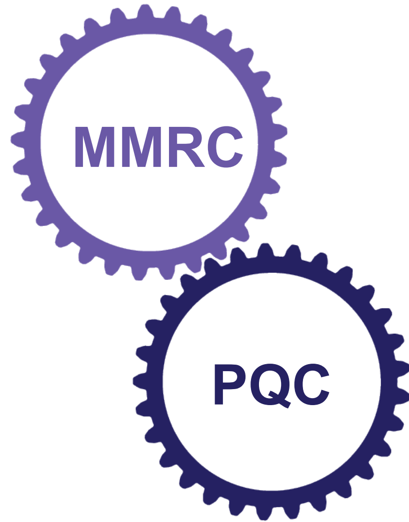


PA PQC

Pennsylvania Perinatal Quality Collaborative

PA PQC Virtual Session

June 10, 2026

Opening Remarks

MEGHNA PATEL, DEPUTY SECRETARY OF HHS POLICY AND PLANNING, GOVERNOR’S POLICY OFFICE

Agenda

1. **Welcome & 2026-2027 Implementation Year Overview** – Jennifer Condel, SCT(ASCP)MT, Senior Program Manager, Perinatal Health, Jewish Healthcare Foundation
2. **A Family Approach to Postpartum Discharge Transition** – Maureen Saxon-Gioia, MHA, BSN, RN, PA PQC QI Coach, Jewish Healthcare Foundation
3. **Prenatal and Postpartum Depression Initiative**– Kristen Brenneman, MSN, RNC-NIC, Women's Health Program Specialist, Jewish Healthcare Foundation
4. **A Family Approach to Services and Transitions for Opioid Use & Exposure** – Jennifer Condel
5. **Wrap-up & Next Steps –** Lisa Boyd, PA PQC QI Coach & Data Manager, Jewish Healthcare Foundation

Learning Objectives

- Identify the 2026–2027 PA PQC active initiatives, including key interventions, goals, measures, and quality improvement priorities.
- Discuss the implementation timeline, participation process, and designation opportunities for the 2026–2027 initiative year

2026-2027 PA PQC Implementation Year

JENNIFER CONDEL, SCT(ASCP)MT

PA PQC

Pennsylvania Perinatal Quality Collaborative

Implementation Period

July 1, 2026 through June 30, 2027

SUSTAINMENT

Maternal Sepsis

ACTIVE INITIATIVES

A Family Approach to Postpartum Discharge Transition Bundle

Prenatal & Postpartum Depression

A Family Approach to Services and Transitions for Opioid Use & Exposure

Initiative in Sustainment: Maternal Sepsis

Sepsis in Obstetrical Care

JULY 1, 2026 – JUNE 30, 2027

PA PQC Sustainment

- **One year period** following the active implementation
- The PA PQC will not be actively providing services and content related to sustaining initiatives
- Your team **CAN** continue implementing new interventions independently
- Coaching and support during this time is focused on sustainability of key interventions that have been implemented to date
- Yes! You are STILL considered a participating PA PQC hospital!

Active vs. Sustained Initiatives

ACTIVE IMPLEMENTATION

Designations

Education Content

QI Coaching Calls

Quarterly Data, Survey and QI Reports

SUSTAINMENT

Not Part of Designations Program

General Sustainment Virtual Sessions

Sustainment Plans

Expectation: Quarterly Data and Surveys

Sustainment Planning

Sepsis in Obstetrical Care

Initiative Specific Sustainment Plans

PA PQC Maternal Sepsis: Sustainability Plan

Compliance Monitoring of key process measures:

1. Cases coded as sepsis during the birth admission
2. Severe maternal morbidity (excluding transfusion codes alone)
3. Multidisciplinary case reviews for obstetric sepsis
4. Proportion of clinical OB providers and nursing staff that have received education on the recognition of and/or unit-standard response to suspected and confirmed obstetric sepsis within the last 2 years
5. Proportion of clinical OB providers and nursing staff that have completed an education program on respectful and equitable care within the last 2 years

Measures will be collected ***QUARTERLY*** (please continue to submit data for the first year of sustainment)

Will you continue to track additional data internally? ☐ Yes ☐ No

Name and email address of team member(s) in charge of data reporting (include name and contact for a backup person/role):

____

____

How often will your QI team meet to review hospital data reports and develop and implement PDSA cycles if compliance on measures starts to decline?

☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other

New Hire Education Plan (applicable for all new hires)

What education tool(s) will you use for new hires?

____

How will you incorporate Maternal Sepsis education, workflows, and protocols into hospital new hire education?

____

Ongoing Education for all staff

What education tool(s) will you use for ongoing education for all staff?

