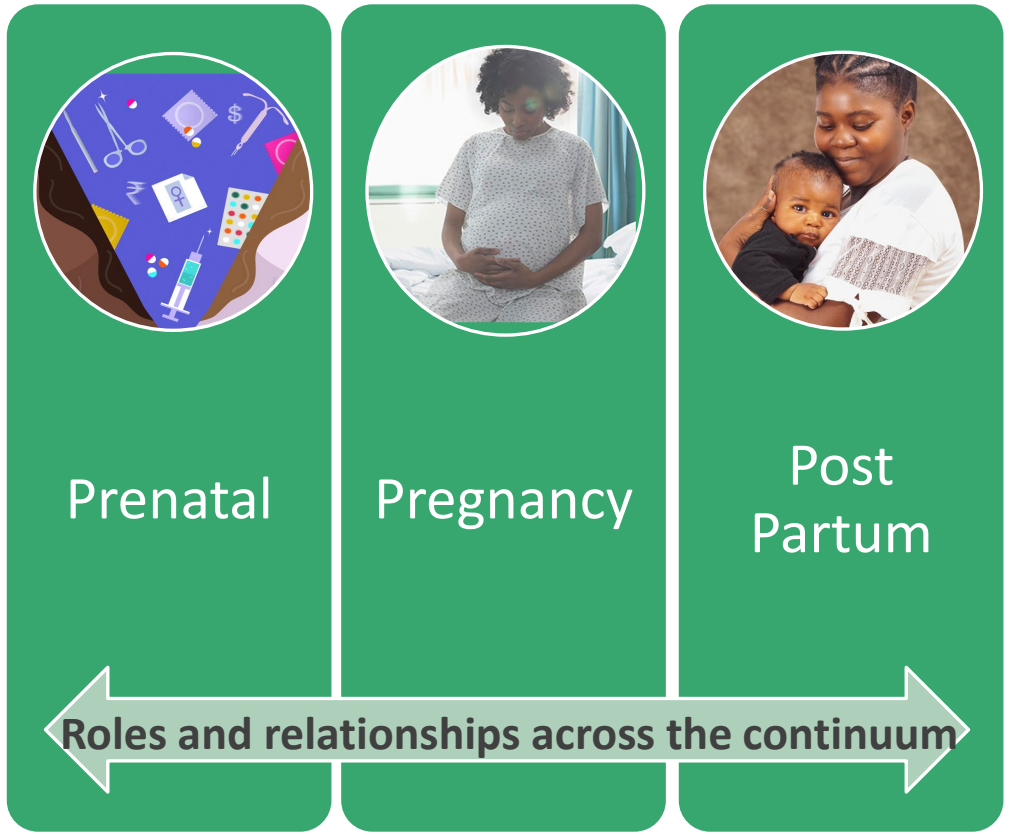
Visualizing the Work: Maternal Care Community

Processes of how care is received, delivered and managed

Place in the birthing biosphere



Elements to show how we work differently

Roles in addressing maternal health inequities

PA PQC: SEN Goals & Plans

- Increase the percent of newborn care teams ***educated on post-discharge services*** from **70% to 80%** of participating hospitals

- Increase the percent of newborn care teams ***educated on the criteria for Plans of Safe Care*** from **70% to 80%** of participating hospitals

- Maintain at least **75%** of newborns with NAS receiving ***non-pharmacotherapy bundled treatments*** (impacting at least 350 newborns per year)

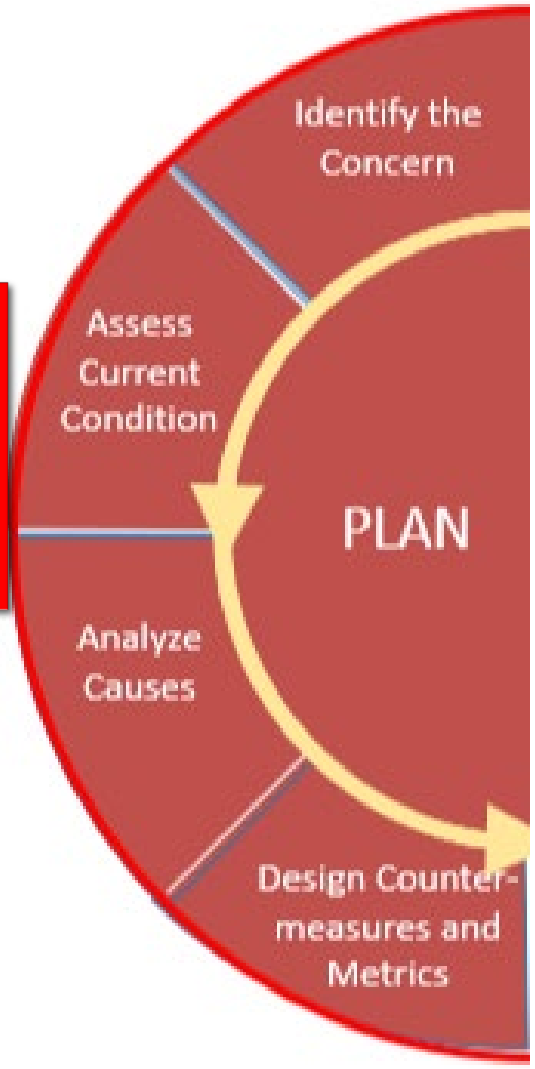
- Increase the percent of newborns with NAS who were ***referred to appropriate follow-up services*** at discharge from **85% to 95%** (impacting at least 350 newborns per year)

- Increase the percent of hospitals with a ***protocol to close the loop*** on the referral status with the post-discharge services and supports from **30% to 50%**

An Organized Approach to Quality Improvement

PLAN - DO - STUDY - ACT

- Identify your goal
- Understand the **current state**
- Design experiment/interventions
- Identify metrics
- Predict results



PA PQC Goal

- Increase the percent of hospitals with a ***protocol to close the loop*** on the referral status with the post-discharge services and supports from **30% to 50%**

What is your Current State or Condition?

What is your healthcare team's protocol to close the loop? Do you have a defined process (standard work)?

What is your healthcare team's data for closing the loop on referrals to discharge services and supports?

Where is this data located and how is it collected?

Do you have Standard Work?

Documentation of the <u>current</u> best practice

Standard work is the foundation of continuous improvement.

We can't improve a process unless we know how it happened in the first place.

Examining Your Current Condition

DIRECT OBSERVATION AND ANALYSIS

The Power of Observation...

Go and See!

