IMPLEMENTATION OVERVIEW

Engage Three Person Core Team
The SMI aims to empower obstetric teams across New York State to share, assess, and implement strategies to reduce the incidence of obstetric hemorrhage, venous thromboembolism, and severe hypertension in pregnancy. An appropriate and effective core team is a key component of successful improvement efforts.

Select a three person core team (see enclosed) that can most effectively work together and serve as champions of the SMI project. Please complete part one of the enclosed SMI hospital engagement form. The activities described herein and directed by the core obstetric team will enhance maternal safety and improve the quality of obstetric care.

Maternal Safety Bundles
Three maternal safety bundles also known as management plans have been developed and evaluated by obstetric experts and key stakeholders from throughout the United States. These management plans were developed through evidence-based safety practices proven to improve maternal outcomes and consist of a variety of tools, including but not limited to key elements, protocols, checklists, algorithms, and laminated hands-on materials for adverse events support. The adoption of standardized clinical management plans to optimize prevention and management of obstetric complications will help reduce the incidence of maternal mortality and morbidity. As the primary focus for the initiative, hospitals will implement the maternal safety bundles and the associated data measures.

In June, the three bundles will be offered to all birthing facilities for implementation. Through bundle implementation, each hospital will have an unprecedented opportunity to:

- Review and amend existing clinical practices to reflect current evidence-based management guidelines in a non-punitive setting.
- Improve obstetric providers’ abilities to identify women at greatest risk for obstetric hemorrhage, severe hypertension and venous thromboembolism, which are among the leading causes of maternal morbidity and mortality.
- Improve recognition of maternal early warning signs.
- Increase readiness of the clinical teams to respond successfully to these obstetric emergencies.
- Internally track responses to these emergencies.

Data Collection
Over the next year, as part of the improvement initiative, teams will collect process and outcome data measures that reflect the changes to track performance and results. SMI core teams will be asked to begin data collection via a user-friendly Excel spreadsheet on SMI quality measures using a private, encrypted web portal. De-identified data results will be reported back to each hospital allowing obstetric departments the opportunity to identify any gaps and implement improvement strategies to reduce maternal mortality and its associated co-morbidities.
PROJECT OVERVIEW

What is the Safe Motherhood Initiative (SMI)?

- The Safe Motherhood Initiative (SMI) is a multi-year, multi-stakeholder project comprised of nurses, midwives, physicians, patient safety specialists, and other partners in New York State working together to standardize care in all obstetric hospitals to prevent obstetric emergencies associated with maternal mortality and morbidity.

- The SMI focuses on the three leading causes of maternal death – obstetric hemorrhage, severe hypertension in pregnancy, and venous thromboembolism.

- The SMI has been working with a team of clinical experts since January 2013 to develop, implement, and evaluate evidence-based practices that have resulted in the formation of maternal safety bundles for these 3 causes of death.

- These 3 bundles (obstetric hemorrhage, severe hypertension in pregnancy, and venous thromboembolism) consist of a variety of step-by-step, evidence-based tools to manage risk, prevent adverse events, respond, and debrief. Examples of tools include key elements, protocols, checklists, algorithms, laminated posters, etc.

- New York State is joining New Jersey, California, Florida, Georgia, and Washington, DC in implementation of parallel maternal safety projects.

- 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.

Why is there a focus on maternal mortality in New York State?

- In comparison to the rapid advances in fetal and neonatal medicine over the last few decades, progress in improving maternal obstetric outcomes has languished in the United States.

- Research funded by the Bill & Melinda Gates Foundation found that maternal mortality increased from 12 to 17 women per 100,000 live births between 1980 and 2008 in the US. African American women are particularly at risk of dying during childbirth.
• How does New York State fare? According to Amnesty International, New York State currently ranks 47th in the country for its abysmal maternal mortality rate.

• In 2009, the maternal mortality rate in New York State was 20.7 maternal deaths per 100,000 live births. This rate far exceeds the established Healthy People 2020 goal for the state of 12.7 maternal deaths per 100,000 live births.

• The leading causes of maternal death are hemorrhage, preeclampsia, and pulmonary embolism. These causes have remained unchanged for over a decade and are representative of national trends.

• New York State is but a microcosm of the country. However, despite some of the world’s leading medical and teaching centers located within our state borders, we are desperately lacking a strategy to assess and treat the most common causes of maternal death.