____

How will you incorporate Maternal Sepsis education, workflows, and protocols into ongoing education?

____

Nursing Champion(s): ____________ Provider Champion(s): ____________

Drafted Date: ______ Quarterly Review Dates: ______ ______ ______ ______

Hospital Name: ____________________________________

2026-2027 Active Initiatives

ENROLLMENT IS OPEN THROUGH JUNE 30TH!

Active Initiatives

Family Approach: Transitions & Connections

Enrollment survey, closes June 30, 2026

- A Family Approach to Postpartum Discharge Transition
- Prenatal and Postpartum Depression Screening and Follow-up
- A Family Approach to Services and Transitions for Opioid Use & Exposure

PA PQC Announces

Respectful Maternity Care Toolkit Implementation Training

Respectful maternity care recognizes the dignity, autonomy, personhood, and individual preferences of women giving birth.

Role of PA PQC Hospitals

With guidance from an assigned PA PQC Coach

Form a multi-disciplinary QI teams

Create and implement QI plans to adopt key interventions in the PQC initiative(s)

Attend learning sessions and events to gain tactics to inform their QI

Submit quarterly data for structure and process measures and QI report outs (achieving the Quarterly Milestones)

PA PQC Programming, Enrollment & Quarterly Milestones

- Enrollment materials provide guidance for the 2026–2027 implementation year
- Hospitals are encouraged to review materials and enroll multidisciplinary healthcare teams
- Participating teams engage in quality improvement activities, coaching, and quarterly reporting

Baseline Data: July 31, 2026

Milestone	Activity	Frequency	Due Date
Milestone 1	Engage with your QI coach **at least once during the quarter**.		
Milestone 2*	Submit an initiative-specific Quality Improvement (QI) Report Out in the **Qualtrics survey**, showing work related to implementing Key Intervention(s)	Quarterly	October 31, 2026 January 31, 2027 April 30, 2027 July 31, 2027
Milestone 3*	Complete initiative-specific PA PQC quarterly survey in **Qualtrics**		
Milestone 4*	Submit initiative-specific aggregated data for the PA PQC process and outcome measure(s) through **Qualtrics survey**		
Milestone 5**	Communicate and celebrate your team's impact in the PA PQC within your hospital and community		

* Initiative-specific milestones
** Once per quarter/hospital

Implementation Year Planning

- Provide initiative overview, goals, key interventions and measures
- Information to support your PA PQC healthcare team in determining which initiative(s) align with your QI work
- Each initiative has multiple key interventions, process and structure measures
  - Required to identify and report on at least one key intervention in an initiative and corresponding process measure
  - Report on all structure measures by indicating progress (not started to fully in place)
- PA PQC QI Coaches are here to help!

A Family Approach to Postpartum Discharge Transition

MAUREEN SAXON-GIOIA, MSN, BSN,RN

A Family Approach to Postpartum Discharge Transition

PA PQC
Pennsylvania Perinatal Quality Collaborative

A Family Approach to Postpartum Discharge Transition
Alliance For Innovation On Maternal Health Patient Safety Bundle

The U.S. maternal mortality rate in 2024 was approximately 17.9 deaths per 100,000 live births, according to preliminary CDC data, compared to the rate of 18.6 in 2023.[1] In addition, significant racial disparities in health outcomes exist for pregnant and postpartum patients.[2] More than 50% of pregnancy-related deaths occur one week to one year after pregnancy, and more than 80% of pregnancy-related deaths are deemed preventable.[3] Currently, up to 40% of birthing people do not attend a routine postpartum visit, and few receive all recommended elements of postpartum care.[4]

In the PA 2025 MMRC report on deaths occurring in 2021, approximately half of pregnancy-related cases (48%) died 43 days to one year after the end of pregnancy. About 31% of the pregnancy-related cases died while pregnant, showing a greater frequency of pregnancy-related deaths occurring after pregnancy (69%). These statistics highlight the need for continued postpartum services both prior to and past the traditional 6 to 12 weeks.[5]

In addition, the 2022-2024 Pennsylvania Title V Interim Needs & Capacity Assessment identified ongoing unmet needs in accessing patient-centered, respectful care at all stages of pregnancy; focusing on meeting family needs and addressing social determinants of health; improving availability and receipt of preventative, behavioral and mental health services; and parent/caregiver social support and education on infant care and safety.[6]

The postpartum period provides an important opportunity to support birthing persons, their infant, and their families, as it is often a time of increased patient motivation, engagement, and access to insurance. Intervention during the postpartum period can contribute to long-lasting maternal health and family benefits. It is therefore critical to ensure that birthing persons receive comprehensive care and support during the postpartum period.

