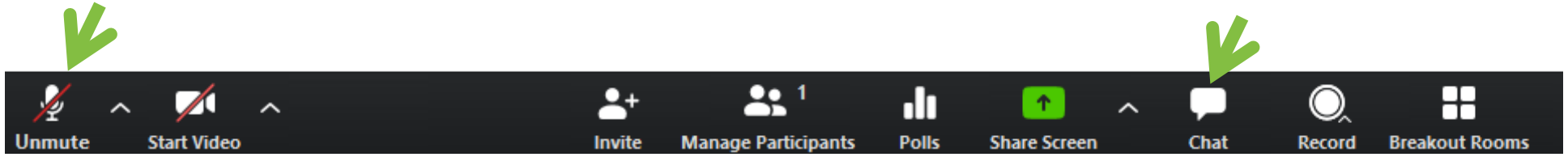
Obstetric Initiatives

Action Period Call
March 20th, 2024
1:00 – 2:00 PM CT

Welcome

- Please type your name and the organization you represent in the chat box and send to "Everyone"
- Please click on the three dots in the upper right corner of your Zoom image, click "Rename" and put your name and organization.
- Please also do for all those in the room with you viewing the webinar.
- Attendees are automatically muted to reduce background noise.
- You may enter questions/comments in the "chat" box during the presentation. We will have a Q&A session at the end.
- Slides will be available via email and at http://www.alpqc.org/initiatives/htn
- We will be recording this call to share, along with any slides.



Agenda

Activity	Time
1:00 – 1:08	Welcome & Updates
1:08 – 1:15	Breakout Groups
1:15 – 1:30	Postpartum Hemorrhage Protocols
1:30 – 1:40	Obstetric Hemorrhage Initiative Data Review
1:40 – 1:50	Reminders
1:50 – 2:00	Q&A

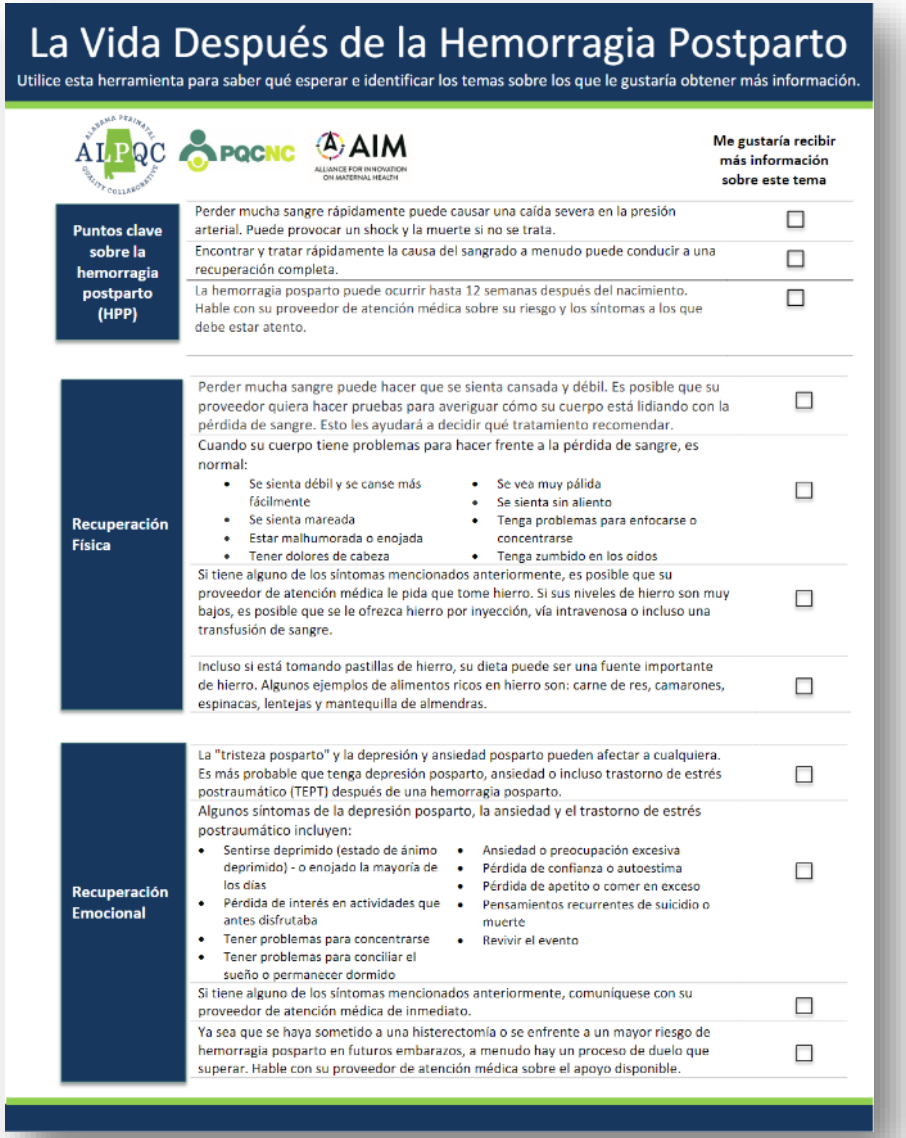
Updates

- The ALPQC Quarterly Newsletter was released on 3/15/24 by email and is available at ALPQC.org

- Monthly Data surveys were emailed on March 15th

- Spanish translation of the Patient Debriefing Tool will be available this month on ALPQC.org

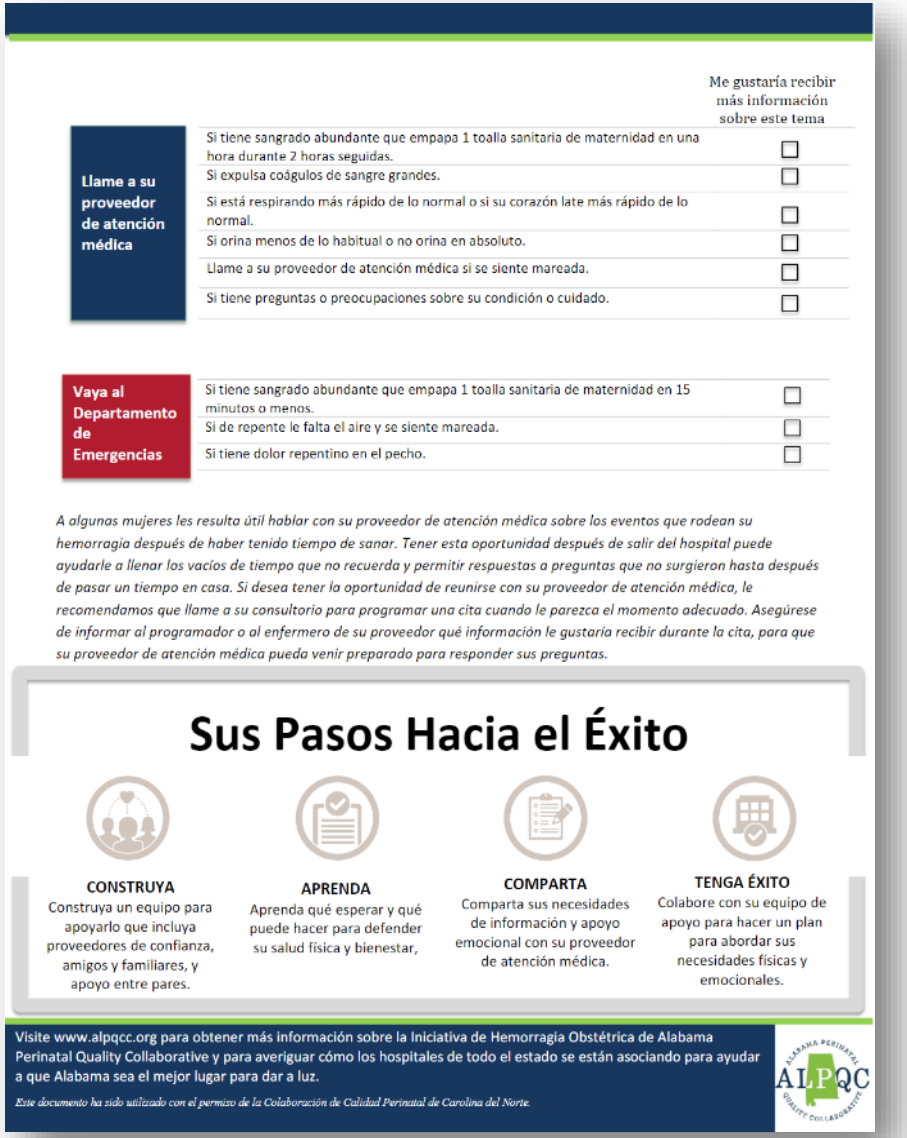
New Resource Available – Spanish Version



La Vida Después de la Hemorragia Postparto

Utilice esta herramienta para saber qué esperar e identificar los temas sobre los que le gustaría obtener más información.

