**Historical Perspective**

**Safe Motherhood Initiative** *(voluntary review program, 2001 – 2009)*

The Safe Motherhood Initiative, a voluntary program to review reported cases of maternal death in hospitals throughout the state, conducted extensive multidisciplinary, on-site reviews from 2001 through 2009. The data gathered from these reviews assisted hospitals in making protocol changes to improve patient safety and raise awareness of risk factors that can contribute to serious morbidity such as obesity, severe hypertension, long-standing diabetes, and pre-existing cardiac conditions. SMI review teams found that timely recognition and intervention in such situations could have prevented many of the deaths reviewed and as a result, the SMI made a commitment to the thorough assessment of chronic medical conditions in the preconception period and during pregnancy, developing and providing much needed clinical education across the state.

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In 2002, the New York State Department of Health, in conjunction with the Centers for Disease Control and Prevention, the Medical Society of the State of New York (MSSNY), and ACOG District II concluded a three-year retrospective maternal mortality study. This study offered numerous recommendations to improve maternity care. ACOG’s SMI would help implement the 2002 recommendations as well as address the underreporting of maternal deaths; maternal mortality health disparities; and a required effort to reduce and prevent pregnancy-related deaths. The 2002 study recommendations included:

- Strengthening regionalization of maternity care;
- Reducing the number of high-risk pregnancies;
- Maximizing ascertainment of maternal deaths;
- Continuing in-depth case reviews of incidents of maternal death;
- Educating community hospital staff on the maternal death review process; and,
- Educating emergency room staff on obstetrical emergencies.
In response to findings identified through the review process, at the conclusion of the SMI in 2009 and within its 2007-09 Triennial Report, ACOG District II and the SMI Committee developed a list of five critical recommendations whose aim was to standardize the reporting and review system in cases of maternal death, and to generate changes in areas of care that were in need of improvement. They were as follows:

1. Establish a statewide, standardized, mandatory reporting and review system for pregnancy-related deaths that occur in a hospital setting or birthing center. This reporting and rapid review by a team of experts must be accomplished using a consistent tool and approach in all cases.

2. Require that all obstetrical units have in place a post-anesthesia care unit (PACU) protocol, consistent with other surgical recovery units.

3. Educate all obstetric and emergency department hospital staff about the early recognition and treatment of severe hypertension during pregnancy and the peripartum period.

4. Promote the practice of multidisciplinary care in patients with co-existing morbidities.

5. Educate all obstetrical staff about the early recognition of critical care situations – shock from sepsis, hemorrhage, thromboembolic phenomena – with knowledge of rapid response approaches to such, and prompt treatment of symptoms.


In June 2010, the New York Academy of Medicine convened a full-day conference of women’s health leaders and organizations to make recommendations and develop “priority action steps” leading to policies that would alleviate and inevitably decrease New York State’s maternal death rate. The result of this conference was a paper entitled, “Maternal Mortality in New York: A Call to Action,” which presented crosscutting findings from this conference, as well as the priority areas for action that emerged from the working sessions and from follow-up discussions with key decision makers in New York State and New York City.

**Optimizing Protocols in Obstetrics (2011-2013)**

In January 2011, the ACOG District II Patient Safety and Quality Improvement (PSQI) Committee mailed a letter to New York State hospital obstetric department chairs requesting a copy of their protocols and/or checklists on:

- Obstetrical Hemorrhage
- Severe Hypertension in Pregnancy
- Management of Shoulder Dystocia
- Use of Oxytocin for Labor Induction

Over 90 protocols were submitted from hospitals across the state. The PSQI Committee divided into four subgroups to review and analyze each protocol using a scoring system.

Rather than create one sample protocol, The Committee’s goal was to identify existing protocols that hospitals across the state could adapt to meet their specific needs and resources. Most of the submitted protocols lacked a systematic approach required to ensure an effective guideline or protocol. However, the Committee was able to identify key elements and model protocol language from the submitted protocols which was featured in the Optimizing Protocols in Obstetrics series.
The Optimizing Protocols in Obstetrics series stresses the importance of obstetrician-gynecologists taking the lead in designing and collaboratively implementing standardized protocols and checklists in their hospitals and office settings. Obstetric departments were strongly encouraged to utilize this resource and work with their medical team to review existing policies and procedures and modify them if necessary to fit the needs of their hospital environment.

The outcome of this project was a multi-chapter volume that is accessible on the ACOG District II website and offers educational tools and resources including model hospital protocols, assessment tools, suggested checklists, posters, and relevant national specialty guidelines and practice bulletins.

**Merck for Mothers (2011 – present)**

Merck for Mothers is a 10-year, $500 million initiative focused on creating a world where no woman dies during pregnancy. This initiative is committed to using Merck’s business and scientific expertise to improve maternal health and is already working in more than 30 countries around the world, including the US. Sponsored US programs, in addition to the SMI, include:

- AMCHP (Every Mother Initiative, state maternal mortality review programs across the US)
- AWHONN (New Jersey, Georgia, and Washington, DC)
- CMQCC (California)
- Enhancing community initiatives that coordinate care for high-risk women before, during and after childbirth, so they have access to services that encourage good health during and beyond pregnancy

In December 2011, Merck for Mothers made a commitment to ACOG District II to invest resources to standardize care practices for the leading causes of maternal mortality in New York State. In doing so not only has Merck for Mothers been able to offer financial assistance, but a wide array of global resources as well, from assistance in quantitative measurement of the SMI’s data from the London School of Tropical Medicine and Hygiene to sharing the depth and breadth of the SMI’s work with global partners in Agra, India.

**Putting the ‘M’ Back in Maternal-Fetal Medicine (2013)**

In the June 2013 issue of the *American Journal of Obstetrics and Gynecology*, Mary E. D’Alton, MD, Co-Chair of the SMI, and colleagues set forth in establishing responsibilities of maternal-fetal medicine (MFM) sub-specialists to lead a national effort to decrease maternal mortality and morbidity. In doing so, Dr. D’Alton, et al. hoped to re-establish the vital role of MFM sub-specialists to take the lead in the performance and coordination of care in complicated obstetrical cases. The groundbreaking article, “Putting the ‘M’ Back in Maternal-Fetal Medicine,” summarized initial recommendations to enhance MFM education and training, established national standards to improve maternal care and management, and addressed critical research gaps in maternal medicine.

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This program is supported by funding from Merck, through Merck for Mothers, the company’s 10-year, $500 million initiative to help create a world where no woman dies giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.