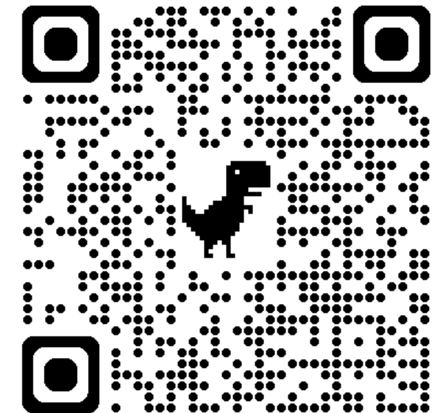
Initial PA PQC Successes

- In 2025, 39 PA PQC hospitals participated in an Urgent Maternal Warning Signs sprint series, focused on patient education, and engagement with the ED, outpatient settings, and community partners to create a broad awareness of identifying and responding to urgent maternal warning signs.

Initiative Overview

- Focused on improving postpartum care and support for birthing persons, infants, and families
- Promotes coordinated follow-up, education, and family-centered care after discharge
- Based on the

Postpartum Discharge Transition Bundle



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2026–2027 Statewide Goals

Postpartum Discharge Transition

Recruit	• 30 multidisciplinary healthcare teams
Increase	• Standardized ED postpartum screening practices
Expand	• Development of **maternal and neonatal** family debrief processes
Improve	• Scheduling of **postpartum and newborn follow-up visits**
Increase	• Implementation of comprehensive postpartum care visit and SSDOH screening

Why Postpartum Discharge Transition?

>50%
of pregnancy-related deaths occur postpartum

>80%
are preventable

Up to 40%
miss a routine postpartum visit

The postpartum period remains a critical opportunity to improve maternal outcomes

Building on PA PQC Successes

- 39 hospitals participated in Urgent Maternal Warning Signs Sprint **creating broad awareness for patient education**
- Increased use of **culturally responsive** patient education materials
- Expanded ED screening and staff education on **obstetric emergencies**
- Conducting **patient debriefs after severe events**
- Laid the groundwork for statewide postpartum care transition efforts

URGENT MATERNAL WARNING SIGNS

Headache that won't go away or gets worse over time

Dizziness or fainting

Thoughts about hurting yourself or your baby

Changes in your vision

Fever

Trouble breathing

Chest pain or fast-beating heart

Severe belly pain that doesn't go away

Severe nausea and throwing up (not like morning sickness)

Baby's movements stopping or slowing

Vaginal bleeding or fluid leaking *during* pregnancy

Vaginal bleeding or fluid leaking *after* pregnancy

Swelling, redness, or pain of your leg

Extreme swelling of your hands or face

Overwhelming tiredness

If you have any of these symptoms during or after pregnancy, contact your health care provider and get help right away.

If you can't reach your provider, go to the emergency room. Remember to say that you're pregnant or have been pregnant within the last year.

Learn more: https://saferbirth.org/aim-resources/aim-cornerstones/urgent-maternal-warning- signs/

Take a photo to learn more

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V5 September 2022

ACOG

A Family Approach to Postpartum Discharge Transition KEY INTERVENTIONS

- Educate maternal and neonatal staff on **Respectful and Equitable Care**
- Verbal screening as part of **ED triage process**
- Process to conduct **debriefs with patients** after severe **maternal and neonatal events**
- System for **scheduling postpartum and specialty visits** prior to discharge or within 24 hours
- A system for **scheduling the initial pediatric visit** prior to discharge
- Comprehensive **postpartum visit template** to share with affiliated outpatient sites
- **Screen for family risks factors** and assess family and social support needs
- **Referrals** for follow-up services including medical, behavioral, and support services

A Family Approach to Postpartum Discharge Transition MEASURES

6 Process Measures

- **Respectful & Equitable Care education** for maternal and neonatal staff
- Life-Threatening Postpartum Concerns education
- **Postpartum visit scheduling** before/within 24 hours discharge
- Scheduling of **first pediatric visit** prior to discharge for within 48-72 hours
- **Social and Structural Drivers of Health** (SSDOH) screening with standardized tool

Teams participating in this initiative will need to complete a DUA (included in Enrollment Packet)

Postpartum Discharge Transition Patient Safety Bundle
Core Data Collection Plan

A Family Approach to Postpartum Discharge Transition MEASURES

9 Structure Measures

Standardized postpartum care transition processes and infrastructure

- Patient and **family debrief** after severe event processes
- Culturally/linguistically appropriate UMWS patient education materials
- ED triage process for current/ one year pregnancy screening
- **Validated SSDOH screening tool** process prior to discharge
- Comprehensive list of community resources
- Established processes for postpartum and pediatric scheduling post discharge visits
- **Postpartum visit templates** shared with affiliated outpatient sites

