TexasAIM

Safe Care for Every Mother

TexasAIM Plus Obstetric Hemorrhage Learning Collaborative (OBH+) Information Packet

TEXAS Health and Human Services

Texas Department of State Health Services

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Contents

TexasAIM Plus Obstetric Hemorrhage Collaborative Background and Overview

Problem

The U.S. rate of maternal mortality has doubled over the last decade. Texas' maternal mortality rate is higher than the Healthy People 2020 goal of 11.4. African American women have a rate of maternal mortality that is more than twice 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, and overdose, mostly involving opioids, is the leading cause of pregnancy-related death. *We need your help in reversing these trends!*

Solution

Your hospital has committed to join TexasAIM, a statewide effort among Texas birthing hospitals to reduce maternal mortality and severe maternal morbidity.

- The overarching goal of TexasAIM is that all Texas birthing hospitals will implement AIM (Alliance for Innovation in Maternal Care) safety bundles related to *obstetric hemorrhage, opioid use disorder* and *severe hypertension in pregnancy* to ensure safe and standardized care for women with these conditions.
- TexasAIM hospitals will work through Winter 2020 to implement and ensure sustainability of the Obstetric Hemorrhage (+AIM) bundle (**Appendix 1. Obstetric Hemorrhage +AIM Council on Patient Safety in Women's Health Care Maternal Safety Bundle**).
- TexasAIM will stagger implementation of the *Obstetric Care of Women with Opioid Use* (+AIM) bundle and the *Severe Hypertension in Pregnancy* (+AIM) bundle, with recruitment for the Opioid Use bundle estimated to begin in Summer 2019.
- 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.
- The TexasAIM Plus Learning Collaborative provides additional resources and support for implementation of all bundle components, including in-person and virtual venues for shared learning with other nearby hospitals and hospitals across the state; individualized coaching, technical assistance, and targeted support; peer-to-peer mentoring opportunities; and opportunities for onsite technical assistance visits.
- TexasAIM aligns with state and national efforts with shared goals.
- The Texas Department of State Health Services (DSHS) is partnering with Texas Hospital Association (THA) and other key organizations to lead this effort.

Target Audience

The target audience includes all Texas hospitals with a maternity care line of service that voluntarily commit to improve maternal health outcomes while engaging in a growing community of hospitals, peers, and local, state, and national partners dedicated to continuously improve maternal safety and healthcare quality[1].

Obstetric Hemorrhage Learning Collaborative Purpose & Aim

The purpose of the TexasAIM Plus Obstetric Hemorrhage (OBH+) Learning Collaborative is to increase maternal health and safety throughout Texas by creating environments that exemplify the following values.:

- **Readiness:** Every unit is ready to respond to an obstetric hemorrhage.
- **Recognition & Prevention:** Every patient is assessed and patient care is managed so that hemorrhage risk is recognized and, when possible, hemorrhage is prevented.
- **Response:** Every hemorrhage is responded to in a standardized, stage-based approach and support is provided for patients, families, and staff for each significant hemorrhage.
- **Reporting/Systems Learning:** Every unit exemplifies a culture of safety, with processes in place to support continuous multidisciplinary learning and improvement.

The Collaborative Aims of the OBH+ Learning Collaborative

are:

1. All Collaborative participants develop and implement a multidisciplinary team response to every massive hemorrhage by January 1, 2020.
2. The proportion of severe maternal morbidity among hemorrhage patients in participating hospitals is reduced by 25% by January 1, 2020.

This is achieved by supporting hospital implementation the Alliance for Innovation on Maternal Health (AIM)-supported Obstetric Hemorrhage +AIM Maternal Safety Bundle (**Appendix 1. Obstetric Hemorrhage +AIM Council on Patient Safety in Women's Health Care Maternal Safety Bundle**) from the Council on Patient Safety in Women's Health Care.

[1] The Agency for Healthcare Research and Quality recognizes that health care quality has six domains, as first laid forth in the Institute of Medicine's *Crossing the Quality Chasm,* and builds upon the Institute of Healthcare Improvement's "Triple Aim" for improving health care quality. The six domains of health care quality are safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The three aims are Better Care; Healthy People/Healthy Communities; and Affordable Care.

Specifically, ≥145 hospitals (**Attachment 1**) across Texas will be engaged over an 18- to 20-month period (**Attachment 2**) in a Breakthrough Series (BTS) Learning Collaborative to increase the number of hospitals that fully integrate and sustain implementation of the Obstetric Hemorrhage +AIM Bundle (**Appendix 1. Obstetric Hemorrhage +AIM Council on Patient Safety in Women's Health Care Maternal Safety Bundle**). The OBH+ Learning Collaborative will focus on engaging hospitals in commitment to

- Foster a safety culture including organizational learning, continuous improvement, and person-/family-centered care;
- Increase teamwork and communication;
- Establish standardized, multidisciplinary systems for rapid recognition and response;
- Reduce disparities in maternal morbidity;
- Engage with patients and families as well as community partners to promote maternal health and safety; and
- "Share seamlessly and steal shamelessly": Participate fully in the learning collaborative with a commitment toward both contributing to, and benefiting from, the OBH+ Learning Collaborative's collective knowledge, expertise, resources, and enthusiasm.

