



Hypertension in Pregnancy and the Postpartum Period Initiative Charter

Background:

Hypertensive disorders of pregnancy are increasing in incidence and are a leading cause of severe maternal morbidity (SMM). Timely treatment of hypertensive emergencies is a well-understood best practice but can be challenging to operationalize consistently.

- Hypertensive disorders of pregnancy are increasingly common, having increased 25% in incidence between 1987 and 2004.
- Minnesota and national data demonstrate Black and Native American women are disproportionately impacted.
- Other compounding and correlated risk factors include:
 - Hypertension prior to pregnancy (pre-existing and or chronic)
 - Advanced maternal age (women 35 years of age or older)
 - Type 1 or 2 diabetes
 - Obesity
 - Multiple gestations, and prior hypertensive disorders of gestation pregnancy
 - Preeclampsia in a previous pregnancy
- Hypertensive disorders of pregnancy are responsible for up to 17% of all maternal mortality in the US.
- Neonatal health outcomes impacted:
 - Premature delivery
 - Growth restricted
 - Need higher levels of care, blood sugar management, oxygen, resuscitation, etc.
- Antihypertensive administration should occur within 30-60 minutes of acute onset sustained severe hypertension. However, the American College of Obstetrics and Gynecology recommends administration of antihypertensive therapy as soon as reasonably possible, after sustained severe range blood pressure (15 minutes after the first) to reduce the risk for stroke and other adverse outcomes.

AIM:

By February 2023, the MNPQC and its participating partners/members will develop reliable processes of recognition and treatment of obstetric (OB) HTN during pregnancy and up to six weeks postpartum. This initiative focuses on all points of care, such as hospitals, clinics, urgent care, emergency departments, first responders, and community organizations. The goal is to reduce severe maternal morbidity by 25% and achieve 80% or higher compliance of the HTN recognition tool and OB HTN emergency pathway.

Family of Measures

Stratify by race/ethnicity.

1. Severe maternal morbidity rate due to severe HTN.
2. Maternal mortality rate due to severe HTN.
3. Percent compliance with OB hypertension emergency pathway from all hospital points of entry.
4. Percent of patients with severe range BP treated w/in 60 minutes.
5. Average time between first and second severe BP reading.
6. Average time from second severe range BP to treatment.
7. Percent of patients with severe HTN offered a blue band with patient education at discharge.
8. Percent of patients with a hypertensive disorder of pregnancy scheduled for post discharge follow up appointments or home health care within 3-5 days.

For more information, please contact:

info@minnesotaperinatal.org



Clinical processes:

The MNPQC Hypertension Faculty adapted a data collection tool developed by the Illinois Perinatal Quality Collaborative and aligned it with the expected guidelines implemented by The Joint Commission (TJC), in combination with the Minnesota Hospital Association (MHA) Perinatal Roadmap.

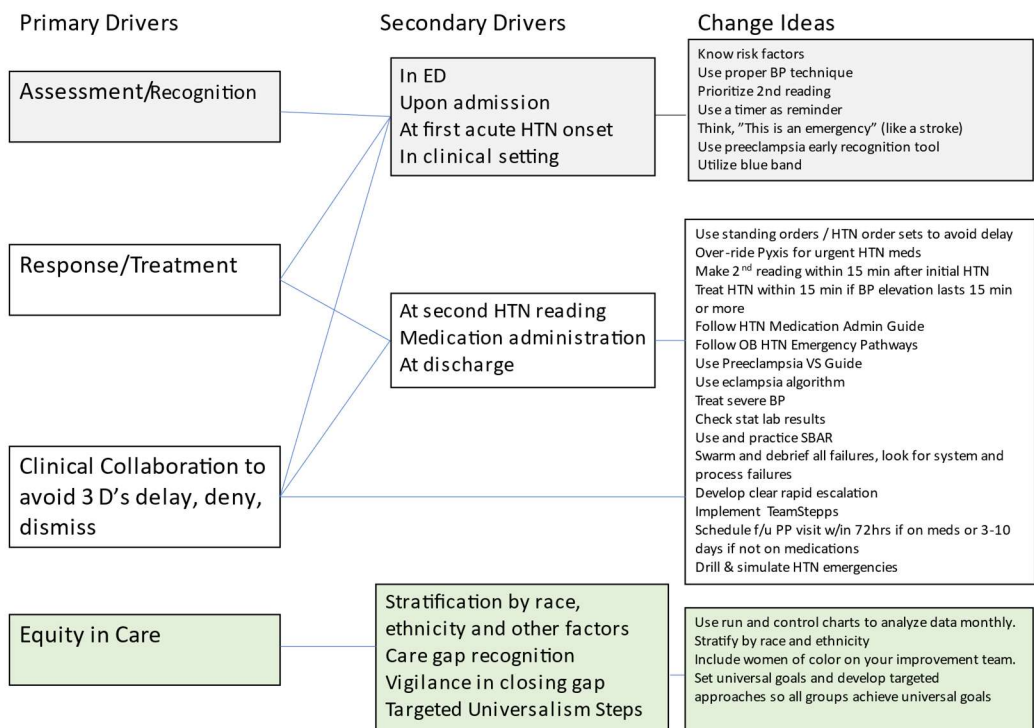
Metrics collected include:

1. Time to treatment < 60 minutes from initial severe range blood pressure:
 - a. New onset severe HTN (≥ 160 systolic OR > 110 diastolic)
 - b. Preeclampsia or Eclampsia
 - c. Chronic/gestational HTN with superimposed preeclampsia

Outcome measures: Percent of Hypertension related morbidity/mortality events in MN childbearing women.

Theory of Change

Aim: By Feb. 2023, we will develop reliable processes of recognition and treatment of obstetric hypertension (HTN) during pregnancy and up to six weeks postpartum to reduce severe maternal morbidity (SMM) by 25% and achieve 80% or higher compliance of the HTN recognition tool and OB HTN emergency pathway.





Health System (*Hospital, Clinic, ER and Triage*) Objectives:

1. Assess individual health system barriers.
2. Facilitate solutions to implement hypertension treatment strategies.
3. Assess provider knowledge of interventions to reduce hypertension that includes treatment inequities and offer education opportunities to increase provider knowledge.
4. Introduce a standardized process for treatment of hypertension including standardized order sets, care algorithms, medication treatment kit and/or discharge planning protocol.
5. Identify methods to incorporate anti-racism into individual practice and organizational guidelines.
6. To increase early recognition and intervention with multiple teaching and education methodologies to engage patients and the community.

Benefits of Participation:

- Receive assistance with implementation of guidelines from The Joint Commission into the healthcare system using information gained from prior learning collaboratives and tools created by MNPQC.
- Access to participate in educational activities offering continuing education (CME/CE) credits.
- Access to Project ECHO for quality improvement education.
- Receive quality improvement analysis of your organization/facility data with comparators to regional/state/national reports.

Expectations of Health Systems:

- Approved participation: Receive support of initiative from Medical Director of Obstetric services and/or Clinic Management, etc. according to your system hierarchy.
- Assemble a team: Identify a team comprised of a minimum of three members within your health system:
 - Clinic and Hospital champion/s (leadership; provider; quality manager)
 - Administrative lead
 - Pharmacy representative (if available)
 - Nurse/Navigator/Case Manager/Care Coordinator (patient interaction)
- Attend initiative activities: All team members actively participate in virtual collaborative activities during the initiative period (estimated 1 year).
 - Orientation/Simple QI training – Monday July 19th, 2021 from 10:00 am – 11:30 am
 - Learning session 2 – Tuesday August 10th, from 9:00 am-12:30 pm
 - Monthly Initiative Project ECHO team member closed calls (Action period calls) Tuesday 12:15-1:15pm
 - Monthly Hypertension Project ECHO's (Open sessions) Tuesday 12:15-1:15pm
- Regular local team meetings: Commitment to convene team for monthly QI meetings to:
 - Test (PDSA cycles)
 - Implement
 - Monitor/share initiative progress (data collection, feedback from patients, healthcare team members)
- Monthly reports: Input data monthly to MNPQC through SimpleQi using the data collection tool to audit 5 charts/cases per month.
 - Baseline data will be presented during Learning Session 2
 - Using PDSA cycles for testing and implementation
 - Develop a spread plan for health systems statewide

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- Evaluation, ongoing and final summary
- Data collection: As a quality improvement initiative, data is gathered to learn and inform PDSA cycle to result in improvement.
 - MNPQC will not request personal health identifiers (PHIs).
 - Data collection and reporting will be deidentified and any disclosed numbers would be aggregated data to partners/stakeholders.

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