Postpartum Discharge Transition Patient Safety Bundle
Core Data Collection Plan

Introduction to Postpartum Discharge Transition Bundle

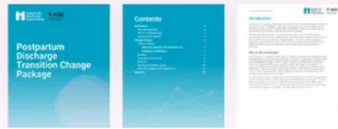
Patient Safety Bundle

Element Implementation Details

Implementation Resources

Data Collection Plan

Change Package



Learning Modules

[Postpartum Discharge Transition | AIM]

PA PQC 2026-2027 Sprint Session Series

Pennsylvania Perinatal Quality Collaborative

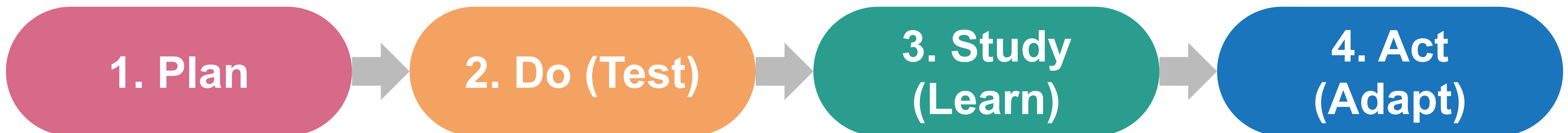
Short, focused implementation periods to test, refine, and strengthen postpartum care before broader adoption.

Benefits of a Sprint

- ✓ Gain buy-in for PA PQC quality improvement initiative work
- ✓ Accelerate adoption of best practices
- ✓ Spot workflow challenges early
- ✓ Gather feedback from patients and care teams
- ✓ Build a foundation for sustainable change

Intended outcome: more consistent, patient-centered postpartum care.

OUR APPROACH — A RAPID IMPLEMENTATION CYCLE



PA PQC Sprint Session Series

Pennsylvania Perinatal Quality Collaborative

Sprint #1

Patient Care Conversations

October 14, 28, November 10, December 2

- Strengthen patient care conversations, severe event debriefs, and discharge communication
- 4 interactive learning sessions
- Patient-centered communication and care transitions

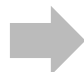
Sprint #2

Comprehensive Postpartum Visit Template

March–April 2027 (Q2 2027)

- Establish a comprehensive postpartum visit template
- 3–4 interactive learning sessions
- Standardized follow-up and continuity of care

EACH SPRINT FOLLOWS A RAPID CYCLE

1. Plan  2. Do (Test) 3. Study (Learn) 4. Act (Adapt)

Prenatal & Postpartum Depression Initiative

KRISTEN BRENNEMAN, MSN, RNC-NIC

Prenatal and Postpartum Depression Initiative

Initiative Overview

- Focused on universal prenatal and postpartum depression screening and follow-up
- Promotes early identification, referral, and coordinated mental health support
- Supports standardized screening, follow-up, and referral processes across care settings

Rev. 6.5.2026

Prenatal and Postpartum Depression Initiative

Globally, postpartum depression is the most common complication of childbirth, affecting 10-15% of birthing people. The rate of postpartum depression increases to 40% for birthing people with a newborn admitted to the NICU.[1] In Pennsylvania, mental health conditions, including drug-related overdose deaths and suicides, are the top cause of pregnancy-related deaths, contributing to 34% of deaths in 2021. The Pennsylvania Maternal Mortality Review Committee (MMRC) determined that mental health conditions other than SUD contributed to 21% of the deaths, and 98% of these deaths were preventable. To prevent these deaths, the MMRC recommends that providers screen for and follow-up on mental health, connect pregnant and postpartum patients to mental health providers, counsel patients on the risks of stopping antidepressants during pregnancy, and follow-up with patients post-discharge and with those who have missed appointments, among other recommendations.[2]

Across the Physical HealthChoices Managed Care Organizations (MCOs) in 2024, 28.29% of pregnant patients were screened for depression and 53.52% of those with an at-risk screen received follow-up during the prenatal period. During the postpartum period, the percentages were 30.56% and 61.23%, respectively.[3] These quality measures are also used in the MCOs' Maternity Care Bundled Payment Model.

Initial PA Successes

- In 2022, the PA PQC led the Moving on Maternal Depression (MOMD) initiative with 20 hospitals, and at the end of 2022, 95% had a standardized protocol in place to follow-up on at-risk depression screens, 62% worked with patient and family representatives or community resources to inform their follow-up processes, and 40% reported data for perinatal depression screening and follow-up rates.
- In 2024, PA established the Perinatal TiPS program to offer provide-to-provider consultation, referral assistance, case management support, and provider training and education for perinatal mental health and SUD.