OBH+ Learning Collaborative Benefits

Through active participation and engagement in the TexasAIM Plus Obstetric Hemorrhage Learning Collaborative, hospitals, it is anticipated that hospitals will

- Improve the safety of maternal and perinatal care in each unit;
- Improve readiness, recognition, response, reporting and review of obstetric hemorrhage;
- Be part of a statewide learning collaborative to improve maternal and infant outcomes;
- Learn about patient safety bundles for the management of women with obstetric hemorrhage from content and quality improvement experts;
- ♦ Access patient safety bundles, tools and resources proven to reduce maternal morbidity;
- Connect with and expand the statewide network for improvement work among peers with like challenges;
- Receive support from the collaborative faculty and coordinators; and
- Champion a culture of maternal safety in Texas and receive recognition for participation.

The most common complications associated with childbirth involve failures in recognition and response from the health care team.

TexasAIM Plus OBH+ Learning Collaborative Methods

The Breakthrough Series (BTS)

The OBH+ Learning Collaborative will use the fundamental design of the Institute for Healthcare Improvement's Breakthrough Series™ (BTS) Collaborative Model for Breakthrough Improvement as the foundation for the program[2]. A BTS Collaborative is a vehicle for identifying, testing, and spreading changes that are effective for improving care and outcomes for defined populations. **Figure 1. Structure of the BTS Collaborative** outlines the general structure of a BTS Collaborative.

Preparation for a BTS Collaborative begins with the following:

1. Selecting and refining a topic such as obstetric hemorrhage;*
2. Holding a meeting of leading experts with experience in both the clinical science and best practices to develop the framework and changes; *
3. Framing a mission and specific set of aims that teams will work toward achieving over the course of the collaborative; and
4. Recruiting and enrolling improvement teams.

*Note that TexasAIM leverages national data-driven, practice tested Maternal Safety Bundles. These bundles were developed through expert consensus, field-tested and refined, and reviewed, endorsed, and adopted by the Council on Patient Safety in Women's Health Care. The bundles are supported by national partner organizations that comprise the Alliance for Innovation on Maternal Health. The Obstetric Hemorrhage Maternal Safety Bundle provides the framework and changes that will be implemented through the TexasAIM OBH+ Learning Collaborative.

According to the Institute for Health Care Improvement (IHI)[3], a bundle is "[a] small set of evidence-based interventions for a defined patient segment/ population and care setting that, when implemented together, will result in significantly better outcomes than when implemented individually." Said another way, a bundle is a structured way of improving habits and processes of care so that, when a practice-proven small, straightforward set of evidence-based practices are performed collectively and reliably, patient outcomes are improved. All components of a bundle must be fully implemented to realize the desired improvement.

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[2] Langley GJ, Moen R, Nolan KM, Nolan TW, Norman CL. *The improvement guide: A practical approach to enhancing organizational performance.* Jossey-Bass; 2009*; The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*: IHI Innovation Series white paper. Cambridge, MA. Institute for Health Care Improvement. 2003. (Available on IHI.org).

[3] Resar R, Griffin FA, Haraden C, Nolan TW. *Using Care Bundles to Improve Health Care Quality.* IHI Innovation Series white paper. Cambridge, MA. Institute for Health Care Improvement; 2012. (Available on www.IHI.org).

The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help reduce variation and facilitate the standardization process to improve outcomes and quality of care.

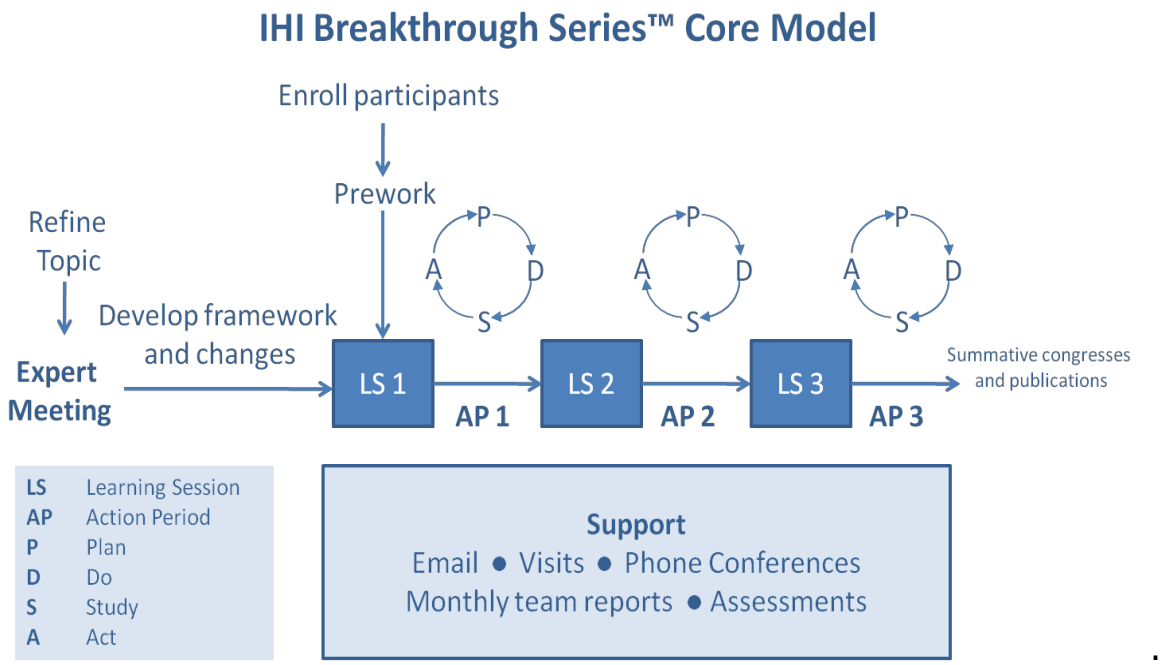


Figure 1. Structure of the BTS Collaborative

TexasAIM also leverages measurement strategies and key learning from obstetric hemorrhage projects in other AIM States, including California, Florida, Oklahoma, North Carolina, and others. DSHS and THA will continue to connect with National AIM, AIM states and other state and national partners to bring relevant experiences and expertise to the TexasAIM effort.

