Severe Hypertension in Pregnancy Patient Safety Bundle Enrollment Form

Idaho Perinatal Quality Collaborative

Program Enrollment Checklist

- ☐ Complete & return Enrollment Form
- ☐ Identify a multidisciplinary team at your hospital to actively champion bundle implementation
- ☐ Assure Zoom capability
- ☐ Complete & return the AIM hospital demographic form
- ☐ Commit to upload process measures into AIM data portal on a quarterly basis
- ☐ Meet monthly as a hospital team to review your progress and data
- ☐ Commit to regularly attend Patient Safety Bundle implementation sessions
- ☐ Attend the IDPQC Annual Summit in 2024
    - Dates TBD (In Person and Virtual attendance will be offered)

The IDPQC is partnering with AIM to implement AIM's Severe Hypertension in Pregnancy bundle for Idaho hospitals.

The Idaho Perinatal Quality Collaborative (IDPQC) is a group of statewide leaders who work together to advocate for improved maternal and neonatal health outcomes through collaboration, implementation of evidence-based practice, and policy change throughout Idaho.

The Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement initiative with the end goal to eliminate preventable maternal mortality and severe morbidity across the United States. It is funded through the federal Health Resources & Services Administration (HRSA) - Maternal and Child Health Bureau (MCHB).

IDPQC will collaborate with _____ (*insert hospital name*), participating on a voluntary basis, to initiate or improve a culture of maternal safety through continuous quality improvement cycles addressing implementation of the AIM Severe Hypertension Bundle.

The areas of focus:

1. Improved readiness to respond to severe hypertension in pregnancy among birthing facilities in Idaho, as evidenced by adaption of readiness components of the Severe Hypertension bundle;
2. Improved recognition and prevention of severe hypertension among pregnant and postpartum patients in Idaho, as evidenced by adaptation of recognition and prevention components of the Severe Hypertension bundle;
3. Optimized treatment for women with pregnant and postpartum patients in Idaho as evidenced by development of a standardized Severe Hypertension checklist;
4. Optimized support for patients, families, and staff following severe hypertension events, as evidenced by participation in the learning sessions and the development of debriefing protocols for significant events.
5. Improved data utilization through the timely collection, submission, and review of project measurement strategies, as evidenced by quarterly submission to the AIM Data Center and evaluation of rapid cycle quality improvement activities.

As part of this initiative, _____ (*insert hospital name*) will receive, free of charge:

1. Access to high quality educational offerings designed to enhance quality improvement capacity and advance quality improvement project work, including free CME;
2. Access to resources, webinars, and other materials to support improvement work on related topics from AIM, ACOG, ACNM, AWHONN, and other professional organizations;
3. Access to data reports to track progress on all topics including run charts, dashboards, and snapshots of the hospital's progress;
4. Support from the ID DHW, Comagine Health, and AIM staff to overcome barriers;
5. Access to subject matter experts who can assist with improvement questions and recommendations;
6. Access to the listservs and other shared forums to assist improvement teams with barriers and provide encouragement to continue the improvement journey.

IDPQC Severe Hypertension Program Enrollment Form

To enroll your birthing hospital, please complete this Enrollment Form and return a scanned copy to Comagine Health.

Basic Hospital Information

Hospital Name: _____

Mailing Address: _____

Your Hospital Team

Please identify an individual for each role, although some team members may play multiple roles. It is critical that all departments with responsibility for implementation of bundle components be represented. ***IMPORTANT:*** *By being listed below, the individual acknowledges their expected participation in this project.*

Day-to-Day Leader (Key Contact Person)

Name: _____

Title: _____

Telephone: _____

Email: _____

Provider Champion

Name: _____

Title: _____

Telephone: _____

Email: _____

Nursing Champion

Name: _____

Title: _____

Telephone: _____

Email: _____

Senior Administrative Leader *(Project Sponsor)*

Name: _____

Title: _____

Telephone: _____

Email: _____

Additional Team Members *(Anesthesia, Lab, Quality, etc.)*

Name: _____

Title: _____

Telephone: _____

Email: _____

Acknowledgment of Local Clinical Oversight & Approval

This project seeks to effectively and efficiently implement evidence-based practice in an active clinical care setting. Quality Improvement tests of change that introduce new processes or modify existing processes require assurance of local clinical oversight of the work of the improvement team. This application requires identification of the provider champion who will be responsible for oversight of your institution or practice's implementation of this project. The Provider and/or RN Champions are responsible for gaining approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical or Nursing Officer (as appropriate) for participation in this project. *Please have the Provider or RN Champion complete this section (initial and signature).*

_____ I agree to provide medical oversight for the work of the improvement team in my facility or practice.

_____ I have gained approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical or Nursing Officer (as appropriate) for participation in this project.

Signature of Provider or RN Champion: _____

Print Name & Title: _____ Date: _____

Senior Leader Authorization and Support

Please have a Senior Leader confirm the following (using initials) and sign.

_____ I will support the team and will work with them to remove any barriers and/or provide the resources necessary for them to achieve success.

Signature of Senior Leader: _____

Title: _____

Print Name: _____ Date: _____

Please return completed form to Genevieve Rasmussen (grassmussen@comagine.org).