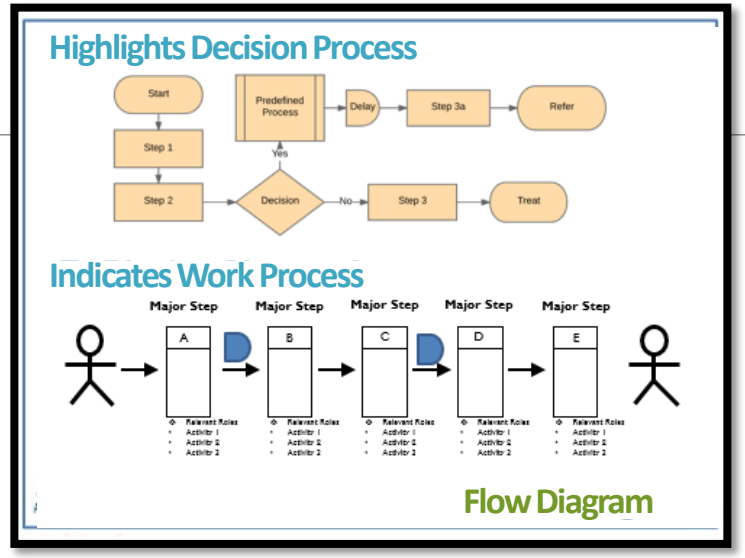
- **Watch how work is *actually occurring***
  - Capture events as they unfold
  - Is the process working the way it is intended?
- **In-depth and detailed understanding** of current state vs. standard work
  - Roles and responsibilities
  - Crosses silos
- Helps to **tell the story** (patient and staff)
  - Gives context to the numbers
- New eyes to see
  - Impacted by perspectives, experiences, expectations—**focus on the facts**
- **Prevents** jumping to solutions
- Solves the **right problem**

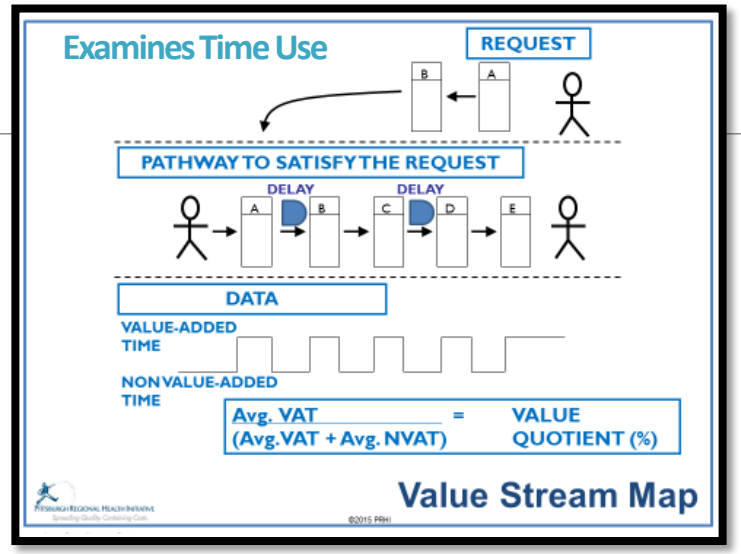
"You can observe a lot just by watching."
-Yogi Berra