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2026–2027 Statewide Goals

Perinatal Depression Initiative

Recruit	• 30 multidisciplinary healthcare teams with 15 of these teams partnering with outpatient sites
Implement	• 95% of participating hospitals & outpatient offices establish universal prenatal and postpartum depression screening protocols
Follow-Up	• 95% of participating hospitals and outpatient offices establish protocols for follow-up after an at-risk screen
Screen	• 85% of patients screened during the prenatal and postpartum periods and 70% of at-risk screens receive follow-up
Expand	• NICU postpartum depression screening protocols among participating teams with a NICU

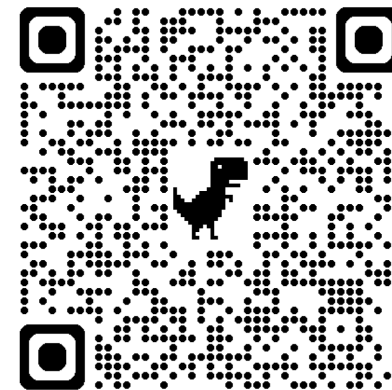
Why Prenatal and Postpartum Depression?

- **34% of deaths in 2021**
  of Pennsylvania pregnancy-related deaths in 2021 were attributed to mental health conditions
- **Rate of postpartum depression increases to 40%**
  for birthing people with a newborn admitted to the NICU
- **Up to 40%**
  of birthing people miss a routine postpartum visit
- **<31%of postpartum patients**
  in PA MCOs were screened for depression in 2024

Improving depression screening, follow-up, referral, and treatment is a critical opportunity to improve maternal outcomes

Building on PA Successes

- 20 PA PQC hospitals in the 2022 **Moving on Maternal Depression** (MOMD) initiative accomplished:
  - **95% standardized protocol** in place to follow-up on at-risk depression screens
  - 62% worked with patient and family or community resources to inform their follow-up processes
  - 40% reported data for perinatal depression screening and follow-up rates
- In 2024, established **Perinatal TiPS Program** for:
  - provider-to-provider consultation,
  - referral assistance,
  - case management support,
  - provider training and education for perinatal mental health and SUD



Perinatal TiPS Program

Prenatal and Postpartum Depression Initiative

KEY INTERVENTIONS

- Educate maternal staff on **Respectful and Equitable Care**
- **Universal depression screening process** with a validated tool
- **Provider training** on protocols for mental health screening, diagnosis, and follow-up
- Create an **organizational suicide risk response policy**
- Establish **co-occurring screening protocol** for at-risk depression screens
- Establish **follow-up protocol** based on severity of symptoms and co-occurring health needs
- Protocol to **close the loop on success of referrals** to mental health and community supports
- Inclusion of **lived experience or community resources feedback** for improving screening and follow-up processes
- **Consistent perinatal depression messaging** with partnering outpatient and community settings

Prenatal and Postpartum Depression Initiative

MEASURES

5 Process Measures

- **Respectful & Equitable Care** education for maternal and neonatal staff
- Prenatal Depression
    - Screening
    - Follow-up after an at-risk screen
- **Postpartum Depression**
    - Screening in the NICU, by OB and during Pediatrics well-child visits
    - Follow-up % in the NICU, by OB, and during Pediatrics well-child visits

Prenatal and Postpartum Depression Initiative

MEASURES

11 Structure Measures

Prenatal & Postpartum Depression Screening

- Inpatient and outpatient screening with validated screening tool
- Provider training and education on mental health screening, diagnosis and follow-up

Follow-up on At-Risk Depression Screens

- Standardized protocol based on severity of depression symptoms and addressing co-occurring health needs
- Organizational suicide risk response policy

Care Coordination & Family Support

- Referral protocols, closing the loop on received referrals
- Patient, family, community resource engagement for quality improvement of screening and follow-up processes
- Promote consistent messaging for maternal depression education with outside organizations

A Family Approach to Services and Transitions for Opioid Use & Exposure

JENNIFER CONDEL,SCT(ASCP)MT

A Family Approach to Services and Transitions for OUD and NAS Initiative

6.5.2026

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A Family Approach to Services and Transitions for Opioid Use & Exposure

Mental health conditions, including drug-related overdose deaths and suicides, are the top cause of pregnancy-related deaths in Pennsylvania, contributing to 34% of deaths in 2021. The highest risk occurs in the postpartum period. The Maternal Mortality Review Committee (MMRC) also identified substance use disorder (SUD) contributed to 26% of the deaths, and 98% of all deaths were preventable.[1]

To prevent these deaths, the MMRC recommends that providers screen for SUD and co-occurring disorders, make warm handoff referrals, standardize discharge plans for postpartum individuals with opioid use disorder (OUD) including naloxone prescription and distribution, consult multi-disciplinary care teams specific to SUD at time of admission, provide medications for OUD or ensure adequate treatment from SUD facilities, follow-up with individuals with SUD after discharge, ensure services and appointments are in place with a closed loop referral prior to discharge, ensure equity use and application of a Plans of Safe Care, ensure standard protocols in place to avoid stigma and discrimination for individuals who are suspected of using substances.