The BTS Model in Action

Between June 2018 and February 2020, TexasAIM Plus, as administered by DSHS in partnership with THA, will engage enrolled Texas TexasAIM Plus hospitals in a BTS Learning Collaborative to improve readiness, recognition & prevention, response, and reporting/systems learning for obstetric hemorrhage. TexasAIM Plus will conduct a learning collaborative with at least five concurrent regional cohorts, each with between 20-40 hospital teams.

To accomplish successful spread of system improvements throughout Texas hospitals, a regional model will be used with a focus on supporting leadership and developing sustainable regional mentorship. Regional cohorts provide an opportunity to enable participating organizations to link to other

regional infrastructures more easily than through single state activities. Cross-region sharing within the collaborative will be facilitated to maximize spread of innovation and learning.

Teams from each hospital will prepare for the TexasAIM OBH+ Learning Collaborative by

1) ensuring that they have local leaders who can enable the work;
2) identifying their hospital's improvement team; and
3) assessing their baseline practice performance based on measures identified in the Measurement Strategy (**Appendix 2: Measurement Strategy**).

The heart of the BTS model is a series of face-to-face collaborative Learning Sessions and virtual Action Periods as illustrated in the previous diagram.

Pre-work

Pre-work is the period of time between a hospital's commitment to participate and the Collaborative's first in-person LS. During this time, the TexasAIM team, project champions, and hospital improvement teams will work to develop and strengthen the needed structures for collaborative improvement.

Learning Sessions (LSs)

LSs are in-person meetings that bring together the multi-disciplinary improvement teams from each participating hospital and expert faculty to exchange ideas about the topic and specific changes outlined in the bundle as well as the Model for Improvement. The LSs will include team time for each hospital's team to work together to integrate learning and plan for how to immediately incorporate learning into their improvement processes.

There will be three LSs conducted in each cohort region during the OBH+ Learning Collaborative. The LSs will be conducted at a regional cohort level to facilitate team-to-team networking and sharing. Teams will progressively learn more and more from each other and from teams in other cohorts in each LS through dynamic scheduled sessions and activities as well as through informal networking and dialogue.

Action Periods (APs)

APs are the time between LSs, when hospital improvement teams use the Model for Improvement (See **Figure 2.** Model for Improvement-Tests of Change) to implement small, rapid-cycle, Plan-Do-Study-Act tests of

change. The impact of those changes is then evaluated with measures including those in the Learning Collaborative's Measurement Strategy (**Appendix 2: Measurement Strategy**). Participating hospitals will submit both monthly and quarterly measure reports, and will be able to review their own progress and the progress of the entire collaborative through de-identified data reports. Improvement teams are supported during APs by conference calls, interactive web-based discussions, online sharing platforms, site visits, coaching, and mentoring to enable them to learn from state- and national experts as well as from other hospital improvement teams across Texas.

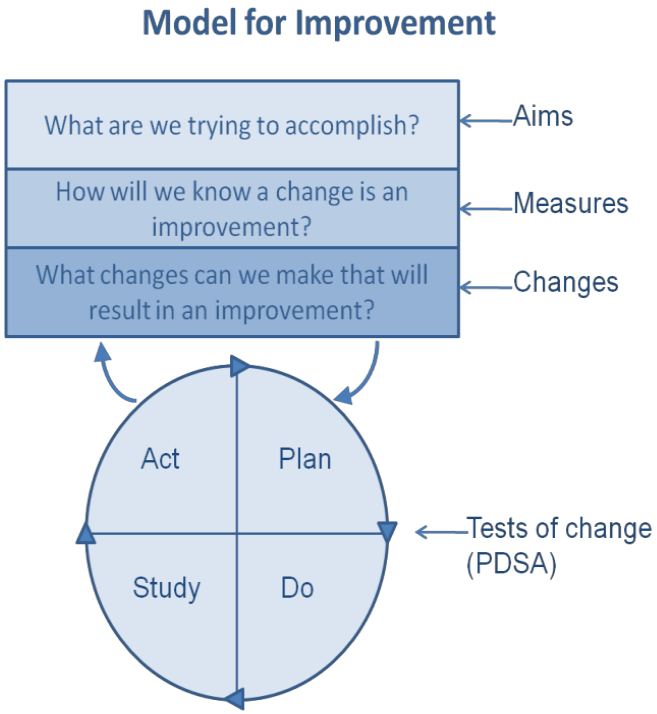


Figure 2. Model for Improvement-Tests of Change
© Associates for Process Improvement

This approach will be used to generate collaboration, spread of learning, and support to give hospital teams the momentum needed to use their locally-relevant methods and resources for improvement to

- Fully integrate the Obstetric Hemorrhage +AIM Bundle (**Appendix 1. Obstetric Hemorrhage +AIM Council on Patient Safety in Women's Health Care Maternal Safety Bundle**) components for a facility-specific standardized approach to reduce risk and improve outcomes for obstetric hemorrhage; and
- Sustain the structures and processes they have developed within their units to continuously improve upon their standardized approach to obstetric hemorrhage readiness, recognition & prevention, response, and reporting/systems learning.

Model for Improvement

To achieve the TexasAIM OBH+ Learning Collaborative goal, purpose and aim, hospital teams will learn to apply the Model for Improvement (MFI), a structured approach that teams use to drive improvement. MFI emphasizes the inclusion of:

- A well-focused and time-limited aim, and
- Process and outcome measures to track improvement and evaluate progress.