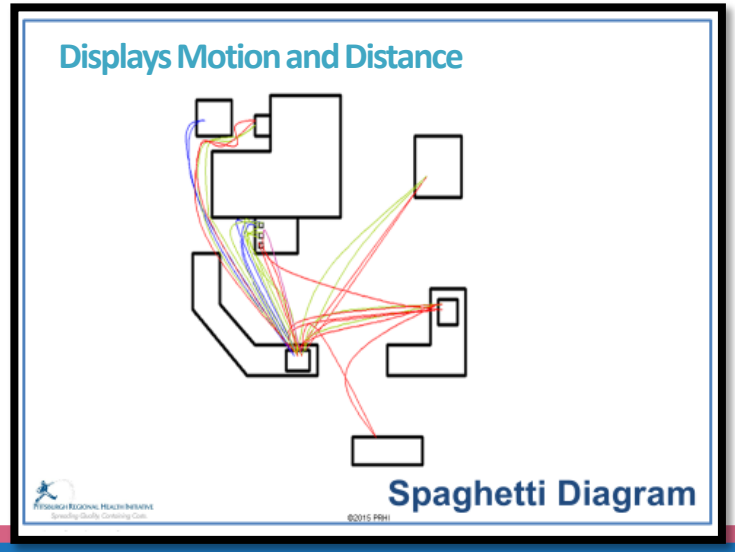
Understanding Your Current Condition

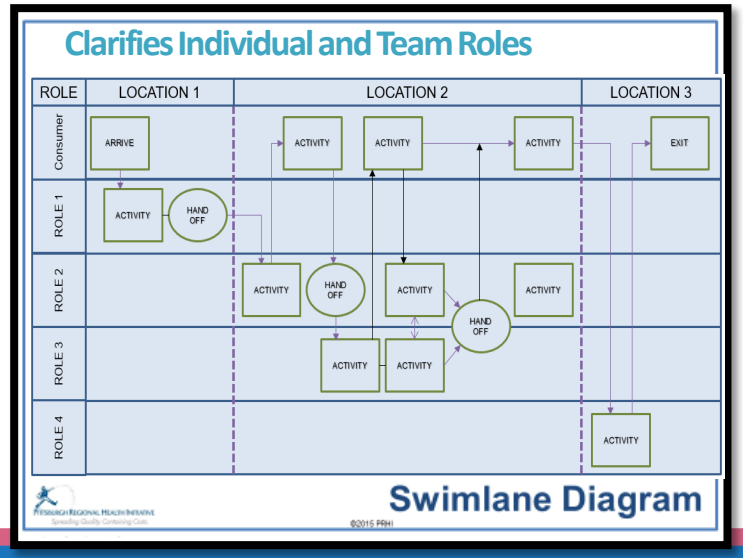
PROCESS MAPPING

Types of Process Maps

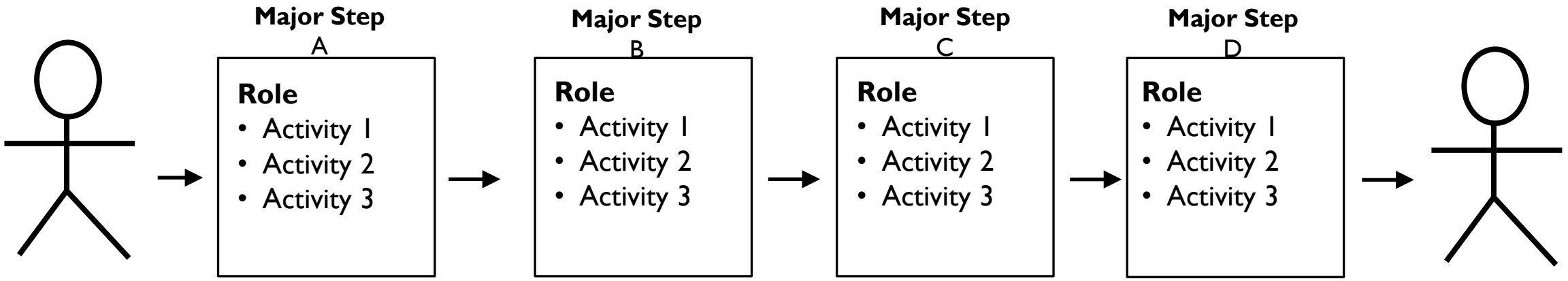




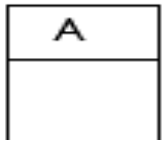




Process Map Template: Mapping Your Workflow



Process Map Symbols



Major step in the process

Delay in the process

Recognized benefit

Opportunity for Improvement

Guiding Principles for Mapping

Rule 1: Specify each step

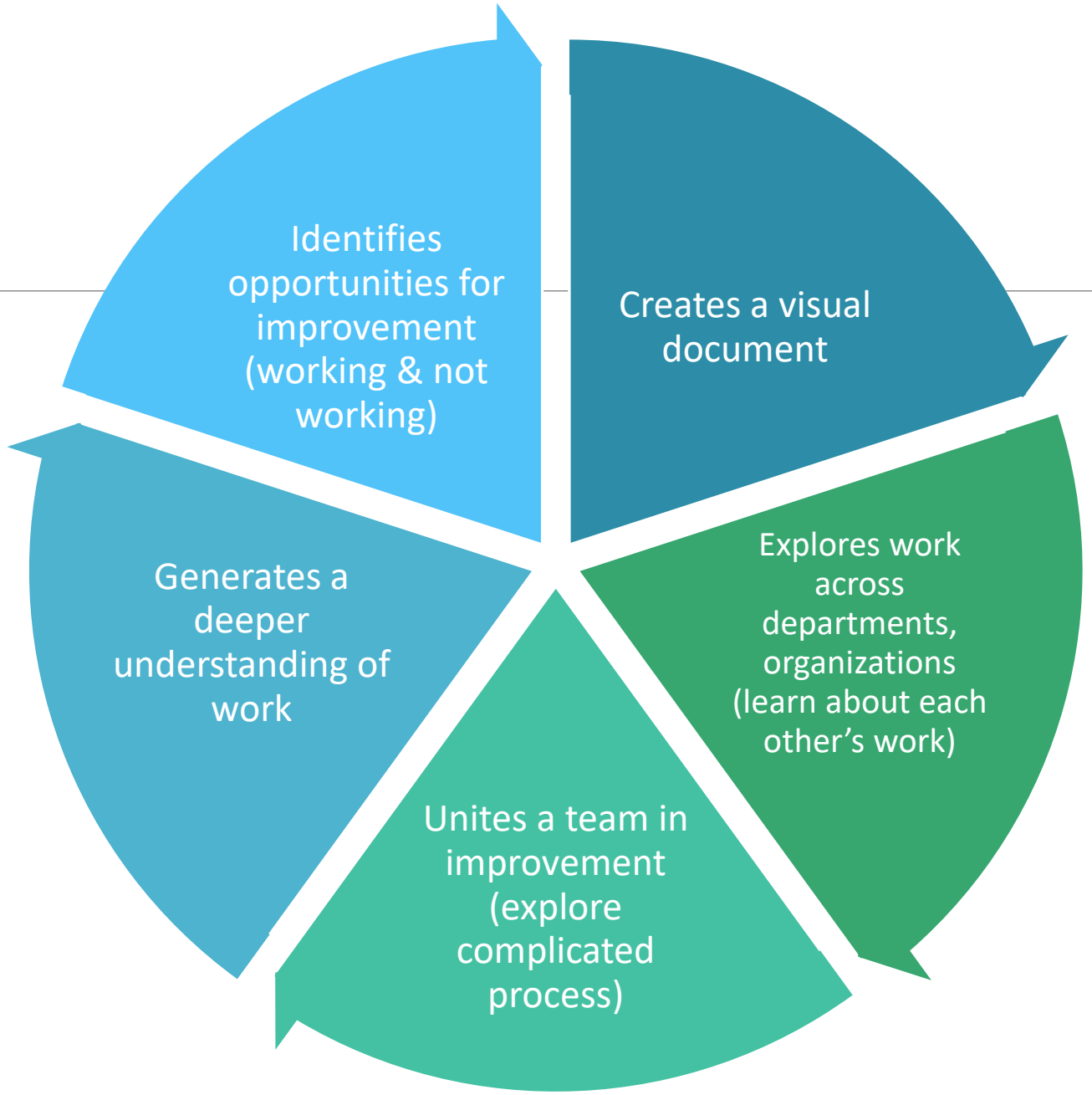
Rule 2: Communicate directly

Rule 3: Follow simple and direct pathways.

Rule 4: Let staff members and data drive process improvements.

What did you observe?

Benefits of Process Mapping



An Organized Approach to Quality Improvement

PLAN - DO - STUDY - ACT

- Identify your goal
- Understand the **current state**
- Design experiment/interventions
- Identify metrics
- Predict results

PA PQC Goal

- Increase the percent of hospitals with a ***protocol to close the loop*** on the referral status with the post-discharge services and supports from **30% to 50%**

What is your Current State or Condition?

Example: our healthcare team does not have a defined protocol to close the loop.

What does the team want to do to address this current state?

Who needs to be on the team?

Substance Exposed Newborn (SEN): Driver Diagram

Key Interventions:

Example:

Aims

5. Increase referrals to and engagement in outpatient family care services, including physical, behavioral, and social services

Establish Family Care Plans Prior to Discharge	▪ Partner with families and social/child services to establish family care plans (Plans of Safe Care) according to federal, state, and county guidelines ▪ Use Cuddler Program to free up parent for treatment

https://www.whamglobal.org/pa-pqc-initiatives

Defining the Problem Approach

Problem

- What is the problem or need?
- How do we know this is a problem?
- Why is it important to solve?

Scope

- Who is experiencing the problem?
- Where is the problem occurring?
- When and how often is the problem happening?

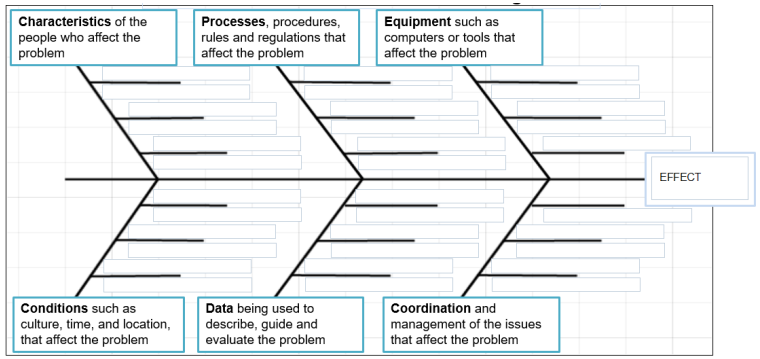
Narrow and define the scope of your QI work

Team

- Who owns the problem (Executive in Charge)?
- Who has an interest in the problem (Stakeholders)?
- Who can make decisions about the problem (Management)?
- Who is directly involved in the problem (Front-line)?