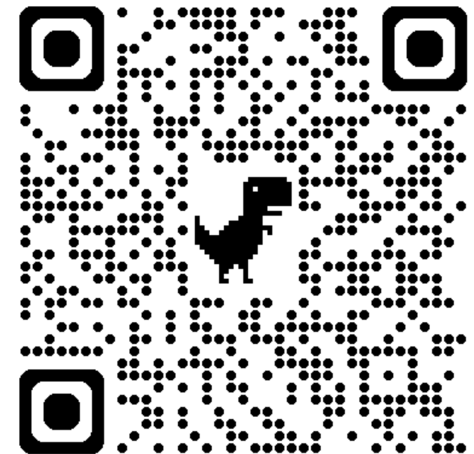
For Neonatal Abstinence Syndrome (NAS), the incidence per 1,000 live births in 2023 was 9.1—a decrease from the 2022 rate of 9.6. In regard to the discharge plan and referrals for those with NAS, 62% had a Plan of Safe Care initiated, 31% were referred to Early Intervention, 11% were referred to home visiting services, and 51% were referred to pediatricians experienced with NAS, among other referrals. PA DOH's NAS report describes the opportunity to improve awareness and education of hospital providers on available services and the importance of coordinated follow-up and referral.[2]

Initial PA Successes

- With funding from the PA Department of Drug and Alcohol Programs (DDAP), the PA PQC has led quality improvement initiatives for OUD and NAS since 2019. Examples of improvements from the most recent initiative include increasing from 22 to 30 hospitals with a system in place to provide naloxone to at-risk patients prior to discharge, sustaining over 90% of pregnant individuals being screened for

Initiative Overview

- Focused on coordinated care for families impacted by OUD and NAS
- Promotes trauma-informed, family-centered care and safe transitions after discharge



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2026–2027 Statewide Goals

A Family Approach to Services and Transitions for Opioid Use & Exposure

Recruit	• **20 multidisciplinary healthcare teams**
Standardize	• **50% Participating hospitals** implement standardized discharge & transition processes for people with OUD
Standardize	• **50% Participating hospitals implement** standardized discharge & transition processes for infants with NAS
Advance	• **5 Hospitals** trained & implementing trauma-informed care approaches in the context of substance use

Why OUD and NAS?

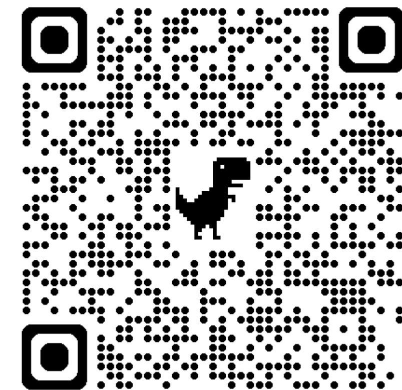
- **34% of deaths in 2021**
  were attributed to mental health conditions
- **In 26% of deaths**
  substance use disorder contributed to pregnancy-related deaths
- **98% of deaths**
  were preventable with improved follow-up & coordinated care
- **9.1 per 1,000 live births**
  affected by NAS in Pennsylvania in 2023

Improving screening, treatment, care coordination, discharge planning, and follow-up can help improve outcomes for families affected by OUD and NAS

Building on PA Successes

- PA PQC led QI initiatives for OUD and NAS since 2019
  - recent initiative improvements:
    - Increase from 22 to 30 hospitals with a system in place to provide Naloxone to at-risk patients prior to discharge
    - 90% (sustained) of pregnant individuals screened for substance use with validated tool
    - 90% (sustained) of substance-exposed newborns receiving non-pharmacological care
    - 20 hospitals trained in trauma-informed care

- In 2024, established **Perinatal TiPS Program** for:
  - provider-to-provider consultation,
  - referral assistance,
  - case management support,
  - provider training and education for perinatal mental health and SUD



