Massachusetts
Perinatal Quality Collaborative

Maternal Hemorrhage Subcommittee Call Minutes
August 27th, 2013

Call participants: Bonnie Glass, Mindy Green, David Kramer, Mark Manning, Fifi Diop, Faye Weir, Glenn Markenson, Karen Downs, Ruth Karacek, Brian Bateman, Mary Ellen Boisvert, Alexis Travis.

Background on work to dates:

- 3 Years ago the Lehman Center Panel convened a panel on OB Safety too describe and define maternal hemorrhage.
- Last year the MPQC designed a survey to engage partners and described current state with MA DPH and AWOHNN, based on the feedback of the survey we decided to develop and intervention. (See documents attached for details).
- Bonnie and Glenn have used different forums such as DPH and ACOG's annual meeting to gain expert insight and endorsements for the project.
- Other documents such as the survey results from November and May summits were distribute. The results show that 58% of the 48 birthing hospitals responded. Due to the geographic location of the Summits, the results were most likely skewed to Boston and Northeast perspective (approximately half of the attendees).
- We have drafted a letter to the Nurse Manager and Chief of OB and we were going to use an intern from DPH to make calls, record data, and distribute results, but the intern has completed her work with DPH so we are looking for someone to take the next steps.
- Additionally, we had the benefit of sharing with other collaboratives in Ohio and North Carolina, relied on their documents and a bibliography that we shared with the whole collaborative.

Next Steps:

- Ruth shared with the group that although the intern that was previously intending on working on the project has left, there is the possibility of having another one work on the project. Karen added that we can reach out to BU to see if they have some interns through Jean or Lois. Bonnie agreed that it would be a good idea and stated that it will make a good paper for them, and serves two purposes as we need someone to follow-up in order to make sure we get a good response rate.
- Faye suggested that we send a letter to the Chief OB and the CEO or Head of Quality for each institution. Karen responded that it hasn't been done successfully in the past, however we might get a better response from the head of maternity. Bonnie suggested we send and FYI letter to the Chief of OB and the QI person and added that the more we can involve the hospital administration the better (based on feedback from ACOG). Karen agreed and said we should make sure to copy the Nursing Director and Physician Director. The group also discussed the issue of turnover and agreed to keep the position/title as a criteria on the summit sign in sheet in order to keep an updated list.
- Bonnie asked the group about the timing for redistribution of the survey, specifically whether it should be before or after labor day and whether it should take place before we design the consultation service. Mindy stated that the Central Region is doing an intervention about hemorrhage in 2 locations at UMass Memorial, where academic blood bank staff work on both what happens when maternal hemorrhage occurs what is the 1st call, 2nd call, and getting a cooler to store blood. At UMass the staff train in 2 locations and pack blood products.

- The group discussed training blood bank personnel as this is a small group of professionals and they have very little turn over. Mindy shared that after each incident the team at UMass sit down and review the event, the sequence of things that occurred, and how we can improve it. Bonnie shared that Mark has invited Mindy to join the hemorrhage consult team and added that it is important to have all involved groups represented.
- Glenn summarized that are approach will be assessing what happens in an event and planning tactics, we can talk specifically about what changes we are going to make and develop off the shelf materials to help individual institutions improve their response. Bonnie agreed and stated that we need to have a consistent approach and collect strategies. So far the consulting team consists of Ron Iverson, Brian Bateman, Mindy Greene, Jeff Ecker, Ellen Delpapae, Michele Helgeson, Kim Pina, Mark Manning, Faye Weir, and Bonnie.
- Glenn suggested that in the meantime we can exchange protocols and materials, including sample simulations. He added that California has an excellent set of materials on their website, which we could incorporate and reference. Bonnie shared that Deborah Bingham suggested we apply for funds from AWHONN, so we can explore that and we could ask South shore to provide a best practice or to contribute something they have read as evidence behind their approach.

Measuring Outcomes:

- Bonnie asked the group to outline ways we will know we have made a difference. Glenn responded that if we simply as show us an example of your process and a hospital has an OB specific protocol, that will be a success. Bonnie agreed that the presence of a policy would indicate success. Ruth added that we could gain approval from DPH to review outcomes. Glenn added that a recommendation from DPH perinatal advisory committee to review each mass hemorrhage would help institutions. Ruth responded that DPH can recommend it but mandating it would mean changing the law. Bonnie stated that the perinatal advisory committee at each hospital is required to meet quarterly, but surveys show the perinatal advisory committee does not review blood product utilization and near misses. David responded that near misses will be difficult to identify, because of when we make the diagnosis. Karen suggested that we can look at the ICD9 definitions we are using to identify near misses.
- Glenn suggested that we look at documentation/auditing whether patients have been screened. Bonnie stated that doctors are require a lot to make risk identification. Mary Ellen suggested that we look at hospitals that do drills and how often.
- Bonnie proposed collaborating with medically induced trauma teams
- Ruth asked how we will request tools and policies. Bonnie responded between members that are on the call and via e-mail, asking people to share with the MPQC. We can also add to the bibliography and reach out to people that we know have a good policy.

Action Items:

- Alexis to e-mail the group and request Maternal Hemorrhage protocol samples
- Bonnie will complete the design of the system and prepare the materials we discussed for distribution and invite institutions to participate.
- Bonnie will assemble the consult team via conference call.