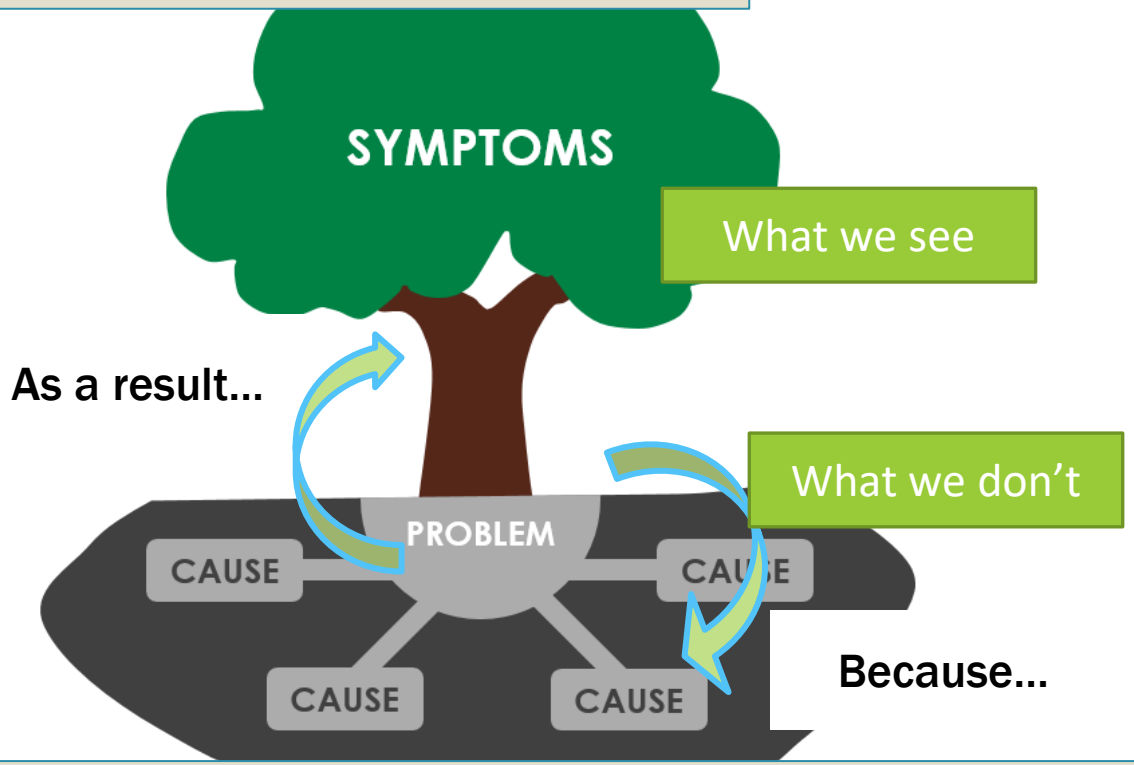
Root Cause Analysis

DEEP EXAMINATION



Root Cause Analysis: Key Points

Addressing symptoms will allow continued *recurrence* of the problem



Addressing the root cause aims to *eliminate* the problem

Listen to the people on the front lines, especially staff and consumers

Explore each suggestion, rather than judging it

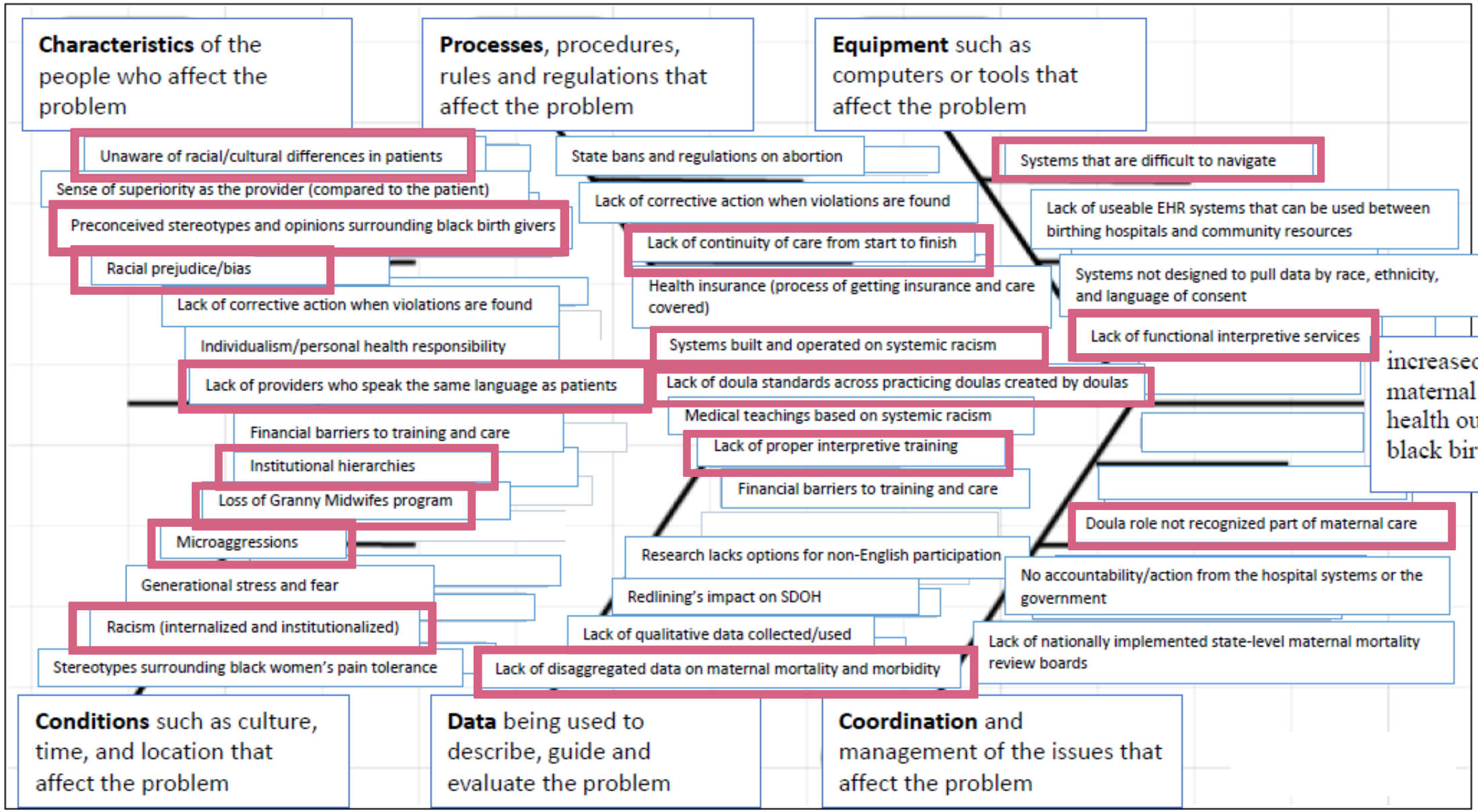
Identify the causes of the problem not the symptoms

Tools: fishbone diagram, 5 WHY's

WHY, focus on the process, not the people

Constructive not punitive

Root Cause Analysis: *Example*



Set Targets and Envision Success

Specific

- What exactly are you going to do for whom?
- *Example: define a protocol for staff to close referral loops, demonstrating a 25% increase in referral completion in 3 months*

Measurable

- Is it quantifiable? Concrete criteria for measuring progress and reaching objective
- *Example: referral loop protocol determined and implemented in 45 days*

Attainable

- Is the objective achievable? Realistic and possible for your team to reach in the time frame and resources
- *Example: designated team will meet every two weeks to refine protocol for implementation in 45 days*

Relevant (Realistic)

- Does this objective impact the desired goal or strategy? Align to your program plan
- *Example: implement a referral loop protocol will increase the ability to effectively refer patients to care and close the loop*

Time- bound

- When will this objective be accomplished? Be specific and reasonable
- *Example: in 3 months, the new referral loop with be implemented and monitored for 3 months*

An Organized Approach to Quality Improvement

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- Identify your goal
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- Design experiment/interventions
- Identify metrics
- Predict results

PA PQC Goal

- Increase the percent of hospitals with a ***protocol to close the loop*** on the referral status with the post-discharge services and supports from **30% to 50%**

Healthcare Team SMART Objective

Examples:

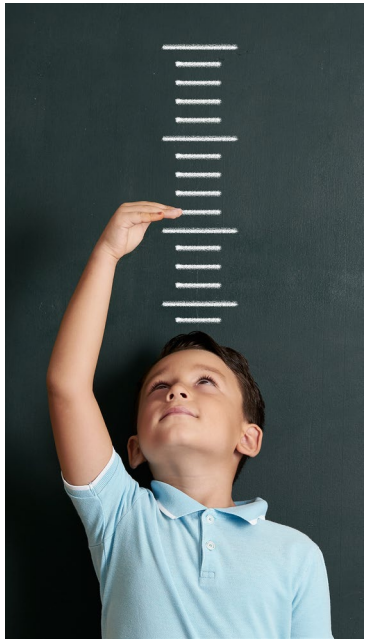
Healthcare Team Project Plan SMART Objective:
Establish a referral process with one social service organization (X) based on **Plans of Safe Care** within the next 6 months.