Ideas for effecting changes in the system are evaluated using the 'Plan-Do-Study-Act' (PDSA) cycle. PDSAs initially test changes on a very small scale in order to quickly identify promising ideas, and then incrementally scale up improvements based on rapid-cycle testing and learning to adapt and develop changes into robust and reliable standard processes. MFI stresses prediction and measurement as critical features of change evaluation, and includes an array of techniques to help guide the journey from change innovation to prototyping, to implementation and spread.

Key Drivers of Improvement

The key drivers of improvement to decrease severe maternal morbidity from obstetric hemorrhage include

1. Readiness for OB Hemorrhage (for Every Unit),
2. Recognition and Prevention of OB Hemorrhage (for Every Patient),
3. Standardized Response to OB Hemorrhage (for Every Hemorrhage), and
4. Reporting and Systems Learning from Every Hemorrhage (for Every Unit and Hospital).

A Driver Diagram for Obstetric Hemorrhage from the American College of Obstetricians and Gynecologists and Council on Patient Safety in Women's Health Care is available in **Appendix 3: Sample Driver Diagram Applied to Obstetric Hemorrhage Patient Safety Bundle**. The Obstetric Hemorrhage +AIM Bundle from the Council on Patient Safety in Women's Health Care constitutes the Change Package for the OBH+ Learning Collaborative. The Bundle, which outlines the key change concepts designed to reduce variation and achieve success, is included in **Appendix 1. Obstetric Hemorrhage +AIM Council on Patient Safety in Women's Health Care Maternal Safety Bundle**.

Measurement Strategy

Measurement is a critical component throughout the project that provides a means to evaluate the impact of strategies and interventions tested and adapted by the hospitals. National AIM and TexasAIM Plus have established core measurements for all participating teams to use in their sites. All participating facilities will be required to collect and report data as part of the improvement experience.

Structure Measures, Process Measures, Outcome Measures, and qualitative data will be used to assess progress toward the OBH+ Learning Collaborative and individual hospital goals. Measures are included in a Measurement Strategy detailed in **Appendix 2: Measurement Strategy**.

Monthly and Quarterly Measures and the data reporting platforms will be discussed in orientation sessions and reviewed in detail in break-out sessions at Learning Session meetings. Your team's designated data collector(s) must attend these sessions.

Learning Collaborative Expectations

Pre-work Activities for Hospital Teams

In order to maximize time and effectiveness of the in-person learning sessions, hospital Improvement Teams are required to complete the following activities prior to Learning Session 1 in Fall 2018. Pre-work assignments are outlined in **Attachment 4. Pre-work Packet**, Pre-work.

- Attend the Orientation Meeting at the June 4th in-person kick off Leadership and Orientation Summit or a make-up virtual orientation session
- Attend Welcome and Pre-work Call
- Form an improvement team
- Develop a hospital improvement team aim statement aligned with the overall Collaborative aim
- Complete a readiness self-assessment survey on your facility's progress toward implementing the Obstetric Hemorrhage +AIM Bundle
- Attend Quality Improvement Basics Webinar
- Register Three or More* Multi-Disciplinary Team Members for Learning Session 1 *(*exceptions may be made for small hospitals on a case-by-case basis)*
- Develop a Storyboard for Learning Session 1

Learning Sessions

Learning sessions are the **key project meetings during which all hospital teams come together in person for focused content and quality improvement learning and sharing**. At each learning session, improvement teams gather to learn about how to test and implement evidence-based care practices through improvement methodology, to share tips and ideas for improving care and to plan their next round of work, including interim goals for improvement.

The initial learning session (LS1) will highlight presentations from experts and hospitals with experience implementing the Obstetric Hemorrhage +AIM Bundle (**Appendix 1. Obstetric Hemorrhage +AIM Council on Patient Safety in Women's Health Care Maternal Safety Bundle**). As the collaborative proceeds, learning session speakers and workshop leaders will be drawn from improvement teams within the Collaborative who are making progress

in overcoming obstacles and achieving success.

Action Periods

In between learning sessions, facility teams will be expected to make significant changes within their organizations:

- to accomplish the overall project aim of decreasing morbidity associated with obstetric hemorrhage; and
- to increase OB hemorrhage Readiness, Recognition and Prevention, Response, and Reporting/Systems Learning

by developing, testing, and implementing evidenced-based care practices as standard, sustainable processes. Repeated PDSA cycles as depicted in Figure 3.PDSA **Cycles conducted simultaneously** serve as opportunities for facilities to learn and make sustainable improvement through rapid, small tests of change. Support will be made available to improvement teams during the action periods, including, but not be limited to conference calls, feedback on periodic progress reports, peer mentoring to enhance collaborative learning, opportunities for site visits, and individual coaching.