A Family Approach to Services and Transitions for Opioid Use & Exposure

KEY INTERVENTIONS

- Educate maternal and neonatal staff on **Respectful and Equitable Care**
- **Standardize discharge and transition process for people with OUD and NAS** to:
  - Provide **opioid reversal medication kits and education**
  - Educate families on **harm reduction strategies**
  - Make **warm handoff referrals** to postpartum and newborn services
  - Provide **evidence-based guidelines**
  - Offer consultations for **breastmilk feeding options**
  - **Follow-up** with individuals with the families after discharge to ensure connections to maternal and newborn services
- **Train** hospital leadership and staff on non-stigmatizing, **trauma-informed** OUD and NAS care to meet individualized needs of diverse populations

A Family Approach to Services and Transitions for Opioid Use & Exposure

MEASURES

8 Process Measures

- **Respectful & Equitable Care** education for **maternal and neonatal staff**
- **% pregnant individuals screened** with validated screening tool for substance use
- % pregnant and postpartum individuals diagnosed with OUD who **self-report taking medications for OUD**
- % individuals diagnosed with **OUD receiving postpartum care**
- % pregnant individuals with at-risk substance use screen **receive appropriate follow-up action for alcohol or other drug use**
- % individuals with substance use **prescribed or received Naloxone prior to discharge**
- % **newborns with NAS referred to appropriate follow-up at discharge**

A Family Approach to Services and Transitions for Opioid Use & Exposure

MEASURES

12 Structure Measures

Trauma-Informed & Non-Stigmatizing Care

- Staff education and implementation of trauma-informed approaches

Plans of Safe Care

- Standardized training and implementation processes

Treatment & Harm Reduction Infrastructure

- Naloxone access
- Evidence-based treatment and breastfeeding guidance
- Maternal OUD consultation pathways

Care Coordination & Family Support

- Referral protocols
- Family education
- Lived experience engagement
- Post-discharge follow-up and service connection processes

PA PQC Healthcare Team 2026-2027 Implementation Year Enrollment Packet

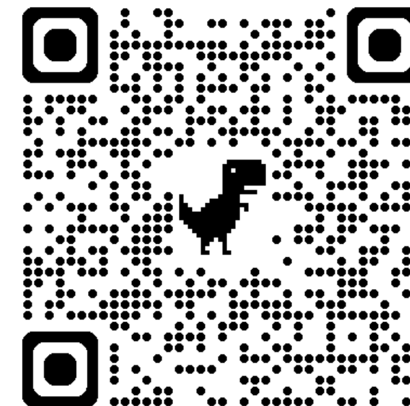
PA PQC Healthcare Team 2026-2027 Enrollment Packet

Table of Contents

Checklist ... 2
PA PQC Overview ... 2
PA PQC Formation & History ... 2
PA PQC Mission & Vision ... 2
Hospitals ... 3
PA PQC Programming ... 3
Implementation Period ... 3
2026-2027 Implementation Year Events ... 4
Designations & Milestones ... 5
Quality Improvement Milestones ... 6
Dates to Remember ... 7
PA PQC Initiatives 2026-2027: A Family Approach ... 7
A Family Approach to Postpartum Discharge Transition Alliance For Innovation On Maternal Health Patient Safety Bundle ... 7
A Family Approach to Services and Transitions for Opioid Use & Exposure ... 8
A Family Approach to Prenatal and Postpartum Depression ... 8
Sustaining Initiatives ... 9
Qualtrics ... 10
Appendix ... 11
Blank Team Roster ... 11
DUA (only necessary for sites enrolling in *A Family Approach to Postpartum Discharge Transition Alliance For Innovation On Maternal Health Patient Safety Bundle*) ... 11
Blank Leadership Template ... 11
Resources ... 11

- ✓ **Complete** Annual Enrollment Survey by June 30
- ✓ **Complete** Team Roster and return to your QI coach (if you do not have an assigned coach, or are not sure, please send to jcondel@prhi.og)

- ✓ **Receive signature on PPDT Data Use Agreement** (DUA) from an authorized signatory at your organization and send to your QI coach **(only necessary for sites enrolling in *A Family Approach to Postpartum Discharge Transition Alliance For Innovation On Maternal Health Patient Safety Bundle*)**



PA PQC Programming, Enrollment & Quarterly Milestones

- Enrollment materials provide guidance for the 2026–2027 implementation year
- Hospitals are encouraged to review materials and enroll multidisciplinary healthcare teams
- Participating teams engage in quality improvement activities, coaching, and quarterly reporting

Milestone	Activity	Frequency	Due Date
Milestone 1	Engage with your QI coach **at least once during the quarter**.		
Milestone 2*	Submit an initiative-specific Quality Improvement (QI) Report Out in the **Qualtrics survey**, showing work related to implementing Key Intervention(s)	Quarterly	October 31, 2026 January 31, 2027 April 30, 2027 July 31, 2027
Milestone 3*	Complete initiative-specific PA PQC quarterly survey in **Qualtrics**		
Milestone 4*	Submit initiative-specific aggregated data for the PA PQC process and outcome measure(s) through **Qualtrics survey**		
Milestone 5**	Communicate and celebrate your team's impact in the PA PQC within your hospital and community		

Baseline Data: July 31, 2026

* Initiative-specific milestones
** Once per quarter/hospital

Designation Criteria

QI Participation *+ Patient Voice +Health Equity*

QI Participation *+ EITHER Patient Voice OR Health Equity*

QI Participation

QI Participation: Meet milestones listed below and maintain a minimum of two "qualifying quarters" for the same initiative during the designation year (July 2026 – June 2027).

