Safety Action Series

Challenges in Management of Severe Hypertension: Beyond the Hospital
Speakers

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Disclosures

➢ Brandi Bigelow has no real or perceived conflicts of interest.

➢ Judette Louis, MD, MPH has no real or perceived conflicts of interest.

➢ Courtney Townsel, MD has no real or perceived conflicts of interest.
Objectives

• Share experiences and lessons learned from implementing the **Severe Hypertension in Pregnancy Patient Safety Bundle**

• Provide patient perspectives of the challenges in diagnosing preeclampsia in the postpartum period

• Identify shared decision-making tools and practices when caring for patients with preeclampsia

• Discuss the implications of the redefinition of the postpartum period
Distribution of Pregnancy-Related Causes of Deaths Florida, 1999-2012

- Hypertensive Disorders: 15.5%
- Hemorrhage: 15.2%
- Infection: 12.7%
- Cardiomyopathy: 11.1%
- Thrombotic Embolism: 10.2%
- Cardiovascular: 8.6%
- Amniotic Fluid Embolism: 6.4%
- Cerebrovascular accident: 3.2%
- Anesthesia: 1.6%
- Other: 11.4%
- Unknown: 4.1%
What Did We Do?

• 32 Florida hospitals enrolled to improve hospital processes, structure, and outcomes.

• Hospitals received change implementation tools, trainings, education materials, personalized technical assistance, and monthly collaborative learning webinars.
What Did We Do?

• Hospitals submitted data on key measures through REDCap for a pre-project baseline period, and 15 months prospectively. Measures included:
  – Chart Audit of severe new-onset hypertension (blood pressure ≥160 or ≥110) patients and whether treatment was within 1 hour, cases were debriefed, patient received discharge education on hypertension, a follow-up appointment was scheduled in the appropriate timing
  – Percent of clinical staff education on HIP
  – Completion of 5 structural measures

• Hospitals received monthly quality improvement data reports to track their progress and promote on Plan, Do, Study, Act (PDSA) cycles
HIP Tentative Timeline

- Hospital Participation Agreements Signed: September 2015
- State Initiative Kick-Off: November 2015
- Individual Hospital Kick-Offs: January 2015
- On-Site TA Visits: Jan – June 2016
- Mid-Project Meeting: Fall 2016
- Initiative Completion: June 2017

- Baseline Data Collection
  Recruit Leadership Team: October – December 2015

- Monthly Learning Sessions
  Ongoing Data Collection
  Technical Assistance Upon Request: January 2015 – June 2017
Number of Reporting HIP Hospitals per Quarter

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<tr>
<th>QUARTER</th>
<th>2016</th>
<th>2017</th>
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<td>Q1-16</td>
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<td>Q1-18</td>
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Figure 1. Percent of Women with persistent new-onset severe HTN who were treated within 1 hour (when no cases presented in a month the hospital data point will be blank)
Figure 2. Percent of All Reporting Hospitals that treated women with persistent new-onset severe HTN within 1 hour

Baseline | Q1-16 | Q2-16 | Q3-16 | Q4-16 | Q1-2017 | Q3-17 | Q4-17 | Q1-18
---|---|---|---|---|---|---|---|---
75 to 100% of women treated within 1 hour: 43% | 9% | 28% | 31% | 50% | 41% | 55% | 48% | 57%
1 to 74% of women treated within 1 hour: 9% | 76% | 69% | 50% | 59% | 45% | 52% | 43% | 43%
No women treated within 1 hour: 7% | 63% | 69% | 50% | 59% | 45% | 52% | 43% | 43%
Figure 3. Percent of Women with persistent new-onset severe HTN whose case was debriefed (when no cases presented in a month the hospital data point will be blank)
Figure 4. Percent of All Reporting Hospitals that debriefed cases of HTN

- Baseline: 93%
- Q1-16: 63%
- Q2-16: 55%
- Q3-16: 38%
- Q4-16: 22%
- Q1-2017: 10%
- Q3-17: 32%
- Q4-17: 48%
- Q1-18: 43%

- 75 to 100% of cases debriefed:
- 1 to 74% of cases debriefed:
- No cases debriefed:
Figure 5. Percent of Women with persistent new-onset severe HTN who received discharge education material (when no cases presented in a month the hospital data point will be blank)
Figure 6. Percent of All Reporting Hospitals where women received discharge education material

Baseline | Q1-16 | Q2-16 | Q3-16 | Q4-16 | Q1-2017 | Q3-17 | Q4-17 | Q1-18
---|---|---|---|---|---|---|---|---
75 to 100% of women received discharge education material |
1 to 74% of women received discharge education material |
No women received discharge education material |
Figure 7. Percent of Women with persistent new-onset severe HTN who had follow-up appointments scheduled in appropriate timing

(when no cases presented in a month the hospital data point will be blank)
Figure 8. Percent of All Reporting Hospitals where women had follow-up appointments scheduled in appropriate timing