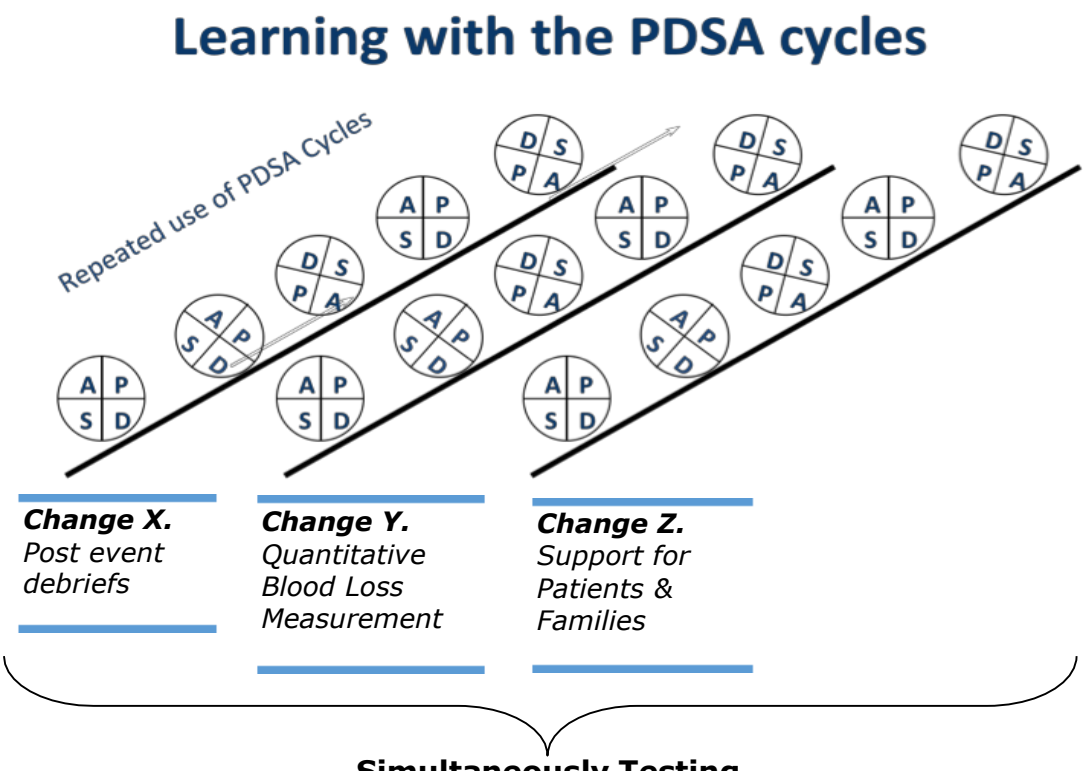


Figure 3.PDSA Cycles conducted simultaneously

Collaborative Support

TexasAIM Plus Support

TexasAIM Plus, as administered by DSHS in partnership with THA, will provide support to improvement teams in a number of ways. This support will include the following elements.

Monthly Action Period Sessions

- Calls and other communications will include content-driven topics and tailored discussions to coach teams in overcoming obstacles and accelerating improvement efforts.

Guidance and Support

- Technical Assistance and Support Calls will be offered to any team throughout the Collaborative period to discuss challenges, barriers, successes and/or to receive feedback and suggestions on possible direction with practice change
- Mentors will be tapped on from across the OBH+ Learning Collaborative and from other states to share experiences and learning
- OBH+ Learning Collaborative Faculty will provide expertise and best-practice guidance to inform improvement
- Opportunities for on-site technical assistance visits will be available on a limited basis for additional customized support

Measurement and Data Reporting Assistance

- Advisors will be available to assist teams with monthly and quarterly data collection and submissions as well as use of data to drive improvement

Collaborative Communications

- TexasAIM OBH+ Learning Collaborative Improvement Teams will receive an invitation to an online sharing platform within which teams may share thoughts, ideas, resources, news, successes and challenges on an ongoing basis
- Collaborative members will receive semi-regular email notices including information about project milestones, highlights of successes, relevant resources and opportunities, and news of supporting efforts that may arise throughout the OBH+ Learning Collaborative's life course

Maternal Early Warning System Tools

Use of maternal early warning systems (MEWS) have been proposed to support timely recognition, diagnosis and treatment of critical illness in pregnant and postpartum women. The Alliance for Innovation on Maternal Health (AIM) provides MEWS Patient Safety Tools, including the National Partnership for Maternal Safety's proposed Maternal Early Warning Criteria, a MEWS Protocol, and information on implementing and using a MEWS

escalation plan. MEWS is an integral part of the recognition and response components of the Obstetric Hemorrhage +AIM and other +AIM bundles. Information about MEWS will be shared throughout the TexasAIM OBH+ Learning Collaborative. In addition, TexasAIM is partnering with the Texas Collaborative for Healthy Mothers and Babies (TCHMB)*[4] to provide TexasAIM participants with additional information and expertise in MEWS.

Team Requirements

All members of the team will need to commit time and concerted effort to participate in the OBH+ Learning Collaborative. Enrolled teams are expected to participate for the full duration of the collaborative from June

The Importance of Leadership Support and Project Sponsorship

"Lack of leadership support is one of the most common reasons that a quality improvement (QI) project fails. In order for a QI effort to be successful, it requires support and buy-in from organizational leaders. Leadership plays an important role in improving quality by setting priorities, providing structure to support the improvement effort, modeling core values, promoting a learning atmosphere, acting on recommendations, advocating for supportive policies, and allocating resources for improvement."

-Council on Patient Safety in Women's Health Care, Implementing Quality Improvement

2018 - February 2020. Senior leaders (e.g. "C-Suite", administrative, and clinical leaders) are critical to guide, support, and inspire the hospital's team in their improvement efforts and to ensure that the needed systems are activated to sustain the team's effective changes.

A team's cumulative time commitment of four days per month is required for participation in the TexasAIM OBH+ Learning Collaborative. We recommend teams meet twice per month or more frequently (e.g. weekly) to plan and review their work. Teams that meet weekly experience the most improvement. Further details on team roles and responsibilities will be provided in future communications and Pre-work

[4]**DSHS convened the Healthy Texas Babies (HTB) Expert Panel in 2011 to engage a network of over 200 multi-disciplinary health- and health care partners from across the state in maternal and infant health projects. The HTB Expert Panel and its members spurred development of the Texas Maternal Mortality and Morbidity Task Force, the Perinatal Advisory Council, and Medicaid Early Elective Delivery policy. The HTB Expert Panel became the state's Perinatal Quality Collaborative, Texas Collaborative for Healthy Mothers and Babies (TCHMB) in 2013. TCHMB was facilitated with DSHS as the lead "backbone" organization until 2015. DSHS then established a contract for operational support of TCHMB with the UT System and continues to sponsor its operations.*

Conference Calls.

