Key Interventions for Connecting Across the Continuum of Care

CROSSWALK DRIVER DIAGRAM, SURVEY, PROCESS AND OUTCOME MEASURES

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.*

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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)