Healthcare Team Project Plan SMART Objective:
Increase the number of social service organizations with established referral processes from one organization to three based on **Plans of Safe Care** within the next 9 months.

We Need Data!

Data: Measure Change for Improvement

Outcome Measures- *what is your ultimate goal?*
- The voice of the customer (patient, staff).
- Reflects the problem you are trying to address.
- Describes how your overall system is performing.



Process Measures- *how will you get there?*
- Steps logically linked to outcome of interest.
- Addresses how key parts of the system is performing.

Balancing Measures- *how impacting upstream and downstream?*
- Describes what happens to the system as processes and outcomes have changed.
- What are the unintended consequences or alternate explanations?

How will we know the change is an improvement?

Substance Exposed Newborn (SEN): Measures

Example:

Survey: Structure Measure (Reported Quarterly)

11. Has your newborn care team (providers, nurses, and social workers) been educated on the **criteria for Plans of Safe Care**, their role in establishing and initiating the Plans of Safe Care, and how to explain it to families in accordance with your hospital's, county's, and state's guidelines and policies?

- Yes, policies and education completed
- No, working on it
- No, have not started

Measures and Specifications: Process and Outcome Measures (Reported Quarterly)

Measure
6. Percent of newborns with NAS who were referred to appropriate follow-up at discharge

https://www.whamglobal.org/pa-pqc-initiatives

An Organized Approach to Quality Improvement

PLAN - DO - STUDY - ACT

PA PQC Goal

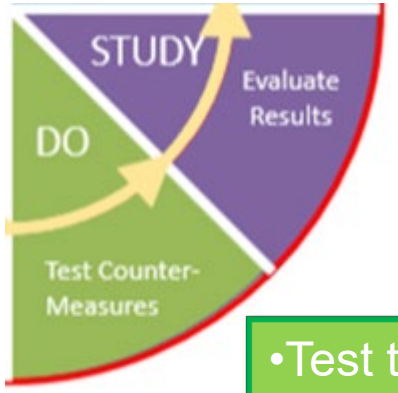
•Increase the percent of hospitals with a ***protocol to close the loop*** on the referral status with the post-discharge services and supports from **30% to 50%**

Example:

Healthcare Team Project Plan SMART Objective:
Establish a referral process with one social service organization (X) based on **Plans of Safe Care** within the next 6 months.

What is the test of the change the team will pilot?

Establish an **action plan** with clearly defined responsibilities, roles, due dates, and expected outcomes



•Review the test
•Analyze results
•Assess learnings

•Test the change
•Carry out a small-scale experiment
•Collect data

Action Planning

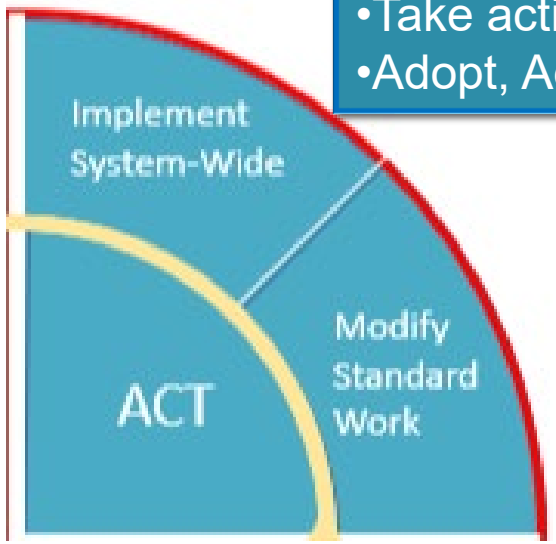
Activity outcome and any barriers

Action Item (What Will Happen)	By Whom (Team Member/Role)	Target Date	Status	Outcomes (Results/Barriers)
Share current data with healthcare team at staff meeting	Jen/ Unit Director	4/1/23	In process	Determining data location and retrieval
Establish 30-day plan to implement pilot	Sue/ Team Lead	4/10/23	To begin after 4/1/23 staff meeting	
Share pilot results with healthcare team at staff meeting	Sue/ Team Lead	5/1/23	To share at 5/1/23 meeting	All staff potentially unavailable for meeting due to conflict
Create new standard work document	Jane/ Nurse Educator	5/1/23		
Determine 60-day plan for spread & dissemination to four campuses	Jen/Unit Director	6/1/23		

Specified Activity

An Organized Approach to Quality Improvement

PLAN - DO - STUDY - ACT



- Take action based on what you learned
- Adopt, Adapt, Abandon

PA PQC Goal

- Increase the percent of hospitals with a ***protocol to close the loop*** on the referral status with the post-discharge services and supports from **30% to 50%**

Example:

Healthcare Team Project Plan SMART Objective:
Establish a referral process with one social service organization (X) based on **Plans of Safe Care** within the next 6 months.

What did the team learn from the pilot?

Establish an **action plan** to implement and monitor new standard work

Data are essential to each step in the process improvement journey.