		Me gustaría recibir más información sobre este tema
Puntos clave sobre la hemorragia postparto (HPP)	Perder mucha sangre rápidamente puede causar una caída severa en la presión arterial. Puede provocar un shock y la muerte si no se trata.	☐
	Encontrar y tratar rápidamente la causa del sangrado a menudo puede conducir a una recuperación completa.	☐
	La hemorragia posparto puede ocurrir hasta 12 semanas después del nacimiento. Hable con su proveedor de atención médica sobre su riesgo y los síntomas a los que debe estar atento.	☐
Recuperación Física	Perder mucha sangre puede hacer que se sienta cansada y débil. Es posible que su proveedor quiera hacer pruebas para averiguar cómo su cuerpo está lidiando con la pérdida de sangre. Esto les ayudará a decidir qué tratamiento recomendar.	☐
	Cuando su cuerpo tiene problemas para hacer frente a la pérdida de sangre, es normal: • Se sienta débil y se canse más fácilmente • Se sienta mareada • Estar malhumorada o enojada • Tener dolores de cabeza • Se vea muy pálida • Se sienta sin aliento • Tenga problemas para enfocarse o concentrarse • Tenga zumbido en los oídos	☐
	Si tiene alguno de los síntomas mencionados anteriormente, es posible que su proveedor de atención médica le pida que tome hierro. Si sus niveles de hierro son muy bajos, es posible que se le ofrezca hierro por inyección, vía intravenosa o incluso una transfusión de sangre.	☐
	Incluso si está tomando pastillas de hierro, su dieta puede ser una fuente importante de hierro. Algunos ejemplos de alimentos ricos en hierro son: carne de res, camarones, espinacas, lentejas y mantequilla de almendras.	☐
Recuperación Emocional	La "tristeza posparto" y la depresión y ansiedad posparto pueden afectar a cualquiera. Es más probable que tenga depresión posparto, ansiedad o incluso trastorno de estrés postraumático (TEPT) después de una hemorragia posparto.	☐
	Algunos síntomas de la depresión posparto, la ansiedad y el trastorno de estrés postraumático incluyen: • Sentirse deprimido (estado de ánimo deprimido) - o enojado la mayoría de los días • Pérdida de interés en actividades que antes disfrutaba • Tener problemas para concentrarse • Tener problemas para conciliar el sueño o permanecer dormido • Ansiedad o preocupación excesiva • Pérdida de confianza o autoestima • Pérdida de apetito o comer en exceso • Pensamientos recurrentes de suicidio o muerte • Revivir el evento	☐
	Si tiene alguno de los síntomas mencionados anteriormente, comuníquese con su proveedor de atención médica de inmediato.	☐
	Ya sea que se haya sometido a una histerectomía o se enfrente a un mayor riesgo de hemorragia posparto en futuros embarazos, a menudo hay un proceso de duelo que superar. Hable con su proveedor de atención médica sobre el apoyo disponible.	☐



		Me gustaría recibir más información sobre este tema
Llame a su proveedor de atención médica	Si tiene sangrado abundante que empapa 1 toalla sanitaria de maternidad en una hora durante 2 horas seguidas.	☐
	Si expulsa coágulos de sangre grandes.	☐
	Si está respirando más rápido de lo normal o si su corazón late más rápido de lo normal.	☐
	Si orina menos de lo habitual o no orina en absoluto.	☐
	Llame a su proveedor de atención médica si se siente mareada.	☐
	Si tiene preguntas o preocupaciones sobre su condición o cuidado.	☐
Vaya al Departamento de Emergencias	Si tiene sangrado abundante que empapa 1 toalla sanitaria de maternidad en 15 minutos o menos.	☐
	Si de repente le falta el aire y se siente mareada.	☐
	Si tiene dolor repentino en el pecho.	☐

A algunas mujeres les resulta útil hablar con su proveedor de atención médica sobre los eventos que rodean su hemorragia después de haber tenido tiempo de sanar. Tener esta oportunidad después de salir del hospital puede ayudarle a llenar los vacíos de tiempo que no recuerda y permitir respuestas a preguntas que no surgieron hasta después de pasar un tiempo en casa. Si desea tener la oportunidad de reunirse con su proveedor de atención médica, le recomendamos que llame a su consultorio para programar una cita cuando le parezca el momento adecuado. Asegúrese de informar al programador o al enfermero de su proveedor qué información le gustaría recibir durante la cita, para que su proveedor de atención médica pueda venir preparado para responder sus preguntas.

Sus Pasos Hacia el Éxito

CONSTRUYA
Construya un equipo para apoyarlo que incluya proveedores de confianza, amigos y familiares, y apoyo entre pares.

APRENDA
Aprenda qué esperar y qué puede hacer para defender su salud física y bienestar,

COMPARTA
Comparta sus necesidades de información y apoyo emocional con su proveedor de atención médica.

TENGA ÉXITO
Colabore con su equipo de apoyo para hacer un plan para abordar sus necesidades físicas y emocionales.

Visite www.alpqcc.org para obtener más información sobre la Iniciativa de Hemorragia Obstétrica de Alabama Perinatal Quality Collaborative y para averiguar cómo los hospitales de todo el estado se están asociando para ayudar a que Alabama sea el mejor lugar para dar a luz.

Este documento ha sido utilizado con el permiso de la Colaboración de Calidad Perinatal de Carolina del Norte.

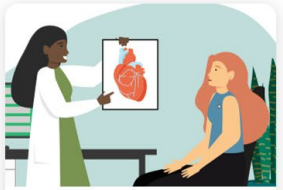
AIM Patient Safety Bundle Courses

The learning modules are **free of charge** but require creating an account with ACOG Online Learning to access.

Obstetric Hemorrhage

Severe Hypertension in Pregnancy

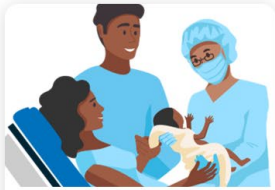
Safe Reduction of Primary Cesarean Birth



Cardiac Conditions in Obstetric Care

Care for Pregnant and Postpartum People with Substance Use Disorder

Perinatal Mental Health Conditions



Postpartum Discharge Transition

Sepsis in Obstetric Care

saferbirth.org/psb-learning-modules/

★ CME/CE CREDITS ARE COMING SOON!

Patient Education Badge Buddy Offer

Urgent Maternal Warning Signs Badge Buddies

Request UMWS Badge Buddies to be shipped to your organization using the **AIM UMWS Badge Buddy Request Form.**

Thank you to Michigan AIM for creating and sharing these badge buddies!

AIM UMWS

https://airtable.com/appID2WPSw7ZIWP9y/shrk8XzQ9NZlEMfM4

Breakout Groups

- Patient Debriefs
  - What is your facility using to perform patient debriefs?
  - Who is performing the debriefs?
  - How is the debrief documented in the EMR?
- Postpartum Hemorrhage Protocols
  - OB or RN driven?
  - Where is the protocol stored – EMR?
  - How is the activation of the protocol documented in the EMR?

PPH Protocols

Evidence-based practices

Dr. Brian Brocato

Benefits of PPH Protocols

- Prompt recognition and timely treatment are crucial in preventing adverse outcomes.
- A well-structured PPH protocol ensures that healthcare providers follow standardized procedures, leading to faster interventions.
- Protocols guide clinicians in managing uterine atony (the most common cause of PPH) and other potential causes effectively.
- Helps to remove implicit biases that could be present

Standard PC.06.01.01

Requirement EP 2	Develop written evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that include the following: • The use of an evidence-based tool that includes an algorithm for the identification and treatment of hemorrhage • The use of an evidence-based set of emergency response medication(s) that are immediately available on the obstetric unit • Required response team members and their roles in the event of severe hemorrhage • How the response team and procedures are activated • Blood bank plan and response for emergency release of blood products and how to initiate the massive transfusion procedures • Guidance on when to consult additional experts and consider transfer to a higher level of care • Guidance on how to communicate with patients and families during and after the event • Criteria for when a team debrief is required immediately after a case of severe hemorrhage *Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, anesthesiology, nursing, laboratory, and blood bank.*
Rationale	• Having defined procedures to manage patients experiencing severe hemorrhage is integral to ensuring that everyone caring for a patient functions well as a team so delays in critical processes are minimized. • Communication between team members during an emergency is a key factor for success. It is important for an organization to standardize the language team members will use to identify patients with severe hemorrhage and trigger a predetermined response from staff. • Post-emergency debriefs are valuable for summarizing how well the team followed procedures and determining if there are opportunities for improvement.

ACOG PPH Protocol Example

Obstetric Hemorrhage Checklist

EXAMPLE

Complete all steps in prior stages plus current stage regardless of stage in which the patient presents.

Postpartum hemorrhage is defined as cumulative blood loss of greater than or equal to 1,000mL or blood loss accompanied by signs or symptoms of hypovolemia within 24 hours. However, blood loss >500mL in a vaginal delivery is abnormal, and should be investigated and managed as outlined in Stage 1.