Recommended TexasAIM Plus OBH+ Learning Collaborative Hospital Improvement Team composition includes:

The OBH+ Core Team: As submitted on your enrollment form, these critical positions to drive and steer the overall project:

- ✓ *Project Sponsor:* An executive authority who can coordinate with senior management and across the organization. The sponsor links the project to the organization's mission, goals and resources, and provides necessary resources and time to devote to testing and implementing changes; This leader also supports and encourages the hospital team and is responsible for the sustainability of the team's effective changes. They are typically not involved in day-to-day operations.
- ✓ *Physician Champion/Clinical Leader:* A physician who believes in this effort and will support the required change in process; This leader understands the clinical implications of proposed changes across the organization, and has authority to test processes, implement change and troubleshoot issues.
- ✓ *Technical Leader:* A staff member who has a strong understanding of the current science, knowledge base, and nationally recognized practice recommendations related to obstetric hemorrhage and also understands the processes of care delivery in your setting; This person is responsible for the scheduling of activities and data collection. This is likely to be a nurse manager or staff nurse leader.
- ✓ *Day-to-Day Leader:* A staff member responsible for driving improvement every day; This leader manages the team and assures changes are being made and data is collected. This is often the OB Nursing Leader.

The Multi-Disciplinary Team Members: These key stakeholders contribute their unique perspectives and practice-based expertise to inform PDSAs, problem solve barriers, and innovate solutions.

- ✓ Data Manager
- ✓ Simulation Leader
- ✓ Patient/Family Representative Leader
- ✓ Anesthesia Provider Leader
- ✓ Blood Bank Leader
- ✓ Social Work Leader
- ✓ Communications/PR Leader
- ✓ IT/EMR support Leader
- ✓ Operating Room Leader
- ✓ Frontline Caregiver Leader
- ✓ Community Organization Leader
- ✓ Other Influential Individuals

Sustainability and Spread

The strategies adopted by the hospitals in this collaborative are designed to promote measurable, sustainable improvements in the quality of maternity care. During the collaborative, we intend to engage interested stakeholders—including

hospitals participating in TexasAIM Basic or not yet participating in TexasAIM— in various ways, including optional, ancillary networking events. This will support learning from the OBH+ Learning Collaborative to be spread and shared with others interested in making a positive impact on maternal health and safety. Following the close of this project, we anticipate that the change strategies and lessons learned from this collaborative be applied by other hospitals seeking to decrease severe maternal morbidity from obstetric hemorrhage.

Appendix 1. Obstetric Hemorrhage +AIM Council on Patient Safety in Women's Health Care Maternal Safety Bundle[5]

TexasAIM Plus Obstetric Hemorrhage Learning Collaborative

Readiness *Every Unit* • Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches • Immediate access to hemorrhage medications (kit or equivalent) • Establish a response team – who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services) • Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched) • Unit education on protocols, unit-based drills (with post-drill debriefs)	**Readiness Resources*** • ACOG Practice Bulletin: Postpartum Hemorrhage (ACOG) • ACOG Committee Opinion 590: Preparing for clinical emergencies in obstetrics and gynecology (ACOG) • Improving Health Care Response to Obstetric Hemorrhage (CMQCC) • Massive transfusion protocols: the role of aggressive resuscitation versus product ratio in mortality reduction (ACS) • Obstetric Hemorrhage Hospital Level Implementation Guide (CMQCC) • Postpartum Hemorrhage Project (AWHONN) • Safe Motherhood Initiative (ACOG) • TeamSTEPPS: National Implementation (AHRQ)
Recognition & Prevention *Every Patient* • Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times) • Measurement of cumulative blood loss (formal, as quantitative as possible) • Active management of the 3rd stage of labor (department-wide protocol)	**Recognition & Prevention Resources*** • AWHONN Practice Brief 2: Oxytocin Administration for Management of Third Stage of Labor (AWHONN) • Postpartum Hemorrhage Project (AWHONN) • Postpartum Hemorrhage: Third Stage Pregnancy (AAFP) • WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage (WHO)

[5] *Available Online: http://safehealthcareforeverywoman.org/patient-safety-bundles/obstetric-hemorrhage/#1472748392134-776d4866-a0fb*

Response *Every Hemorrhage* • Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists • Support program for patients, families, and staff for all significant hemorrhages	**Response Resources*** • ACOG Committee Opinion 590: Preparing for clinical emergencies in obstetrics and gynecology (ACOG) • Improving Health Care Response to Obstetric Hemorrhage (CMQCC) • Medically Induced Trauma Support Services. Tools for Building a Clinician and staff Support Program (MITSS) • Obstetric Hemorrhage Initiative (OHI) Tool Kit for Hospital Implementation (FPQC) • Postpartum Hemorrhage Project (AWHONN) • Safe Motherhood Initiative (ACOG District II)
Reporting/Systems Learning *Every Unit* • Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities • Multidisciplinary review of serious hemorrhages for systems issues • Monitor outcomes and process metrics in perinatal quality improvement committee	**Reporting/Systems Learning Resources*** • Facility-Based Identification of Women with Severe Maternal Morbidity: It is Time to Start • Preventing Maternal Death Sentinel Event Alert 44 (The Joint Commission) • Safe Motherhood Initiative (ACOG District II) • Standardized Severe Maternal Morbidity Review: Rationale and Process

Maternal Early Warning Signs Patient Safety Tools
Maternal Early Warning Criteria and Maternal Early Warning Signs Protocol
	MEWS Resources*
	• Downloadable PDF of Maternal Early Warning Signs (MEWS) Protocol
	• Supporting Commentary: *Obstetrics & Gynecology* [abstract]*; JOGNN* [full text]
	• Presentations
	  ○ Maternal Early Warning Criteria Overview
	  ○ Maternal Early Warning System: Successfully Implementing and Utilizing an Escalation Plan

*TexasAIM will review, synthesize, and share these and other resources, including resources from other AIM States, throughout the OBH+ Learning Collaborative.