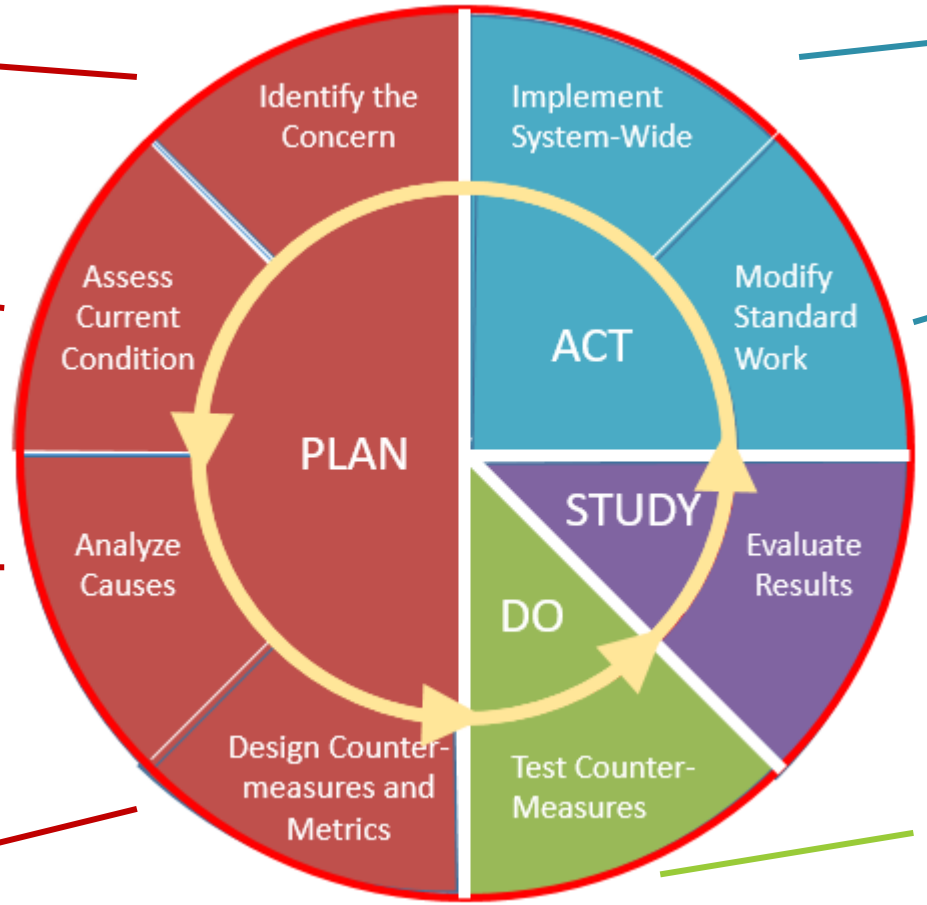
Example: SUD Screening Rate

Substance use screening for pregnant patients is 80%, <90% goal

20% of pregnant patients are not screened for substance use

Staff are unaware of the missed substance use screenings

Timely identification and data for staff of missed substance use screenings



New standard work document implemented across four hospital campuses; system substance use screening rate of 90%

New standard work document created for substance use screening process

Last three months, missed substance use screening for pregnant patients decreased by 10%, increasing overall screening rate to 90% goal

Revise process and electronic prompts for substance use screening at point of care producing timely data

PA PQC
Pennsylvania Perinatal Quality Collaborative

PA PQC Health Equity and Patient Voice Intervention Plan Template

Hospital site: Click or tap here to enter text.

Person completing this form: Click or tap here to enter text.

Contact information: Click or tap here to enter text.

Choose one:

1. What intervention will your team be focusing on? Click or tap here to enter text.

2. What is your SMART goal? *(specific, measurable, achievable, relevant, timebound)* *more info here*

Click or tap here to enter text.

3. Why is this an important focus for your team? Click or tap here to enter text.

4. What skills and resources are required to achieve the goal? If they are not currently available, how can you obtain them? Click or tap here to enter text.

5. Who will be involved? Click or tap here to enter text.

6. What actions/steps will you take to accomplish your goal? Click or tap here to enter text.

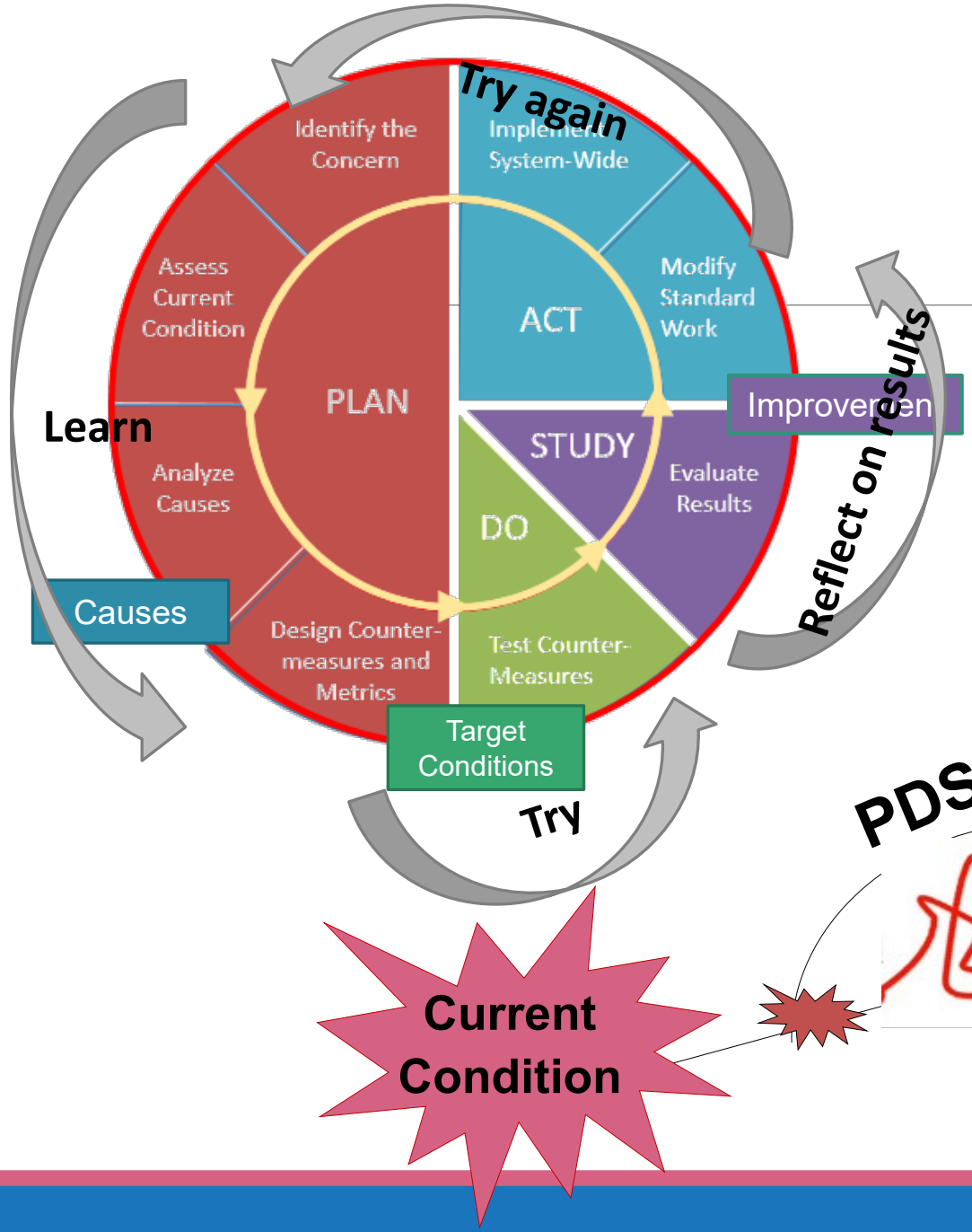
7. How will you measure success? Click or tap here to enter text.