RECOGNITION:

- ☐ Call for assistance (Obstetric Hemorrhage Team)

Designate: ☐ Team leader _____ ☐ Checklist reader/recorder ☐ Primary RN

Announce: ☐ Cumulative blood loss ☐ Vital signs _____ ☐ Determine stage

STAGE 1: Blood loss >1000mL after delivery with normal vital signs and lab values. Vaginal delivery 500-999mL should be treated as in Stage 1.

INITIAL STEPS:

- ☐ Ensure 16G or 18G IV Access
- ☐ Increase IV fluid (crystalloid without oxytocin)
- ☐ Insert indwelling urinary catheter
- ☐ Fundal massage

MEDICATIONS:

- ☐ Ensure appropriate medications given patient history
- ☐ Increase oxytocin, additional uterotonics

BLOOD BANK:

- ☐ Confirm active type and screen and consider crossmatch of 2 units PRBCs

ACTION:

- ☐ Determine etiology and treat
- ☐ Prepare OR, if clinically indicated (optimize visualization/examination)

Oxytocin (Pitocin):
10-40 units per 500-1000mL solution

Methylergonovine (Methergine):
0.2 milligrams IM (may repeat);
Avoid with hypertension

15-methyl $PGF_2\alpha$ (Hemabate, Carboprost):
250 micrograms IM (may repeat in q15 minutes, maximum 8 doses); **Avoid with asthma; use with caution with hypertension**

Misoprostol (Cytotec):
800-1000 micrograms PR
600 micrograms PO or 800 micrograms SL

Tone (i.e., atony)
Trauma (i.e., laceration)
Tissue (i.e., retained products)
Thrombin (i.e., coagulation dysfunction)

STAGE 2: Continued Bleeding (EBL up to 1500mL OR ≥ 2 uterotonics) with normal vital signs and lab values *(*two or more uterotonics in addition to routine oxytocin administration; or ≥ 2 administrations of the same uterotonic)*

INITIAL STEPS:

- ☐ Mobilize additional help
- ☐ Place 2nd IV (16-18G)
- ☐ Draw STAT labs (CBC, Coags, Fibrinogen)
- ☐ Prepare OR

MEDICATIONS:

- ☐ Continue Stage 1 medications; consider TXA

BLOOD BANK:

- ☐ Obtain 2 units PRBCs (DO NOT wait for labs. Transfuse per clinical signs/symptoms)
- ☐ Thaw 2 units FFP

ACTION:

- ☐ For uterine atony --> consider uterine balloon or packing, possible surgical interventions
- ☐ Consider moving patient to OR
- ☐ Escalate therapy with goal of hemostasis

Tranexamic Acid (TXA)
1 gram IV over 10 min (add 1 gram vial to 100mL NS & give over 10 min; may be repeated once after 30 min)

Possible interventions:
- Bakri balloon
- Compression suture/B-Lynch suture
- Uterine artery ligation
- Hysterectomy

Huddle and move to Stage 3 if continued blood loss and/or abnormal VS

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Revised September 2020

STAGE 3: Continued Bleeding (EBL > 1500mL OR > 2 RBCs given OR at risk for occult bleeding/ coagulopathy OR any patient with abnormal vital signs/labs/oliguria)

INITIAL STEPS:

- ☐ Mobilize additional help
- ☐ Move to OR
- ☐ Announce clinical status (vital signs, cumulative blood loss, etiology)
- ☐ Outline and communicate plan

MEDICATIONS:

- ☐ Continue Stage 1 medications; consider TXA

BLOOD BANK:

- ☐ Initiate Massive Transfusion Protocol (If clinical coagulopathy: add cryoprecipitate, consult for additional agents)

ACTION:

- ☐ Achieve hemostasis, intervention based on etiology
- ☐ Escalate interventions

Oxytocin (Pitocin):
10-40 units per 500-1000mL solution

Methylergonovine (Methergine):
0.2 milligrams IM (may repeat);
Avoid with hypertension

15-methyl $PGF_2\alpha$ (Hemabate, Carboprost):
250 micrograms IM
(may repeat in q15 minutes, maximum 8 doses)
Avoid with asthma;
use with caution with hypertension

Misoprostol (Cytotec):
800-1000 micrograms PR
600 micrograms PO or 800 micrograms SL

Tranexamic Acid (TXA)
1 gram IV over 10 min (add 1 gram vial to 100mL NS & give over 10 min; may be repeated once after 30 min)

Possible interventions:
- Bakri balloon
- Compression suture/B-Lynch suture
- Uterine artery ligation
- Hysterectomy

STAGE 4: Cardiovascular Collapse (massive hemorrhage, profound hypovolemic shock, or amniotic fluid embolism)

INITIAL STEP:

- ☐ Mobilize additional resources

MEDICATIONS:

- ☐ ACLS

BLOOD BANK:

- ☐ Simultaneous aggressive massive transfusion

ACTION:

- ☐ Immediate surgical intervention to ensure hemostasis (hysterectomy)

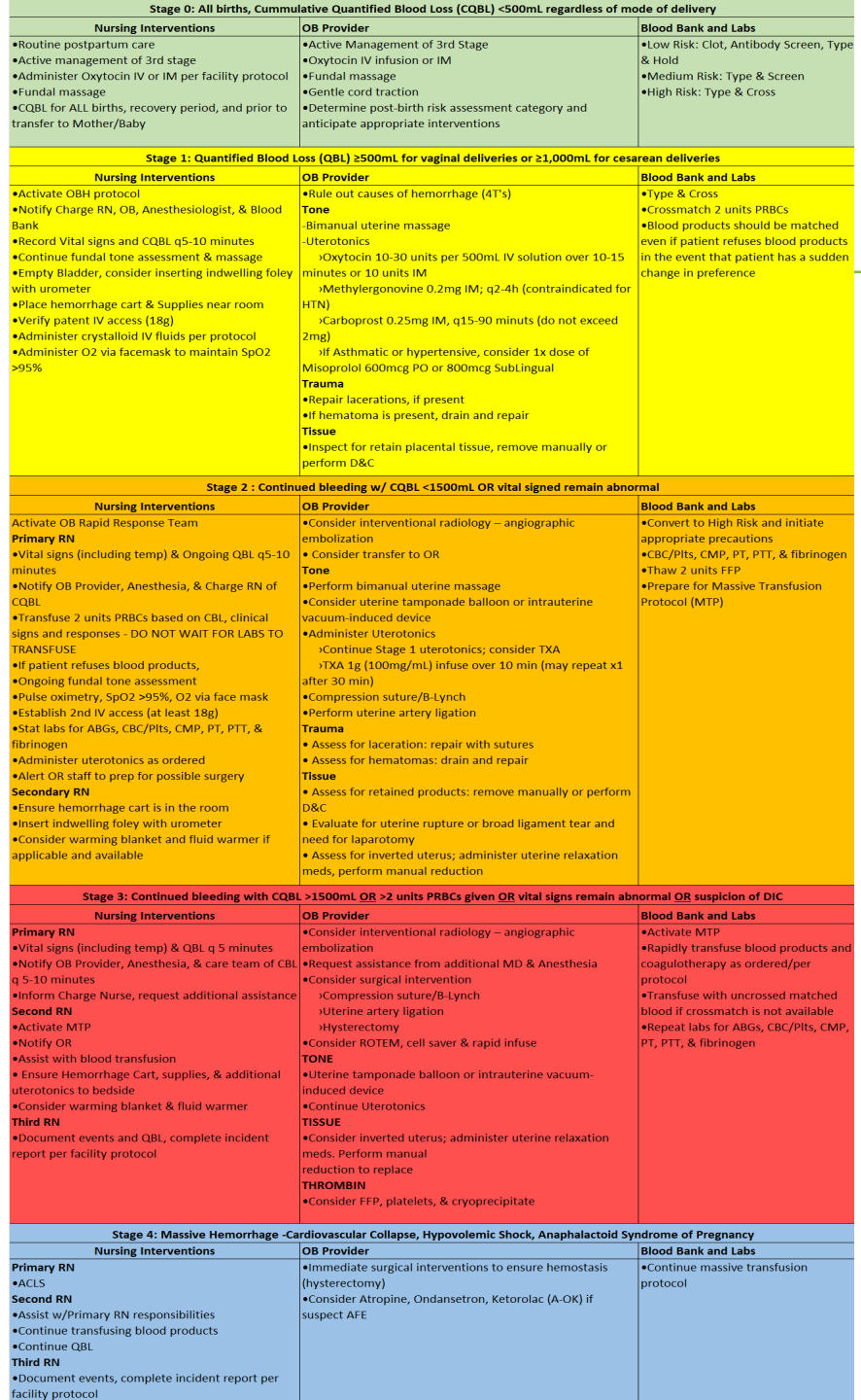
Post-Hemorrhage Management
- Determine disposition of patient
- Debrief with the whole obstetric care team
- Debrief with patient and family
- Document

Revised September 2020

Safe Motherhood Initiative

ACOG The American College of Obstetricians and Gynecologists District II

Obstetric Hemorrhage Stages Algorithm



Stage 0: All births, Cummulative Quantified Blood Loss (CQBL) <500mL regardless of mode of delivery