Appendix 2: Measurement Strategy

TexasAIM Plus Obstetric Hemorrhage Learning Collaborative

Overview

The table on the following page includes measures that will be collected during the Collaborative, referred to as the Project "Family of Measures." DSHS will establish multi-year baseline rates for outcome measures using hospital discharge data.

Please identify one individual from your team to designate as data manager. A webinar will be scheduled to orient data managers and team leads to the AIM Data Center. The data manager will be charged with monthly data collection and will be required to attend a session to introduce and practice baseline data collection during Learning Session 1. When possible, the data manager individual should be different from the team leader.

Quarterly Reporting - AIM National Measures

Each quarter your team, working with the designated data manager, will review records to determine appropriate Process and Structure Measures data (as specified below) to submit to the AIM Data Center. DSHS is responsible for Outcome Measures reporting, as described below. Data reports may be generated and shared with the hospital improvement team to track improvement patterns and to inform improvement. Data should be used to regularly communicate progress and identify priorities for improvement to leadership and to frontline staff.

Monthly Reporting – TexasAIM Plus Quality Measures

Reporting of TexasAIM Plus Quality Measures will be phased in after AIM National reporting has been established.

Each month your team, working with the designated data manager will review records to determine appropriate data (as specified below) to submit to the Texas Hospital Association. Data reports may be generated and shared with the hospital improvement team to track improvement patterns and to inform improvement. Data should be used to regularly communicate progress and identify priorities for improvement to leadership and to frontline staff.

Each record review is estimated to take approximately 6 minutes. Unless data is available electronically, it is highly recommended to incorporate the Chart Review Tool into your daily / weekly work to minimize the burden at the close of each month. The sampling method below should be used to reduce the burden of data collection when volume is high. Samples based on your knowledge of the process. For example, do not select 30 deliveries from the same week /same shift since it would not be a representative sample.

Collect and report data on a **sample of 25% of the mothers** who visited your facility in the **one month** prior to your data submission month.

- Monthly census is above 120 mothers→submit **maximum of 30** records
- Monthly census is below 40 mother→submit **minimum of 10** records
- Monthly census is sufficiently small→use records from the previous month to reach 10 mothers

Data Tools

Many AIM data tools and resources are available from the Council on Patient Safety in Women's Health Care website at http://safehealthcareforeverywoman.org/aim-data/, including:

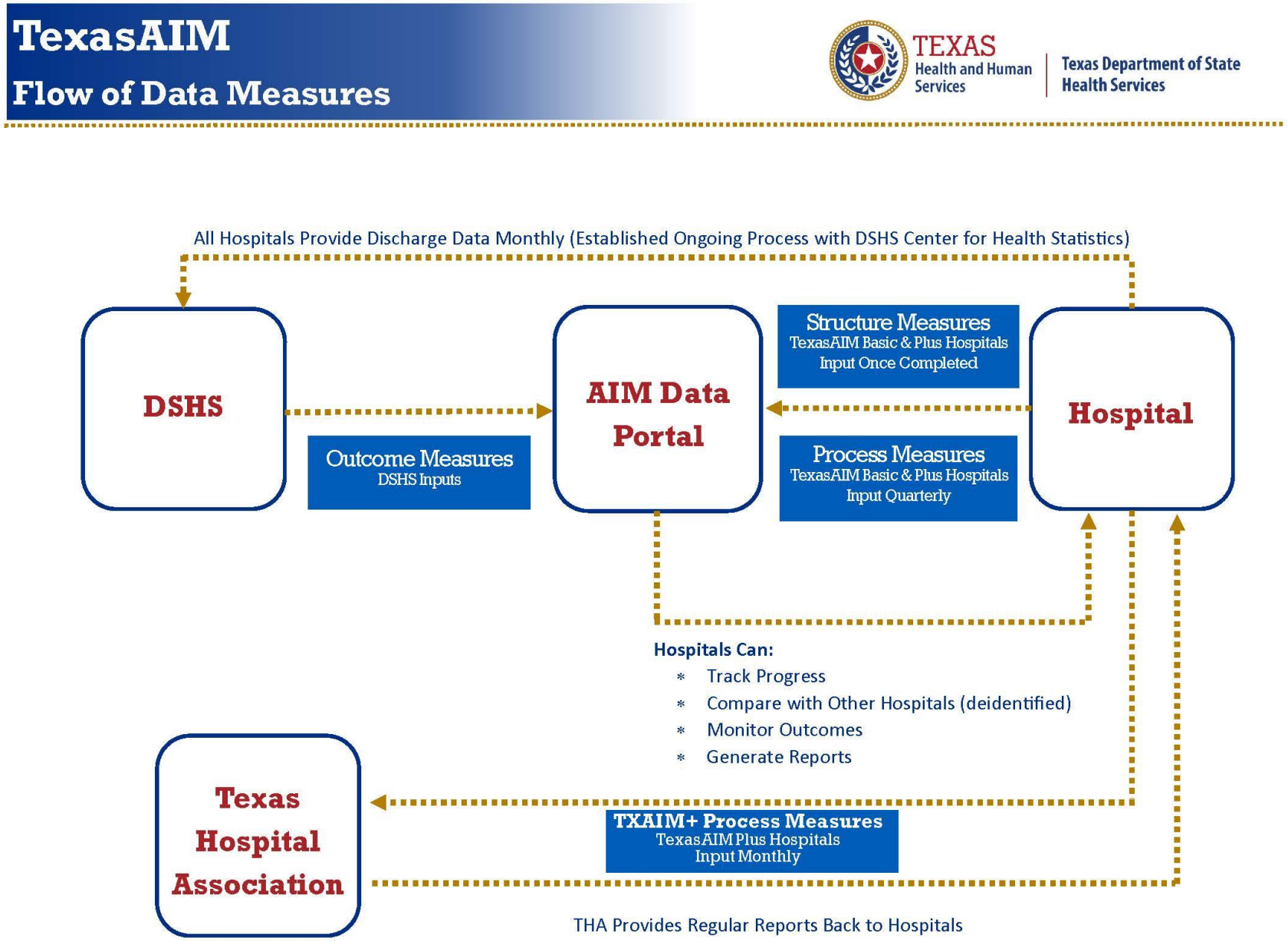
- AIM Collaborative Knowledgebase (Resource Library)
- AIM Data Collection Plan
- AIM Data Center User Guide (Includes information about accessing the AIM Data Center Demo Site)
- AIM Severe Maternal Morbidity Codes List
- AIM Data FAQ: Blood Transfusion Coding