Summary

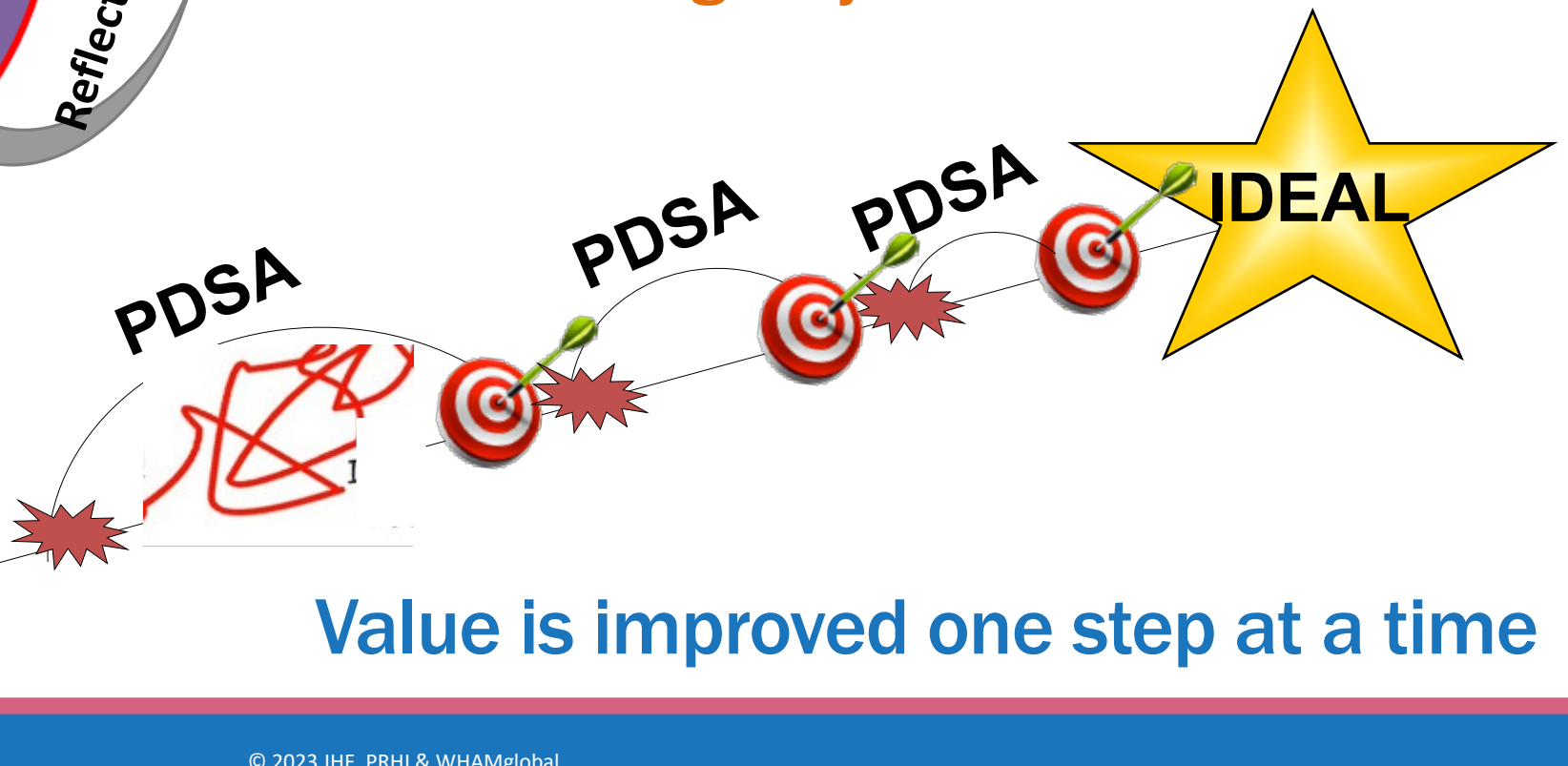
QUALITY IMPROVEMENT

PLAN-DO-STUDY-ACT

Capture and document your QI work!



Each PDSA gets you closer to success



Value is improved one step at a time

Value of PDSA Thinking

"Everyone, every day, closer to better"

- Rooted in the scientific method
- Standardized and systematic approach to iteratively address problems
- Organizational culture driven by leadership actively engaged in continuous improvement
- Deeper examination of problems by team members at all organizational levels
- Builds system stability and reliability using lean design principles
- QI Tool
- This is hard work!

Core Values:
Continuous improvement
Respect for people

Discussion

Wrap Up & Next Steps

SARA NELIS, RN

PROJECT MANAGER

JEWISH HEALTHCARE FOUNDATION

QI Participation Reminder for Q1 2023

Milestone 1: Attend a Virtual Session

Milestone 2: Submit a Quality Improvement (QI) Report Out, showing work related to implementing Key Intervention(s) **April 30, 2023**

Milestone 3: Complete a PA PQC quarterly survey for the initiative **April 30, 2023**

Milestone 4: Submit at least one quarter's worth of aggregated data for a PA PQC process or outcomes measure(s) through Life QI **April 30, 2023**

Milestone 5: Communicate and celebrate your team's impact! **April 30, 2023**

https://www.whamglobal.org/pa-pqc-initiatives/criteria-for-quality-improvement-awards

2023 Theme: Continuum of Care

Recruitment: January to March 2023

Implementation: April 2023 to March 2024

Sustaining: April 2024 to March 2025

Please complete the Annual Enrollment Survey by **March 31** →

Upcoming Learning Opportunities

Annual Meeting

- May 4, 8:30 a.m. to 4:30 p.m.
- In-person only!

https://www.whamglobal.org/member-content/register-for-sessions

Speak Up! Training – March 23 & 30

NAS Symposium presented by Mercer County Children & Youth, Sharon, PA – May 19

https://www.whamglobal.org/member-content/additional-events

Credentialing Guidelines:

1. ***PLEASE*** complete the electronic evaluations by Thursday, March 23rd
2. Please indicate on the evaluation which CEUs you are requesting: CME, CNE or Social Worker credits.
3. The UPMC Center for Continuing Education will follow up with you, via email, after Thursday, March 23rd notify you about how you can claim your credits.

https://www.surveymonkey.com/r/98WCBB6

Key Interventions for Connecting Across the Continuum of Care

JENNIFER CONDEL, SCT(ASCP)MT
MANAGER, LEAN HEALTHCARE STRATEGY AND IMPLEMENTATION
JEWISH HEALTHCARE FOUNDATION

PA PQC: SEN Goals & Plans

- Increase the percent of newborn care teams ***educated on post-discharge services*** from **70% to 80%** of participating hospitals

- Increase the percent of newborn care teams ***educated on the criteria for Plans of Safe Care*** from **70% to 80%** of participating hospitals

- Maintain at least **75%** of newborns with NAS receiving ***non-pharmacotherapy bundled treatments*** (impacting at least 350 newborns per year)

- Increase the percent of newborns with NAS who were ***referred to appropriate follow-up services*** at discharge from **85% to 95%** (impacting at least 350 newborns per year)

- Increase the percent of hospitals with a ***protocol to close the loop*** on the referral status with the post-discharge services and supports from **30% to 50%**

Substance Exposed Newborn (SEN): Driver Diagram

Aims

5. Increase referrals to and engagement in outpatient family care services, including physical, behavioral, and social services

Establish Family Care Plans Prior to Discharge

- Partner with families and social/child services to establish family care plans (Plans of Safe Care) according to federal, state, and county guidelines
- Use Cuddler Program to free up parent for treatment

Substance Exposed Newborn (SEN): Survey, Structure Measures (Reported Quarterly)

11. Has your newborn care team (providers, nurses, and social workers) been educated on the **criteria for Plans of Safe Care**, their role in establishing and initiating the Plans of Safe Care, and how to explain it to families in accordance with your hospital's, county's, and state's guidelines and policies?

