

Every Mother Counts

Reducing Severe Maternal Morbidity and Maternal Mortality in Oklahoma

- Oklahoma's pregnancy-related death rate for 2009-2013 was 20.4 deaths per 100,000 live births*
- Maternal mortality and severe morbidity rates are increasing in the U.S. and Oklahoma

*Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics, on Oklahoma Statistics on Health Available for Everyone OK2SShare

OPQIC



OKLAHOMA PERINATAL QUALITY
IMPROVEMENT COLLABORATIVE



Every Mother Counts Collaborative

PROBLEM

The U.S. rate of maternal mortality has doubled over the last decade, ranking it 47th in the world. Oklahoma's maternal mortality rate, one of the worst in the nation, is approximately **two times** the Healthy People 2020 goal of 11.4. Black women and Native American women have a rate of maternal mortality that is greater than that of white women. U.S. state maternal mortality reviews show that obstetric hemorrhage and severe hypertension are the two leading causes of preventable severe maternal morbidity and maternal mortality. Approximately 620 women die from pregnancy related conditions each year in the U.S. It is estimated that severe maternal morbidity occurs **fifty times** more than maternal mortality. *We need your help in reversing these trends!*

SOLUTION

Your hospital is invited to join the Oklahoma Every Mother Counts collaborative, a cost-free, statewide effort among Oklahoma birthing hospitals to reduce maternal mortality and severe maternal morbidity.

- The goal is that all Oklahoma birthing hospitals will implement safety bundles related to *obstetric hemorrhage and severe hypertension in pregnancy* to ensure safe, standardized care for women with these conditions.
- [Resources](#), including toolkits and bundles developed by national partners, will be utilized. Standardized approaches to clinical situations have been proven to decrease errors and improve safe care.
- Oklahoma is one of six states selected to participate in the *Every Mother Initiative* supported by a grant from the Association of Maternal & Child Health Programs.
- The Every Mother Counts collaborative aligns with national efforts with shared goals.
- The Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) will lead this effort.

COLLABORATIVE WORK

As with the Every Week Counts collaborative, we will be using improvement models based on the Institute for Healthcare Improvement (<http://www.ihl.org>). At the unit level, project teams will assess their individual needs, establish priorities, and work to achieve their individual goals.

- Improving practices collaboratively has been proven to be more effective than attempting to improve individually at the unit or hospital level.
- Tools will be provided and assistance will be given to participating hospitals to ensure their readiness, recognition, response and reporting for obstetric hemorrhage and severe hypertension.

- Data collection tools will be provided to teams by OPQIC. OPQIC will provide individual hospital and aggregate reports to participating teams.
- Special emphasis will be placed on hospital simulation training and facility review of events.

There is no cost to join the collaborative, thanks to the support of the Health Resources and Services Administration (HRSA) and the Association of Maternal Child Health Programs (AMCHP). In fact, a stipend of a minimum of \$500 is being offered to each participating hospital which meets certain requirements. Participating hospitals will be publicly recognized for their participation.

We hope that you are able to join this collaborative. If you have any questions, please contact Barbara O'Brien at 405-271-7777 or barbara-obrien@ouhsc.edu

EXPECTATIONS OF THE CLINICAL TEAM

The following expectations must be met to receive the \$500 stipend at the conclusion of the first year of the collaborative.

- Develop an internal quality improvement team minimally consisting of:
 - ✓ Physician champion*- A physician who believes in this effort and will support the required change in process.
 - Need one physician champion for hemorrhage and hypertension initiatives (can be same person)
 - ✓ Executive leader-Connects the team's aim to the organization's mission. Provides necessary resources and time to devote to testing and implementing changes. Supports and encourages the improvement team. Responsible for the sustainability of the team's effective changes.
 - ✓ Day to day leader*- Responsible for driving the improvement process every day. Manages the team and assures the changes are being made and data is collected. This person is likely to be the OB nursing leader.
 - ✓ Technical expert- The focus of this collaborative revolves around the implementation of the hemorrhage and severe hypertension safety bundles; therefore the technical expert is the person who has a strong understanding of the process to be improved. This person is responsible for the scheduling of activities and data collection. This is likely to be a nurse manager or staff nurse leader.
 - ✓ Anesthesia provider- Leads the process changes that require implementation by anesthesia providers.
 - ✓ Blood bank leader-Leads the process changes that require implementation with the blood bank.
 - ✓ Simulation leader- Responsible for ensuring multi-professional simulations are initiated and sustained. May have another role listed above.
 - ✓ Other influential people may participate.

- **At least 3 members of the team** (adjustments may be made according to hospital size) must attend one day-long, in-person educational sessions in Oklahoma City on April 24, 2015
 - *Required to attend
- EMC clinical team members must participate in local simulation sessions
- Collect baseline data as instructed
- Participate in scheduled conference calls
- Report monthly data to the project team
- Share barriers and successes
- Implement components of [national bundles](#) to ensure readiness, recognition and response in managing obstetric hemorrhage and severe hypertension for women in their care.

BENEFITS OF PARTICIPATION

- Improve the safety of perinatal care provided in your unit
- Improve readiness, recognition, response, reporting and review of obstetric hemorrhage and severe hypertension management
- Be part of a state-wide collaborative to improve maternal and infant outcomes
- Learn about patient safety bundles for the management of women with obstetric hemorrhage or severe hypertension from national content and quality improvement experts
- Receive useful resources
- Expand the statewide network for improvement work among peers with like challenges
- Receive support from the collaborative faculty and coordinators
- Receive a minimum of \$500 stipend for successful completion
- Receive recognition for participation

KICK-OFF EVENT April 24

An all-day event will be held at Moore Norman Technology Center South Penn Campus, 13301 S. Penn, OKC on **April 24, 2015** from 9:00-4:00.

- Featured speakers:

William Callaghan, MD, MPH
Chief, Maternal and Infant Health Branch
Division of Reproductive Health
Centers for Disease Control and
Prevention

Eleni Z. Tsigas
Executive Director
Preeclampsia Foundation

- No cost to attend event
- **At least one physician champion team member must attend**

EVERY MOTHER COUNTS

Reducing Severe Maternal Morbidity and Maternal Mortality in Oklahoma

Registration: Please complete and fax to (405) 271-7177

*****At least 3 members of the team, one being a physician, must attend the Kick-Off Meeting.**

Yes, our organization will commit to participate in the Every Mother Counts collaborative to reduce maternal deaths and severe maternal morbidity through the implementation of patient safety bundles related to obstetric hemorrhage and severe hypertension.

Hospital _____

Your Hospital's Team

Key Contact Person:

Name: _____ Credentials: _____ Title: _____

Email address: _____ Phone: _____

Physician Champion(s):

- Hemorrhage: _____
- Severe Hypertension: _____

Executive Leader: _____

Day-to-Day Leader: _____

Technical Expert: _____

Anesthesia Provider: _____

Blood Bank Leader: _____

Simulation Leader: _____

Others: (Space at the Kick-Off Meeting is limited. This will determine how many team members can attend).