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<tr>
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<th>Baseline</th>
<th>Q1-16</th>
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<th>Q3-16</th>
<th>Q4-16</th>
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<td>75 to 100%</td>
<td>40%</td>
<td>58%</td>
<td>53%</td>
<td>56%</td>
<td>59%</td>
<td>64%</td>
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<tr>
<td>1 to 74%</td>
<td>38%</td>
<td>50%</td>
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<td>32%</td>
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<td>29%</td>
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<tr>
<td>No</td>
<td>31%</td>
<td>39%</td>
<td>44%</td>
<td>6%</td>
<td>3%</td>
<td>5%</td>
<td>38%</td>
<td>10%</td>
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- **Sustainability**
Structural Measures 1 – 5 at Baseline

- Hypertension Protocol: Percent of hospitals that have hypertension in pregnancy policies and procedures
- EHR Integration: Percent of hospitals where Severe Preeclampsia processes are integrated into the EHR
- Patient, Family, Staff Support: Percent of hospitals that have developed OB specific resources and protocols to support patients, family and staff through major OB complications
- Multidisciplinary case reviews: Percent of hospitals that have policy and process to perform multidisciplinary systems-level reviews on all cases of severe maternal morbidity
- Hypertension discharge education for all patients: Percent of hospitals that have policy and process to provide preeclampsia discharge education for all patients
Overall, Have We Sustained?

• 1/3 Improvement over time

• 1/3 Sustained

• 1/3 Worsened
Challenges

• Physician engagement

• Debriefing
  – Need to be flexible
  – Need to get creative

• Site Visits make a difference
  – May need to be tailored
  – Earlier rather than later
“The challenge is not starting, but continuing after the initial enthusiasm has gone”
The Rogers Curve

- Innovators: Techies try stuff (2.5%)
- Early Adopters: Visionaries get ahead (13.5%)
- Early Majority: Pragmatists stick with the herd (34%)
- Late Majority: Conservatives hold on (34%)
- Laggards: Skeptics: No way! (16%)

Rogers Innovation Bell Curve
Sustainability Suggestions

• Sustainability should be planned from the beginning

• Staff must be trained, confident and competent in the new way of working

• May need to make adaptations to system changes
Our Work is Not Done
Brandi’s Story
Key Points

• Preeclampsia can be difficult to identify in women with chronic hypertension

• How much should we hang our hat on proteinuria?

• Are all members of the team on the same page?
Shared Decision-Making

• A model of patient-centered care that enables and encourages people to play a role in the medical decisions

• First, consumers armed with good information and will participate in the medical decision-making process by asking informed questions and expressing personal values and opinions about their conditions and treatment options.

• Second, clinicians will respect patients' goals and preferences and use them to guide recommendations and treatments.
Why Do It?

• Increased satisfaction
• Improved outcomes
• Lower demand for health care resources.
• Both patients and physicians benefited
  – Increased level of understanding
  – Allowed discussions to focus on the critical risk/benefit tradeoffs
Why Don’t We Do More Of It?

• Don’t believe in it
• Didn’t know that was a “thing”
• Implicit bias
• Insufficient time
• Fear of litigation
• Insufficient educational materials
Courtney’s Story
Delivery is **not** the cure!

97% of preeclampsia-related maternal deaths happen **after** birth

May 2018

Preeclampsia Awareness Month

still at risk
Take Home Points

• Delivery is not the cure
  – Be vigilant
  – Have a high level of suspicion

• Listen to your patients

• Do not delay the evaluation
Redefining Postpartum Care

• Should become an ongoing process

• Tailored to the individual

• Starts during the prenatal period
  – Reproductive life planning
  – Coordination of care beyond pregnancy

• Includes lifelong risk assessment
ACOG Committee Opinion No. 736: Optimizing Postpartum Care

<table>
<thead>
<tr>
<th>Postpartum Process</th>
<th>Primary maternal care provider assumes responsibility for woman’s care through the comprehensive postpartum visit</th>
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<tbody>
<tr>
<td>Contact with all women within first 3 weeks</td>
<td>Ongoing follow-up as needed 3–12 weeks</td>
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<tr>
<td>BP check 3–10 days</td>
<td>High risk f/u 1–3 weeks</td>
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<tr>
<td>Wks</td>
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<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Traditional period of rest and recuperation from birth 0–6 weeks</td>
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<tr>
<td>6-week visit</td>
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• What it says
  – To women: “Your life is just as important as your baby’s life.”
  – You are an individual with individual needs

• What it doesn’t say
  – How you need to achieve the above goals
In Summary

• We still have work to do

• Postpartum is a time of vulnerability

• New tools and innovation can get us there
  – Shared decision making
  – Redesigning Postpartum Care
  – Think outside the box
References

• http://health.usf.edu/publichealth/chiles/fpqc/hip
References

Q&A Session

Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Next Safety Action Series

Improving Care and Support for Patients Experiencing Birth Trauma

May 18, 2018
1:00 p.m. Eastern

Heidi Koss, MA, LMHC
Perinatal Mental Health Specialist,
Perinatal Support Washington

Dawn Thompson
Founder and President,
Improving Birth

Click Here to Register