- Yes, policies and education completed
- No, working on it
- No, have not started

https://www.whamglobal.org/pa-pqc-initiatives

Substance Exposed Newborn (SEN): Driver Diagram

Aims

5. Increase referrals to and engagement in outpatient family care services, including physical, behavioral, and social services

Support **Engagement in Family Care Plans**	▪ Refer SENs to appropriate follow-up services prior to discharge, including but not limited to Early Intervention (EI) Services, lactation support, and home visits, and close the loop on those referrals ▪ Follow-up with outpatient providers to ensure that the family care plans are adopted and engagement in outpatient care ▪ Follow the dyad for up to 15 months

Substance Exposed Newborn (SEN): Survey, Structure Measures (Reported Quarterly)

12. Has your newborn care team been educated on the criteria, protocols, and **best practices for referring substance-exposed newborns and families** to post-discharge services and supports?

- Yes, policies and education completed for: (Check all that apply)
  - early intervention
  - home visiting services
  - physicians experienced with NAS
  - high-risk infant follow-up clinic / developmental assessment clinic
- No, working on it
- No, have not started

13. Has your neonatal care team (providers, nurses, and social workers) created a **protocol for closing the loop** on the referral status with the post-discharge services and supports?

- Yes, policies and education completed for: (Check all that apply)
  - Early intervention
  - Home visiting services
  - Physicians experienced in working with NAS
  - High-risk infant follow-up clinic/ development assessment clinic
- If yes, does this process also include notifying the family's outpatient primary provider?
  - No, working on it
  - No, have not started

Substance Exposed Newborn (SEN): Process and Outcome Measures

Measures and Specifications (Reported Quarterly)

Measure
6. Percent of newborns with NAS who were referred to appropriate follow-up at discharge
7. Percent of NAS who were readmitted to the hospital within 30 days of discharge (New balancing measure)
8. Percent of NAS with an emergency department visit within 30 days of discharge (New balancing measure)

PA PQC Maternal Substance Use Goals & Plans

- Increase the percent of hospitals with ***trauma-informed protocols*** in the context of substance use from approx. **10% to 20%**

- Increase the percent of hospitals with a system in place to ***provide naloxone*** to at risk patients prior discharge from **8% to 30%**

- Increase the percent of hospitals from **60% to 70%** with ***established perinatal care pathways*** for SUD that coordinate services across multiple providers up to 1 year postpartum

- Maintain at least **90%** of pregnant individuals being ***screened for substance use*** with a validated screen (impacting at least 30,000 individuals per year)

Maternal Substance Use: Driver Diagram

READINESS – EVERY UNIT

Aims

1. Increase **education** among patients related to substance use
2. Increase **education** among healthcare team members to address stigma related to substance use

Form a **Multi-Disciplinary Team**	• Engage appropriate partners to assist pregnant and postpartum people and families in the development of family care plans, starting in the prenatal setting • Establish a multidisciplinary care team to provide coordinated clinical pathways for individuals experiencing SUD
Ensure **Access to Resources for all Identities**	• 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 social determinants of health needs, behavioral health supports, and SUD treatment. • Have evidence-based substance use resources that are inclusive for people of all backgrounds, race, ethnicity, gender, social class, language, ability, and other personal or social identities and characteristics.*

https://www.whamglobal.org/pa-pqc-initiatives

Maternal Substance Use: Driver Diagram

READINESS – EVERY UNIT

Aims

1. Increase **education** among patients related to substance use
2. Increase **education** among healthcare team members to address stigma related to substance use

Form a **Multi-Disciplinary Team**	• Engage appropriate partners to assist pregnant and postpartum people and families in the development of family care plans, starting in the prenatal setting • Establish a multidisciplinary care team to provide coordinated clinical pathways for individuals experiencing SUD

Maternal Substance Use: Survey, Structure Measures (Reported Quarterly)

14. Has your site established specific prenatal, intrapartum and postpartum care pathways (algorithms) for substance use that facilitate coordination among multiple providers during pregnancy and the year that follows?

- Multiple Choice:
  - Yes (in place)
  - No (working on it)
  - No (have not started)

Maternal Substance Use: Driver Diagram

READINESS – EVERY UNIT

Aims

1. Increase **education** among patients related to substance use
2. Increase **education** among healthcare team members to address stigma related to substance use

Ensure **Access to Resources for all Identities**

- 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 social determinants of health needs, behavioral health supports, and SUD treatment.
- Have evidence-based substance use resources that are inclusive for people of all backgrounds, race, ethnicity, gender, social class, language, ability, and other personal or social identities and characteristics.*

Maternal Substance Use: Survey, Structure Measures (Reported Quarterly)

13. Has your hospital developed referral relationships with any SUD treatment services in your area/county?

- Multiple Choice:
  - Yes (in place)
  - No (working on it)
  - No (have not started)

If yes, please indicate which recovery treatment services (Check all that apply)

- Programs offering Medications for Opioid Use Disorders (MOUD)
- Residential treatment
- Inpatient treatment
- Outpatient behavioral health counseling
- Peer support (e.g., certified recovery specialist (CRS) or other peer support specialists)
- 12-step programs

Maternal Substance Use: Driver Diagram

RECOGNITION & PREVENTION – EVERY PATIENT

Aims

3. Increase universal **screening and follow-up** for substance use among pregnant and postpartum individual

Screen all pregnant and postpartum individuals for substance use and co-occurring needs	• Screen all pregnant and postpartum people for substance use using validated self-reported screening tools and methodologies during prenatal care and during the delivery admission • Screen each pregnant and postpartum person for co-occurring medical and behavioral health needs (e.g., HIV, Hepatitis B and C, behavioral health conditions, physical and sexual violence, Sepsis, Endocarditis), and provide linkage to community services and resources • Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans, and provide linkage to resources

Maternal Substance Use: Survey, Structure Measures (Reported Quarterly)

13. Has your hospital developed referral relationships with any SUD treatment services in your area/county?

If yes, please indicate which recovery treatment services (Check all that apply)

14. Has your site established specific prenatal, intrapartum and postpartum care pathways (algorithms) for substance use that facilitate coordination among multiple providers during pregnancy and the year that follows?

Maternal Substance Use: Driver Diagram

RESPONSE – Every Event

Aims

1. Increase prenatal and postpartum individuals with SUD who initiate SUD treatment (including Medication for OUD)

Link all pregnant and postpartum individuals with SUD to **substance use treatment** programs (including Medication for OUD)

- Establish specific prenatal, intrapartum and postpartum care pathways that facilitate coordination among multiple providers during pregnancy and the year that follows (Question 14)
- 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 start treatment, as well as referral for treatment with warm hand-off and close follow-up (Question 13)

Maternal Substance Use: Survey, Structure Measures (Reported Quarterly)

13. Has your hospital developed referral relationships with any SUD treatment services in your area/county?

If yes, please indicate which recovery treatment services (Check all that apply)

14. Has your site established specific prenatal, intrapartum and postpartum care pathways (algorithms) for substance use that facilitate coordination among multiple providers during pregnancy and the year that follows?

Maternal Substance Use: Process and Outcome Measures

Measures and Specifications (Reported Quarterly)

Measure
3. Percentage of pregnant and postpartum individuals diagnosed with OUD who initiate Medication for Opioid Use Disorders (MOUD)
4. Percentage of individuals diagnosed with OUD receiving postpartum care
5. Percentage of pregnant individuals with a positive substance use screen who received an appropriate follow-up action for alcohol or other drug use (New Maternal Substance Use Measure)
6. Percentage of postpartum individuals with a positive substance use screen who received an appropriate follow-up action for alcohol and other drug use (New Maternal Substance Use Measure)