Nursing Interventions	OB Provider	Blood Bank and Labs
•Routine postpartum care •Active management of 3rd stage •Administer Oxytocin IV or IM per facility protocol •Fundal massage •CQBL for ALL births, recovery period, and prior to transfer to Mother/Baby	•Active Management of 3rd Stage •Oxytocin IV infusion or IM •Fundal massage •Gentle cord traction •Determine post-birth risk assessment category and anticipate appropriate interventions	•Low Risk: Clot, Antibody Screen, Type & Hold •Medium Risk: Type & Screen •High Risk: Type & Cross

Stage 1: Quantified Blood Loss (QBL) ≥500mL for vaginal deliveries or ≥1,000mL for cesarean deliveries

Nursing Interventions	OB Provider	Blood Bank and Labs
•Activate OBH protocol •Notify Charge RN, OB, Anesthesiologist, & Blood Bank •Record Vital signs and CQBL q5-10 minutes •Continue fundal tone assessment & massage •Empty Bladder, consider inserting indwelling foley with urometer •Place hemorrhage cart & Supplies near room •Verify patent IV access (18g) •Administer crystalloid IV fluids per protocol •Administer O2 via facemask to maintain SpO2 >95%	•Rule out causes of hemorrhage (4T's) **Tone** -Bimanual uterine massage -Uterotonics ›Oxytocin 10-30 units per 500mL IV solution over 10-15 minutes or 10 units IM ›Methylergonovine 0.2mg IM; q2-4h (contraindicated for HTN) ›Carboprost 0.25mg IM, q15-90 minuts (do not exceed 2mg) ›If Asthmatic or hypertensive, consider 1x dose of Misoprolol 600mcg PO or 800mcg SubLingual **Trauma** •Repair lacerations, if present •If hematoma is present, drain and repair **Tissue** •Inspect for retain placental tissue, remove manually or perform D&C	•Type & Cross •Crossmatch 2 units PRBCs •Blood products should be matched even if patient refuses blood products in the event that patient has a sudden change in preference

Stage 2 : Continued bleeding w/ CQBL <1500mL OR vital signed remain abnormal

Nursing Interventions	OB Provider	Blood Bank and Labs
Activate OB Rapid Response Team **Primary RN** •Vital signs (including temp) & Ongoing QBL q5-10 minutes •Notify OB Provider, Anesthesia, & Charge RN of CQBL •Transfuse 2 units PRBCs based on CBL, clinical signs and responses - DO NOT WAIT FOR LABS TO TRANSFUSE •If patient refuses blood products, •Ongoing fundal tone assessment •Pulse oximetry, SpO2 >95%, O2 via face mask •Establish 2nd IV access (at least 18g) •Stat labs for ABGs, CBC/Plts, CMP, PT, PTT, & fibrinogen •Administer uterotonics as ordered •Alert OR staff to prep for possible surgery **Secondary RN** •Ensure hemorrhage cart is in the room •Insert indwelling foley with urometer •Consider warming blanket and fluid warmer if applicable and available	•Consider interventional radiology – angiographic embolization • Consider transfer to OR **Tone** •Perform bimanual uterine massage •Consider uterine tamponade balloon or intrauterine vacuum-induced device •Administer Uterotonics ›Continue Stage 1 uterotonics; consider TXA ›TXA 1g (100mg/mL) infuse over 10 min (may repeat x1 after 30 min) •Compression suture/B-Lynch •Perform uterine artery ligation **Trauma** • Assess for laceration: repair with sutures • Assess for hematomas: drain and repair **Tissue** • Assess for retained products: remove manually or perform D&C • Evaluate for uterine rupture or broad ligament tear and need for laparotomy • Assess for inverted uterus; administer uterine relaxation meds, perform manual reduction	•Convert to High Risk and initiate appropriate precautions •CBC/Plts, CMP, PT, PTT, & fibrinogen •Thaw 2 units FFP •Prepare for Massive Transfusion Protocol (MTP)

Stage 3: Continued bleeding with CQBL >1500mL OR >2 units PRBCs given OR vital signs remain abnormal OR suspicion of DIC

Nursing Interventions	OB Provider	Blood Bank and Labs
Primary RN •Vital signs (including temp) & QBL q 5 minutes •Notify OB Provider, Anesthesia, & care team of CBL q 5-10 minutes •Inform Charge Nurse, request additional assistance **Second RN** •Activate MTP •Notify OR •Assist with blood transfusion • Ensure Hemorrhage Cart, supplies, & additional uterotonics to bedside •Consider warming blanket & fluid warmer **Third RN** •Document events and QBL, complete incident report per facility protocol	•Consider interventional radiology – angiographic embolization •Request assistance from additional MD & Anesthesia •Consider surgical intervention ›Compression suture/B-Lynch ›Uterine artery ligation ›Hysterectomy •Consider ROTEM, cell saver & rapid infuse **TONE** •Uterine tamponade balloon or intrauterine vacuum-induced device •Continue Uterotonics **TISSUE** •Consider inverted uterus; administer uterine relaxation meds. Perform manual reduction to replace **THROMBIN** •Consider FFP, platelets, & cryoprecipitate	•Activate MTP •Rapidly transfuse blood products and coagulotherapy as ordered/per protocol •Transfuse with uncrossed matched blood if crossmatch is not available •Repeat labs for ABGs, CBC/Plts, CMP, PT, PTT, & fibrinogen

Stage 4: Massive Hemorrhage -Cardiovascular Collapse, Hypovolemic Shock, Anaphalactoid Syndrome of Pregnancy

Nursing Interventions	OB Provider	Blood Bank and Labs
Primary RN •ACLS **Second RN** •Assist w/Primary RN responsibilities •Continue transfusing blood products •Continue QBL **Third RN** •Document events, complete incident report per facility protocol	•Immediate surgical interventions to ensure hemostasis (hysterectomy) •Consider Atropine, Ondansetron, Ketorolac (A-OK) if suspect AFE	•Continue massive transfusion protocol

- **Stage-based nursing interventions**
- **Based on CMQCC's PPH Algorithm**
- **Can be used as a tool to design a nurse-driven PPH protocol**

ACOG PPH Protocol Example

KEY DOCUMENTS

CLINICAL DOCUMENTS

- OBH Patient Debriefing Tool – Spanish
- OBH Patient Debriefing Tool
- AIM OBH Element Implementation Details
- ACOG OBH Risk Assessment Table
- ACOG Patients Who Decline Blood Products (Guidance Example)
- Checklist for Patients Who Decline Blood Products Example (CMQCC)
- Maternal Compensatory Diagram
- Medications for Postpartum Hemorrhage (CMQCC)
- Obstetric Hemorrhage Stages Algorithm (Example) *-updated 02/20/2024*
- Team Debreifing Form (Example)
- ACOG Hemorrhage Checklist/Protocol (Example)

