Massachusetts
Perinatal Quality Collaborative

Massachusetts Maternal Hemorrhage Clinical Improvement Initiative

Maternal Hemorrhage Initiative

2010 Lehman Center OB Safety Panel Report made five (5) recommendations to improve maternal newborn care in the areas of:

- Elective delivery before 39 weeks
- Cesarean section rate
- Antenatal steroid administration
- Maternal hemorrhage
- Communication and collaboration

Maternal Hemorrhage Initiative

Maternal Hemorrhage recommendations were that each institution in Massachusetts providing obstetrical care would have concrete clinical guidelines for managing maternal hemorrhage including:

- Risk identification
- Early recognition
- Massive transfusion protocol
- System support and practice drills
- Review and debrief

Maternal Hemorrhage Initiative

2011 MPQC formed to execute the work recommended by the Lehman Center OB Safety Expert Panel.

- Modeled after other state perinatal collaboratives.
- Initial funding by the March of Dimes
- Support from the MA DPH
- Membership invited from each of the 48 hospitals
- Participation achieved (MD, RN) from all

Expansion to MPNQC

In June of 2104, the MPQC responded to a RFP from the CDC to funding as a designated State Perinatal Quality Collaborative. We formally joined forces with the MA DPH and NeoQIC and submitted a Grant Proposal.

We were notified of Grant Award in September 2014.

We join, CA, OH and NY with NC and ILL as CDC designated Perinatal Quality Collaboratives.

Severe Maternal Morbidity

Is one of the six MPNQC Funded CDC Grant Initiatives

Has supported continuation of our work on Recognition and Management of Maternal Hemorrhage.

Maternal Hemorrhage Initiative

Maternal Hemorrhage Work Completed:

Data Review:	MA DPH and MA MMMRC	Ongoing
Education:	MPQC Summits Individual Hospital Consultations Bibliography	2012-2015
Survey:	70% response Convenience sample	2012
Findings:	Inconsistent practices 90% requested consultation 2/3 annual maternal deaths r/t maternal hemorrhage	
Collaboration:	AWHONN,ACNM, ACOG, IHI, MHA, HSPH, MA DPH BU School of Public Health	Ongoing
ABC's of PI	NICHQ led Performance Improvement Program on Maternal Hemorrhage in 10 hospitals	2015

Maternal Hemorrhage Initiative

Next Steps:

- Define - measurement parameters/data sources. Identify, develop data sets and information sources.
- Distribute bibliography and learning materials.
- Participate – identify RN and MD champion for **each** OB hospital
- Use existing guidelines: TJC, NQF, AWHONN, ACOG, DPH, IHI, etc.
- Identify, develop data sets and source.
- Adopt successful practices.
- Revise Survey Tool and resurvey to achieve 100% in 2016
- Construct data collection to capture ICU admissions, hysterectomy, blood product utilization and EBL methods
- Establish baseline- each hospital complete practice profile, set goals, identify resources,accountable persons
- Consider IRB application and confidentiality agreement
- Assemble regional traveling consult team to include Obstetrician, Anesthesiologist, Pathologist and Labor and Delivery Nurse.
- Apply and extend the lessons learned in the 2015 ABC's of QI Program 10 hospital program
- Monitor , measure, report by institution, region and state.

Progress

Maternal Hemorrhage Clinical Improvement Initiative (MHCII)

Performance Improvement Project with 10 Massachusetts Hospitals led by NICHQ Performance Improvement experts, June – September 2015.

On-line Learning Resources, Webinars, Coaching Sessions, Written Resource and Results.

Participation

- Baystate Medical Center, Springfield
- University of Massachusetts Memorial, Worcester
- Mt. Auburn Hospital, Cambridge
- MetroWest Hospital, Framingham,
- Harrington Hospital, Southbridge
- Holyoke Hospital, Holyoke
- Winchester Hospital, Winchester
- Cape Cod Hospital, Hyannis and Falmouth
- South Shore Hospital, S Weymouth
- Steward Good Samaritan, Brockton

Results

We will receive a summary with findings and plans from each of the 10 hospitals .

We will share those finding and plans on the MPQC Website.

We will use what was learned to guide plans for dissemination to the 36 other hospitals in Massachusetts with obstetrical services.

Assessment Opportunity

AWHONN has invited MPNQC to engage the 46 hospitals in Massachusetts with Obstetrical programs to use the:

AWHONN PPH Preparedness Survey

as a free resource to each of the hospitals with regular data reporting, analysis and benchmarking from AWHONN.

Survey data will be dynamic and real-time.

More information:

https://pphsurvey.awhonn.org

Resources

- MMPQ Maternal Hemorrhage Bibliography,
  Articles available electronically or paper
  by request.

- Main EK, Hoffman D, Scavone BM, Lo LK, Bingham D, Fontaine PL, Gorlin JB, Lagrew DC and Levy B,
  "National Partnership for Maternal Safety:
  Consensus Bundle on Obstetric Hemorrhage",
  JOGNN, July/August 2015, pp.462-470.

- AWHONN/TJC /ACOG/SMFM policy on Severe Maternal Morbidity and Sentinel Events
  Awhonn.informz.net/awhonn/data/images/clarifyingstatement.pdf

- Collaboration with other hospitals

Maternal Hemorrhage Initiative

Every woman, every baby. AWHONN

We measure what we value.
We improve what we measure.

Debra Bingham, Dr PH, RN

State-based maternal death reviews and maternal quality collaboratives have the potential to identify deaths, review the factors associated with them and take action on the findings.

Berg CJ et al, Obstet and Gynecol 2010;116: 1302-9

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