Obstetric Hemorrhage Initiative

Getting Started Kit

October 2023

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An Overview of the Obstetric Hemorrhage Collaborative

Welcome to the Obstetric Hemorrhage (OBH) Collaborative. Our goal is to reduce by 20% the rate of severe maternal morbidity and mortality associated with obstetric hemorrhage among pregnant and postpartum patients in participating facilities by Dece 2025. Our key goals are to:

- Increase the % of patients who receive a hemorrhage risk assessment
- Increase the % of deliveries utilizing quantitative blood loss (QBL) measurements
- Increase % of patients who receive verbal briefing on OBH event before discharge
- Narrow the Black/White inequities in SMM among patients with OBH

This initiative takes the structure of the Institute for Healthcare Improvement's Breakthrough Series Collaborative. A Breakthrough Series (BTS) Collaborative is a systematic approach to health care quality improvement in which organizations and staff test and measure practice innovations and share their experiences in an effort to accelerate learning and widespread implementation of best practices. BTS uses the Model for Improvement as a framework to guide improvement work. Your experience will involve working together with hospital teams from across Alabama who share the same goals.

The OBH Collaborative aims to optimize care for obstetric patients by reducing risks and complications associated with obstetric hemorrhage by implementing the Alliance for Innovation on Maternal Health (AIM) Obstetric Hemorrhage Bundle, focusing on the following components of patient care:

1) **Readiness**: Improve readiness to respond to an obstetric hemorrhage by:
   a) Developing obstetric hemorrhage rapid response teams
   b) Standardized, facility-wide, stage-based obstetric hemorrhage emergency management plan
   c) Implementing massive transfusion protocols, including coordinating emergency release transfusion protocols with blood bank
   d) Developing unit policies, protocols, and refusal checklists for blood products/blood product alternatives
   e) Establishing a hemorrhage cart or equivalent to ensure rapid access to surgical instruments and tools designed to treat obstetric hemorrhage, including instruments needed to treat vaginal/ cervical lacerations and perform uterine tamponade or uterine/ovarian artery ligation.
   f) Ensuring accessibility of first line hemorrhage medications.
   g) Performing interprofessional and interdepartmental team-based drills with simulated patients and

timely debriefs that emphasize all elements of the facility obstetric hemorrhage emergency management plan, transfusion protocols, and patient-centered, empathetic, trauma-informed care.

2) **Recognition & Prevention:** Improve recognition and prevention of OB hemorrhage by:
   a) Performing risk assessments during periods of transition including, at a minimum, on admission, pre-birth, and transition to postpartum care
   b) Quantifying cumulative blood loss during vaginal and cesarean births intrapartum, during birth, and during recovery.
   c) Aligning patient education efforts with health literacy, culture, language, and accessibility needs regarding warning signs/symptoms, postpartum follow up, and future pregnancy hemorrhage risks.
3) **Response:** Initiating appropriate interventions for every event by:
   a) Administering first line hemorrhage medications according to evidence-based protocols.
   b) Performing nonpharmacological interventions for hemorrhage management, including uterine tamponade devices, compression techniques, non-surgical and surgical procedures, blood product and fluid resuscitation.
   c) Communicating trauma-informed support, both verbally and in a written clinical summary, regarding details of birth events, follow-up care, resources, and appointments with patients and identified support network, with consideration for person's health literacy, culture, language, and accessibility needs.
4) **Reporting and Systems Learning:** Developing a standardized system for identifying cases for multidisciplinary review by:
   a) Establishing a standardized facility definition and criteria of "serious complications," which may include ICU admission or ≥4 units total/packed red blood cell (PRBC) transfusion.
   b) Reviewing identified cases for alignment with standard policies and procedures and appropriately updating policies and procedures for future events.
   c) Systematically sharing findings from reviews and data reporting with all associated staff and involved facility stakeholders.
5) **Respectful, Equitable, and Supportive Care:** Patient-centered care provided by every unit/provider/team member through:
   a) Inclusion of the patient as part of the multidisciplinary care team.
   b) Welcoming identified patient support networks, including nonfamilial supports such as doulas and home visitors, to participate, with the postpartum patient's permission, in any teaching or planning provided.
   c) Ensuring staff are informed regarding patients who decline blood or blood products and the potential use on blood product alternatives for these patients.

Contact information

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OBH Collaborative Schedule

The OBH Collaborative will begin January 2024.

Learning Sessions

- Learning Session 1:
  - TBD (Virtual)
- Future Learning Session(s): TBD

Action Periods

- Monthly Action Period Calls:
  - 4th Friday of every month at 12:00 pm CST, starting January 2024 (Virtual)

1:1 with RN-Quality Improvement

- Recurring monthly 1:1 call with ALPQC RN – Quality Improvement

Learning Sessions (LS) are meetings bringing together participating hospital teams and expert faculty to exchange ideas in real time, learn about new changes for testing, and get energized for the work ahead. We will have at least two LSs during the project cycle.

Between Learning Sessions, hospitals engage in Action Periods (APs). During APs, teams actively try new ideas within their organizations, and come together for monthly "All Teach, All Learn" sessions to share and receive support from ALPQC and peers. See **OBH Charter** for more information on Learning Sessions and Action Periods.

Facilities taking part in the OBH Collaborative will meet with the ALPQC Quality Improvement RN to discuss data, facility performance, identify opportunities for improvement, provide support and generate resources to improve outcomes.