QUALITY IMPROVEMENT TOOLS

OBH BOOTCAMP SERIES

DATA RESOURCES

OTHER RESOURCES

Obstetric Hemorrhage

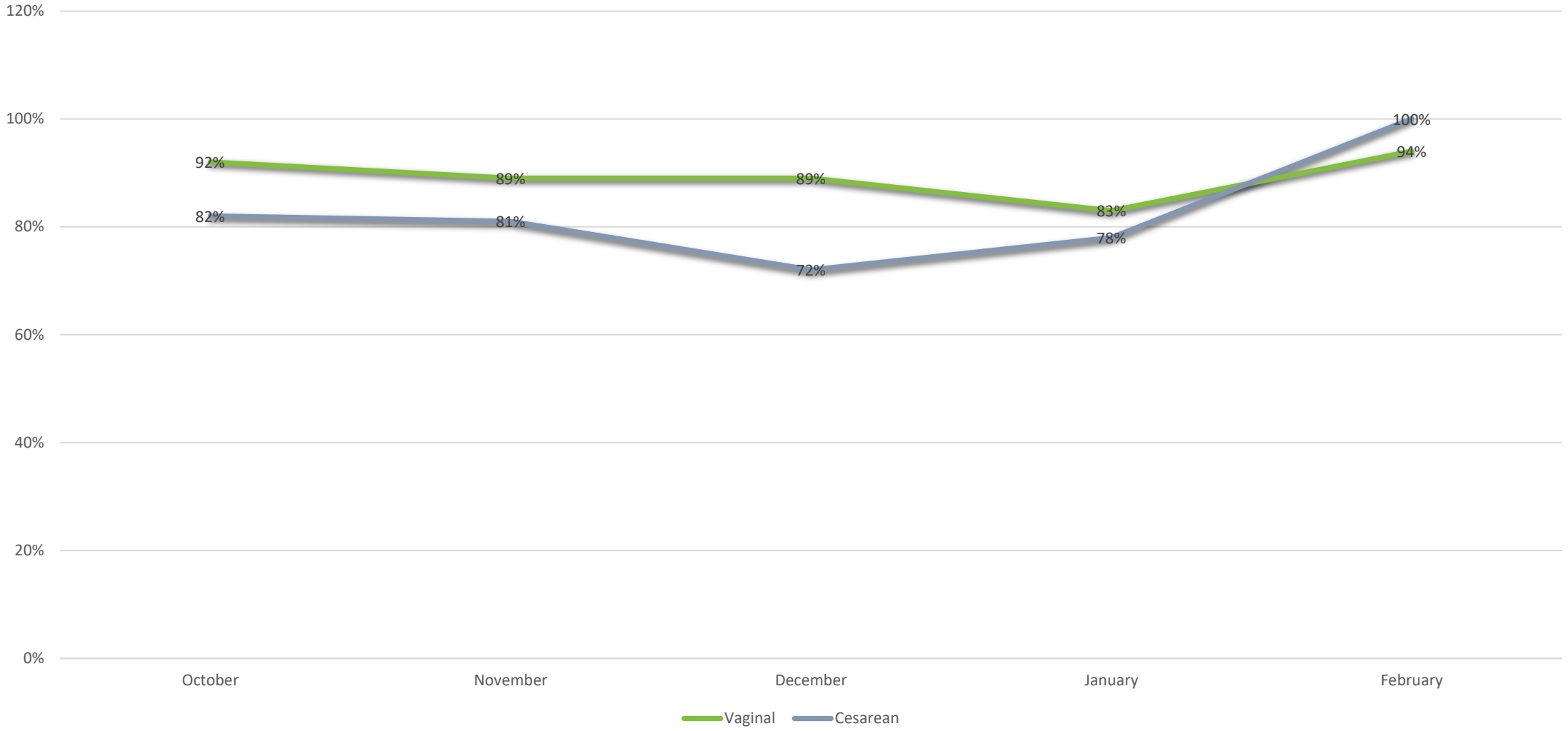
Process Measures

Process Measures

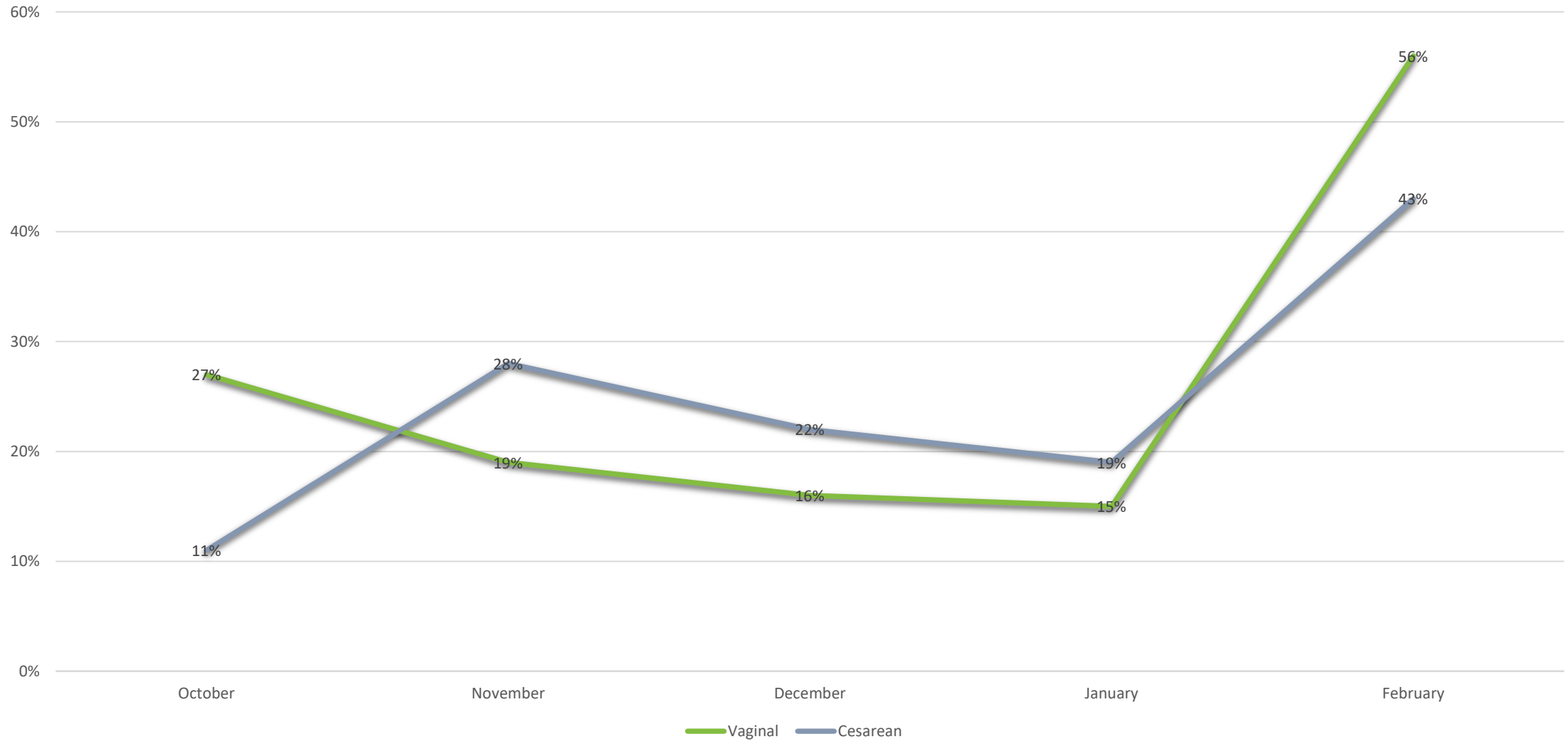
Measures	Vaginal - January	Vaginal - Baseline	Cesarean - January	Cesarean - Baseline
P1. Hemorrhage Risk Assessment	82.67%	90.16%	77.78%	78.42%
P2. Quantified Blood Loss	65.33%		72.22%	
P3. Patient Support After Obstetric Hemorrhage	14.67%	21.24%	18.52%	20.53%
P4. PPH Protocol	54.67%		61.11%	
P5. Transfusions	21.33%	30.57%	33.33%	45.79%
L&D	10.67%	15.54%	16.67%	20.53%
MBU	10.67%	14.51%	11.11%	18.95%
ICU	0%	0.52%	0%	2.63%
Other	0%	1.55%	5.56%%	6.32%

*Note: As of 3/20, 32 of the 35 hospitals have reported baseline data and 27 of the 35 hospitals have submitted data for January. Please enter data ASAP or email info@alpqc.org for assistance.