Patient Voice: Show proof of including lived experience voices in PA PQC quality improvement work by implementing one or more community and patient partnership interventions.

Health Equity: Show proof of health equity interventions in PA PQC quality improvement work that demonstrate a commitment to narrowing the equity gap.

Designations August 2026-June 2027

APPLICATION

August 3, 2026: Application submission link goes live

August 31, 2026 by 11:59pm: Submissions due – upload entire designations packet WITH COMPLETED DESIGNATIONS APPLICATION

Please be as specific as possible in your Designations Application. There will not be opportunity for revisions at this stage.

REPORT

June 1, 2027: Report submission link goes live

June 29, 2027 by 11:59pm: Submissions due – upload entire designations packet WITH COMPLETED DESIGNATIONS REPORT

July 28, 2027: PA PQC Project Team, clarifying questions as needed

August 11, 2027: Answers to clarifying question(s) are due

Wrap-Up

LISA BOYD

Upcoming Virtual Sessions

JULY 8, 2026

Incorporating Patient Voice

11:00 a.m. – 12:00 p.m.

Zoom

AUGUST 12, 2026

Plans of Safe Care Model

11:00 a.m. – 12:00 p.m.

Zoom

PA PQC
Pennsylvania Perinatal Quality Collaborative

Home About Initiatives Hospitals Events Data Resources

Learn about the Initiatives

Access Session Materials

Pennsylvania Perinatal Quality Collaborative

The PA PQC provides quality improvement support to healthcare teams to improve the standard of care for pregnant and postpartum people and babies.

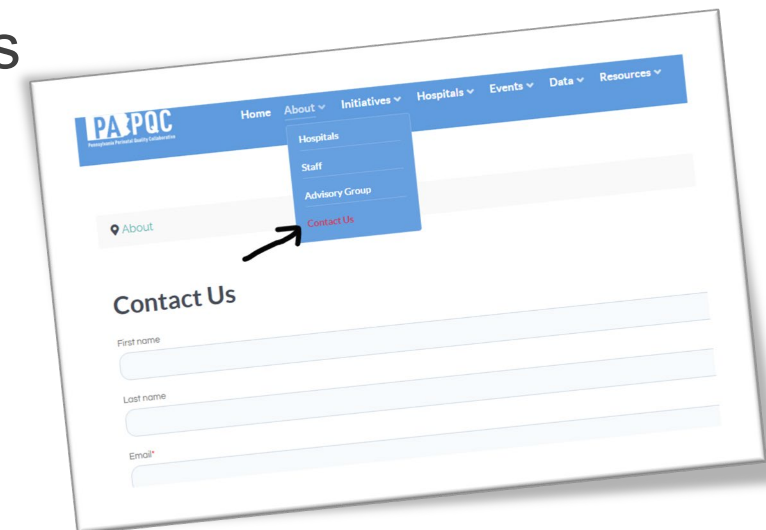
REGISTER FOR SESSIONS

https://www.papqc.org/

Updated Contact Info.

Upcoming changes to your email address? Haven't heard from us in a while?

- Please reach out to your coach to provide them updated contact info. for anyone at your site who is involved in the PA PQC.
- If you haven't gotten a newsletter or PA PQC emails in a while, check to make sure you are subscribed to our newsletter with your updated email address.
- You can always reach us here



PA PQC QI Coaches

Kristen Brenneman,
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Women's Health Program Specialist, Jewish Healthcare Foundation

Lisa Boyd
Data Manager and QI Coach, Jewish Healthcare Foundation

Jennifer Condel,
SCT(ASCP)MT
Senior Program Manager, Perinatal Health, Jewish Healthcare Foundation

Karena Moran,
PhD
Improvement Optimization Advisor, Geisinger Health & NEPaPQC

Maureen Saxon-Gioia,
MHA, BSN, RN
Nurse Project Manager, Jewish Healthcare Foundation

Hadar Re'em
Program Associate and QI Coach, Jewish Healthcare Foundation

Thank You!

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