• In developing a systematic strategy to reduce maternal mortality, the challenges New York State faces are representative of the United States as a whole.

• For the leading causes of maternal death, there is an urgent need for specific, standardized perinatal safety protocols (management plans) including checklists to facilitate effective safety systems for inpatient obstetrics.

Why does your hospital need to be involved?

• Success in reducing maternal mortality is contingent upon understanding and evaluating sources of maternal morbidity and mortality which may differ in small, medium, and large academic and community obstetric centers.

• In other medical specialty areas, individual hospitals and health systems have demonstrated improvement in patient care by employing protocols to standardize clinical management. There is no doubt that the same can be accomplished in obstetrics.

• Although there are numerous, reasonable approaches to improving patient care, broad use of specific standardized guidelines may reduce medical errors, simplify clinical management, and decrease preventable maternal deaths of which, nearly half are preventable.

• The universal adoption of standardized clinical protocols to optimize the recognition, management, and prevention of the leading causes of maternal mortality can help reduce the incidence of mortality and morbidity. This is the cornerstone upon which the SMI project is built upon.

• There is no question that hospitals across New York State can improve communication, management, and leadership efforts to reduce maternal mortality. Your hospital can become a nationally-recognized leader and role model in obstetric quality improvement processes through participation in the SMI.
**What will the SMI offer you?**

The SMI will offer participating hospitals the following:

- A unique and unprecedented opportunity to review and amend existing clinical practices to reflect current evidence-based management guidelines in a non-punitive setting.

- Access to expert opinion leaders across the country.

- The ability to review and identify internal hospital systems and implement any changes that will help to reduce the risk of adverse events. You will be provided with the infrastructure and tools to collect quality data associated with maternal mortality and morbidity, and compensated for your efforts. In turn, you will be able to share the data across your obstetrics department to better assess where deficiencies may exist and, over time, reduce maternal mortality and morbidity.

- Tools to understand important nomenclature for obstetric hemorrhage, severe hypertension in pregnancy, and venous thromboembolism.

- Education that promotes teamwork and communication by standardizing core clinical knowledge for the multidisciplinary obstetric team.

- A public relations campaign for your hospital, giving you the ability to not only showcase your hospital as a community and statewide leader in obstetric care, but also as an initial stakeholder in a much larger nationwide effort to decrease maternal mortality and morbidity.

- A private, encrypted web portal for your team to input quality data measures.

**What does hospital participation entail?**

- All obstetric hospitals in New York State will be asked to review and amend existing clinical practices to reflect current evidence-based management guidelines in a non-punitive setting; improve obstetric providers’ abilities to identify women at greatest risk for obstetric hemorrhage, severe hypertension and venous thromboembolism, which are among the leading causes of maternal morbidity and mortality; improve recognition of maternal early warning signs; increase readiness of the clinical teams to respond successfully to these obstetric emergencies, and internally track responses to these emergencies.

- Hospitals will be paid to offset their costs associated with the collection of minimal data. Data is returned to each hospital and is only used to assess whether guideline concordant care improves maternal mortality and morbidity outcomes.

- Participate in regional teaching days, webinars, and conference calls to share implementation stories with peers across the state, including successes and challenges.
What is the timeframe for the Safe Motherhood Initiative’s activities?

Winter 2013 – Spring 2014

ACOG District II will:

- Finalize 3 maternal safety bundles and resource tools.
- Offer hospitals their own departmental data on a culture assessment survey completed and de-identified by each provider specialty.
- Promote hospital participation and provider engagement in SMI activities.
- Conduct informational conference calls for hospitals to learn more about the SMI.

Summer 2014 - Summer 2015

ACOG District II will:

- Roll out 3 maternal safety bundles to all obstetric hospitals on or about June 1, 2014.
- Visit participating hospitals as requested, to assist with on-site implementation.
- Offer special programming to hospitals on bundle implementation.
- Provide staff support on an as-needed basis, to help answer questions about the initiative, including data collection.
- Begin data collection on quality measures using a private, encrypted web portal. Return data to each hospital.
- Offer all obstetric hospitals a targeted, paid-for, public relations campaign and other marketing opportunities to promote the hospital before maternity patients in regional catchment areas.
- Engage in informal monthly conference calls with ACOG physicians and experts to review bundles.
- Assist hospitals as needed, with amendment to their existing protocols and add and encourage the use of checklists and algorithms.
- Promote teamwork and communication by standardizing core clinical knowledge for the entire obstetric team.