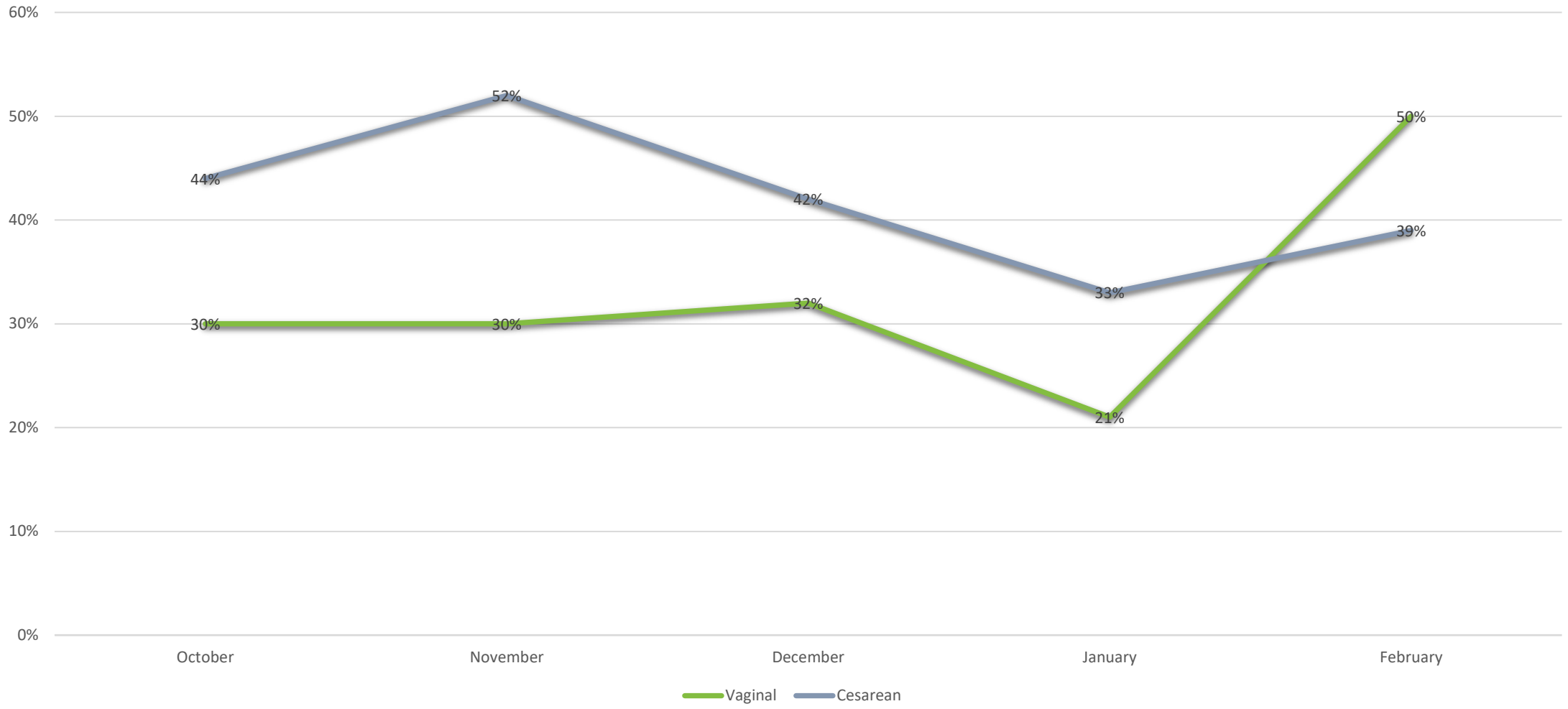
P1. Hemorrhage Risk Assessment



P3. Patient Support After OBH



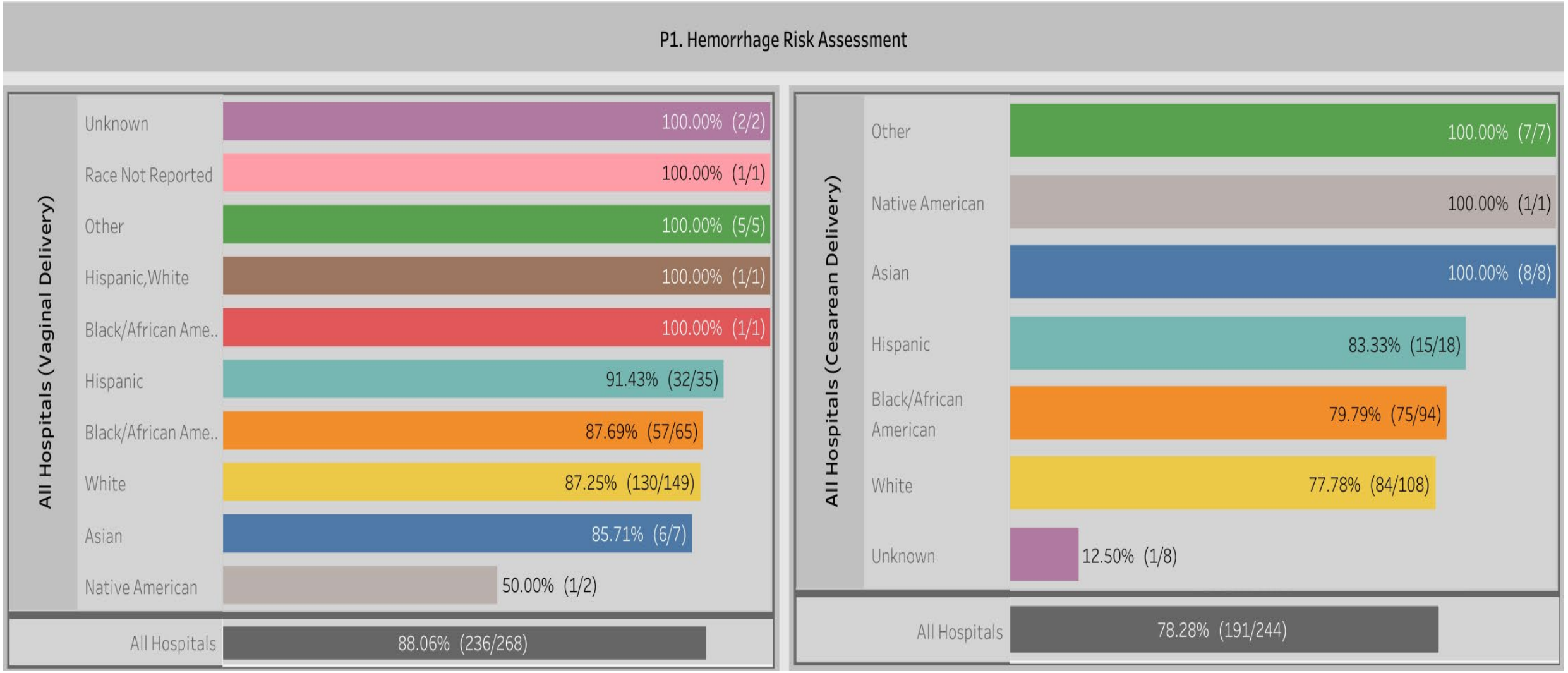
P5. Transfusions



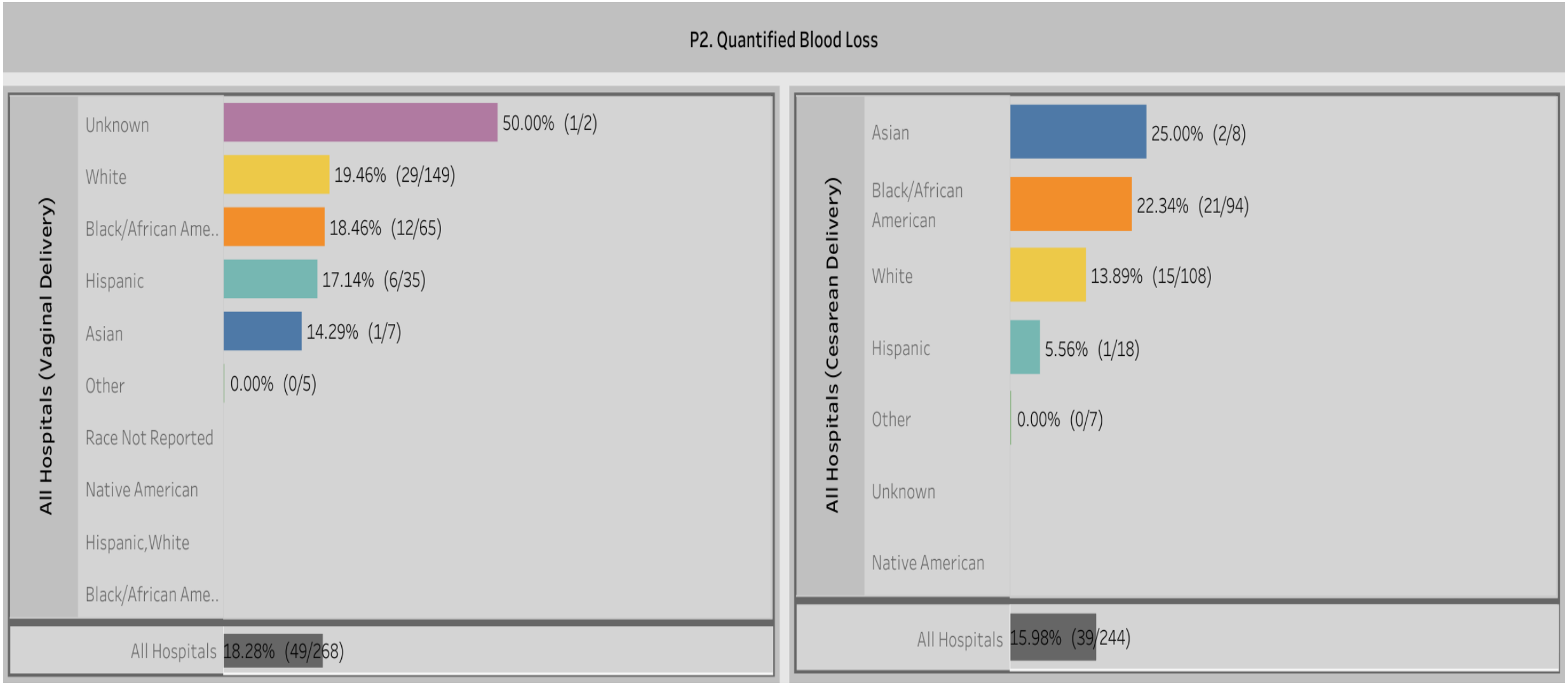
Obstetric Hemorrhage

Process Measures – Race/Ethnicity Data

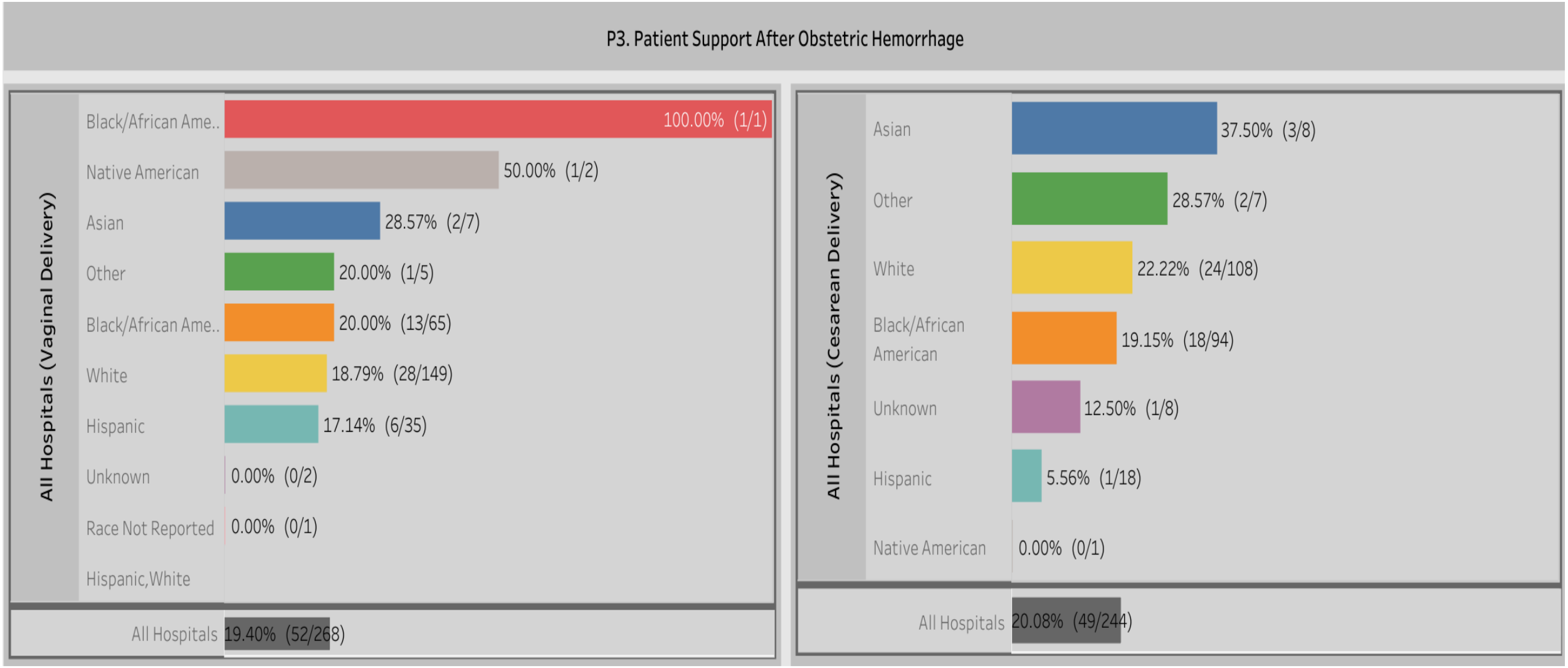
P1 – Hemorrhage Risk Assessment



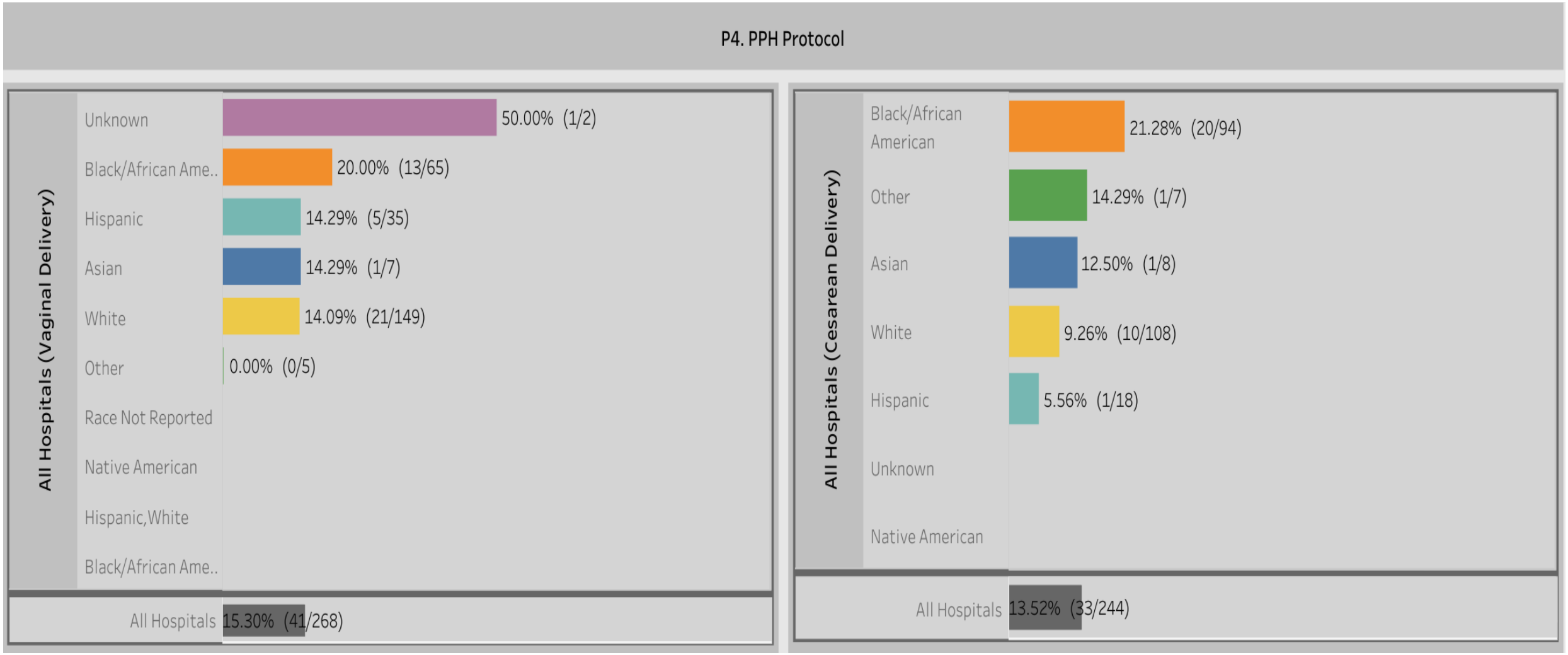
P2 – Quantified Blood Loss



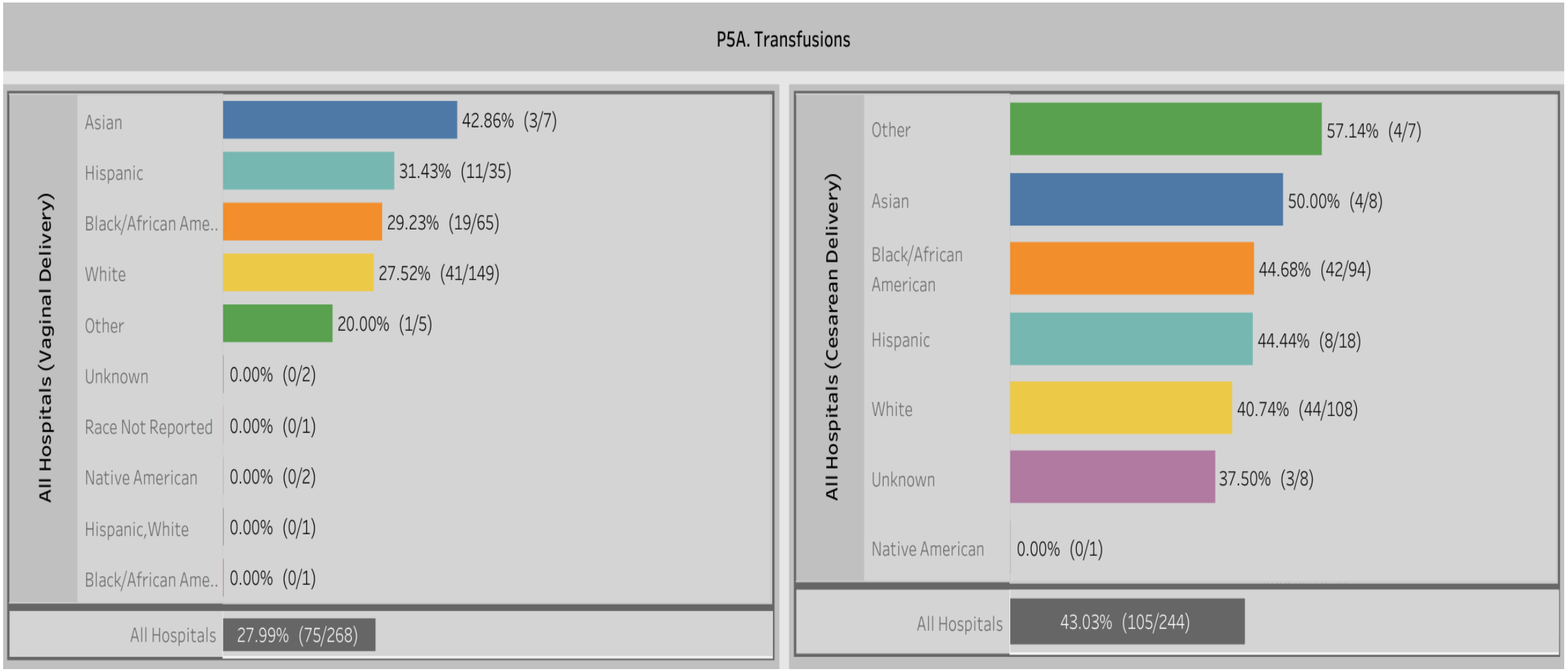
P3 – Patient Support/Debriefing



P4 – PPH Protocol



P5 - Transfusions



Obstetric Hemorrhage

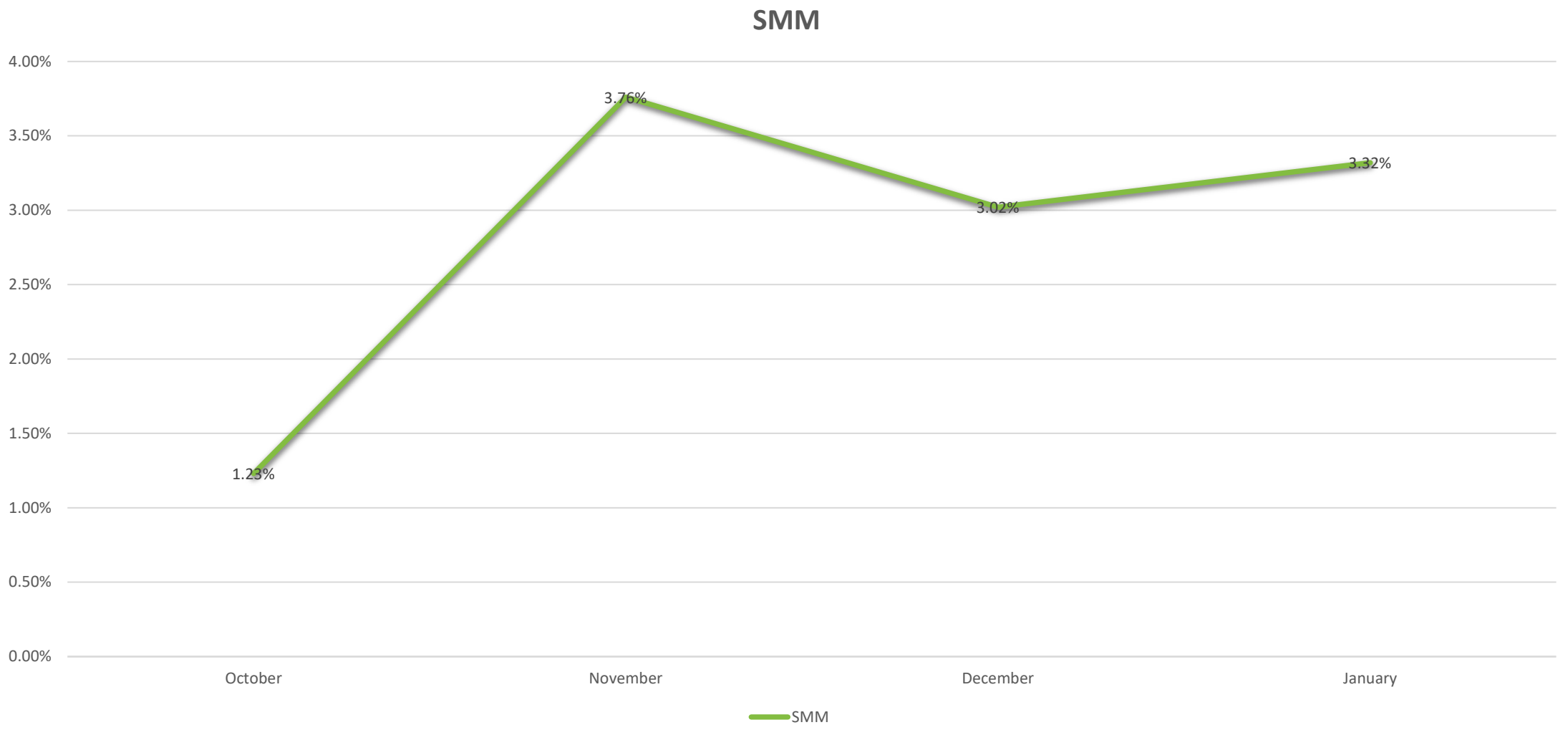
Outcome Measures

Outcome Measures