Getting Started Checklist

1. Review OBH Collaborative Charter and Toolkit, and complete *Assessment Checklist* inside Toolkit
2. Create Your Team
    a. Confirm Sponsor
    b. Select Day-to-Day Leader
    c. Create Your Team
    d. Select Pilot Unit
    e. Fill out Team Roster
3. Fill out the AIM-ALPQC OBH Initiative baseline survey
4. Become familiar with resources in the OBH Initiative website
5. Review and share with colleagues the Model for Improvement

Step 1: Review OBH Collaborative Charter and Toolkit

Inside the OBH Charter and OBH Toolkit you will find more in-depth information on the project description, the data measures, and each component noted in the Overview section of this document.
Please also complete the "Current Assessment" checklist found inside the OBH Toolkit, including assigning a responsible person for each component. These steps will help you start gaining an understanding of the change ideas we will implement, the best practices that underpin them, and will help you start identifying current gaps and action steps.

You will find these documents along with data collection forms and further resources to help with implementation at www.alpqc.org/initiatives/obh.

Step 2: Team Formation

a. Select a pilot unit

This is the first patient care area in your hospital where testing of the concepts in the change package (toolkit) will occur. In a small hospital, it may not be necessary to select a pilot unit but in medium to large size hospitals, it's more beneficial to begin testing in a focused location to keep the tests on a small enough scale and to allow for revision of the tests before implementation and spread occur. Ideally, hospitals would select a unit that has individuals who are excited about creating change and have a high tolerance for rapid change early on.

b. Confirm Project Sponsor

In addition to the working members of your team, a successful improvement team needs a sponsor—someone with executive authority who serves as a liaison with other areas of the organization, provides structure to support the team effort, advocates for supportive policies, and allocates resources for improvement to overcome barriers. The Sponsor is not a day-to-day participant in team meetings and testing but reviews its progress on a regular basis.

The sponsor is responsible for:

- Encouraging the team to set its goals at an appropriate level to meet organizational goals
- Providing the team with the resources needed, including staff time and operating funds
- Making it clear to the team that they have the time, resources, and authority needed to change organizational systems to accomplish their goal
- Regularly reviewing the work of the team
- Developing a plan to spread the successful changes from the improvement team to the rest of the organization, including: communicating what is learned from the improvement work in ways that motivate and mobilize the rest of the organization, and designating someone who will be responsible for leading the activities needed to support spread

c. **Select the day-to-day leader for the initiative**

The day-to-day leader is the person who drives the project forward, ensures that changes are tested and implemented, and oversees data collection. It is important that this person understands the details of the system and the various levers for making changes in the system; and will be someone who can work effectively with the physician and nurse champions, other technical experts, and leaders. This person typically devotes a significant amount of time to the improvement team's work. The main contact person identified on your Team Roster may be the same person who serves in this role, but not necessarily.

The day-to-day leader should be someone who:

- Has a working knowledge of the project topic
- Is in a position to carry the work of the improvement team beyond the pilot
- Is able to organize and coordinate a functioning team that is engaged in rapid cycles of improvement and has time allocated by senior leadership to work on this project
- Is motivated and excited about change and new designs to improve care

d. **Create your team**

Your implementation team will guide the work and execute the tests of change throughout the Collaborative. Including the right persons in an improvement team is critical to the success of the improvement effort. Some helpful steps to consider:

1. Review the project aim
2. Consider the system that is related to the aim: what components of patient care will be affected by the improvement effort?
3. Select team members that represent and are familiar with all the different parts of the process

It is critical to get all team members on board early in the process to build a strong foundation for driving the project forward. **You will want to meet as a team at least monthly**, likely more frequently at the beginning as you get the initiative established. For more information, see IHI's Science of Improvement: Forming the Team.

e. **Fill out Team Roster**

If you have not already done so, please fill out a Team Roster to help us better communicate with your team and keep everyone abreast of initiative information. You will find the Team Roster form here.

f. <u>Considerations of team rules, roles, and attributes</u>

Determine your team's ground rules - ex. meeting frequency, meeting venue/format, meeting attendance. Agree on roles of each team member, including who will prepare agendas, who will take notes, etc.

Consider the attributes of highly effective teams: highly effective teams don't just happen! Time, cultivation, and attention are needed to create an environment for high-functioning teams. Here is a short list of attributes of such teams:

- The purpose and objectives of the team are clear
- The roles of team members are clear
- A climate exists that a) seeks and supports participation of all team members, and b) supports problem solving and learning
- Decision making processes are clear
- Leaders model a clear conflict resolution process
- The team practices good housekeeping: clear agendas, start and stop times, role assignments (facilitator, note taker, timekeeper)
- Leadership is distributed and shared among team members
- Team members' strengths are utilized to the fullest
- The team encourages risk taking and creativity
- The team has a method to assess itself as a team

Step 3: Fill out the AIM-ALPQC OBH Initiative baseline survey

Please fill out the AIM-ALPQC OBH Initiative baseline survey. This survey will help you assess your current practices at your facility, will help you determine what to first focus on during implementation, and will help us tailor technical assistance to teams. The survey can be filled out here. You will receive an email with a PDF of the survey questions for ease of gathering the answers needed, but please also feel free to reach out to our team at info@alpqc.org and we will share the PDF with you. Please aim to fill out the survey by January 31, 2024.

Step 4: Become familiar with resources in OBH Initiative website

The OBH Collaborative website (www.alpqc.org/initiatives/obh) is where you will find all materials needed for implementation, including how-to documents on entering and visualizing data in the portal.

Step 5: Become Familiar with the Model for Improvement

We will use a simple improvement approach for the OBH Collaborative called the Model for Improvement (MFI). The MFI will be taught at the Learning Sessions. However, if your team does not have experience with the MFI, we encourage your team to review some of the videos and resources below.

- An Illustrated Look at Quality Improvement in Health Care – 8 minute video
- The Model for Improvement (Part 1) – 3 minute video
- Science of Improvement: Testing Changes