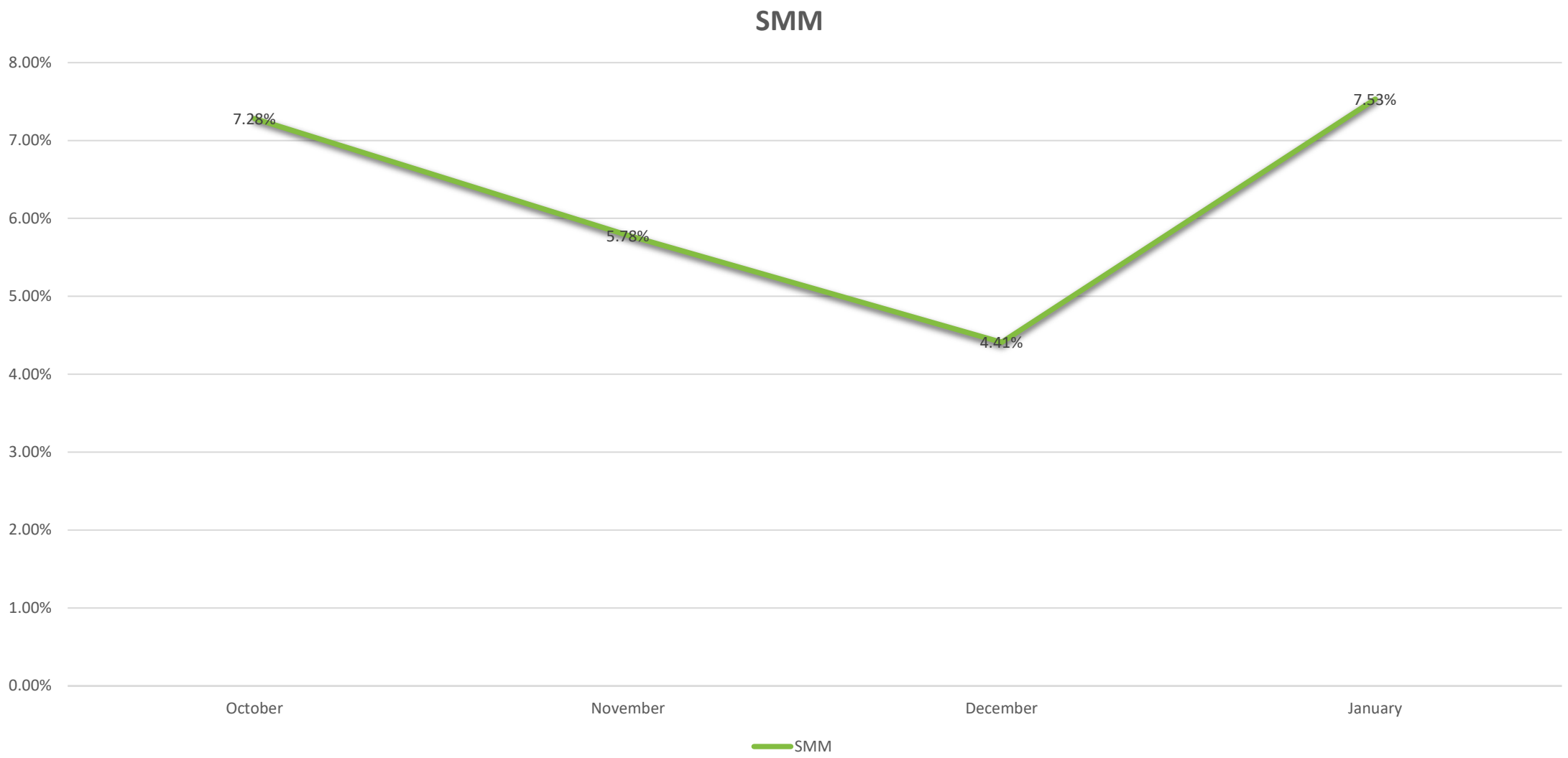
Measures	January 2024	Baseline (Oct-Dec 2023)
O1. Severe Maternal Morbidity	3.32%	2.67%
O2. SMM Among People Who Experienced OBH	7.53%	5.82%

*Note: As of 3/20, 32 of the 35 hospitals have reported baseline data and 27 of the 35 hospitals have submitted data for January. Please enter data ASAP or email info@alpqc.org for assistance.

SMM


SMM
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
3.76%
3.32%
3.02%
1.23%
October
November
December
January
SMM

SMM Among Patients With OBH



Q&A

Please feel free to **unmute** and ask questions

You may also enter comments or questions in the "chat" box

Reminders

-Next Obstetric Initiatives Action Period Call: Wednesday, 4/17 at 1 pm

-Monthly 1-on-1 QI Coaching Calls with the ALPQC Quality Improvement RNs are one of the benefits of participating in the collaborative. Please email info@alpqc.org if your facility has not yet scheduled your recurring meeting

Reminders

-OBH Monthly Reporting for February due March 31st, 2024

-Next HTN Sustainability Reporting Due April 30th for Jan-Mar 2024

-Please enter your data if you have not already

-Email Lora at lham17@uab.edu if you need to change any data after you have submitted the survey

Stay Connected!

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