As TexasAIM Plus Quality Measures are phased in, record review and tally tools for monthly data collection and tallying will be provided for use in preparation of data reporting to the Texas Hospital Association.

Obstetric Hemorrhage Learning Collaborative: Family of Measures

Process Measures TexasAIM Basic & Plus Hospitals Submit to AIM Data Center Quarterly	**Structure Measures** TexasAIM Basic & Plus Hospitals Submit to AIM Data Center Once Completed	**Outcome Measures** Submitted to AIM Data Center by DSHS Quarterly for each TexasAIM Basic & Plus Hospital
1. How many OB drills were performed on your unit for any maternal safety topic? 2. What were covered in the OB drills? 3. What cumulative proportion of OB physicians and midwives has completed an education program on OB Hemorrhage? 4. What cumulative proportion of OB physicians and midwives has completed an education program on OB Hemorrhage bundle elements and the unit-standard protocol? 5. What cumulative proportion of OB nurses had completed an education program on OB Hemorrhage? 6. What cumulative proportion of OB nurses has completed an education program on OB hemorrhage bundle elements and the unit-standard protocol? 7. What cumulative proportion of mothers had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team? 8. What proportion of mothers had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques?	1. Has your hospital developed OB specific resources and protocols to support patients, family and staff through major OB complications? 2. Has your hospital established a system to preform regular formal debriefs after cases with major complications? 3. Has your hospital established a process to perform multidisciplinary systems-level review on all cases of severe maternal morbidity? 4. Does your hospital have OB hemorrhage supplies readily available, typically in a cart of mobile box? 5. Does your hospital have an OB hemorrhage policy and procedure that provides a unit-standard approach using a stage-based management plan with checklists? 6. Were some of the recommended OB hemorrhage bundle processes integrated into your hospital EMR system?	1. Severe Maternal Mortality 2. Severe maternal Morbidity (excluding cases with only a transfusion code) among All Delivering Women 3. Severe Maternal Morbidity Among Hemorrhage Cases 4. Severe Maternal Morbidity (excluding cases with only a transfusion code) among Hemorrhage Cases **TexasAIM Plus Performance Measures** TexasAIM Plus Hospitals Submit to THA Monthly 1. What cumulative proportion of mothers had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team? 2. For what cumulative proportion of hemorrhage cases with greater than 1,000 cc blood loss was a debrief session held and documented? 3. For what cumulative proportion of hemorrhage cases with greater than 1,000 cc blood loss was a hand off report assessing for cumulative blood loss held and documented between labor and delivery and postpartum medical and nursing staff? 4. What cumulative proportion of mothers had documented abnormal parameters per unit protocol and, among those, how many had appropriate escalation? 5. How many units of blood product were transfused for maternal hemorrhage during the birth hospitalization per 1,000 mothers?

Obstetric Hemorrhage Learning Collaborative: Data Reporting Flow



AIM Obstetric Hemorrhage Measures: Data Details

Structure Measures (S)	Description	Data Source	Frequency	Data Coordinator Options	*Notes*
S1: Patient, Family & Staff Support	**Report Completion Date** Has your hospital developed OB specific resources and protocols to support patients, family and staff through major OB complications?	Hospital	Once	●Perinatal Nurse Manager ●Designated QI Leader	***see Support after a Severe Maternal Event Patient Safety Bundle (+AIM)***
S2: Debriefs	**Report Start Date** Has your hospital established a system in your hospital to perform regular formal debriefs after cases with major complications?	Hospital	Once	●Perinatal Nurse Manager ●Designated QI Leader	*Major complications will be defined by each facility based on volume, with a minimum being The Joint Commission Severe Maternal Morbidity Criteria*
S3: Multidisciplinary Case Reviews	**Report Start Date** Has your hospital established a process to perform multidisciplinary systems-level reviews on all cases of severe maternal morbidity (including women admitted to the ICU, receiving ≥4 units RBC transfusions, or diagnosed with a VTE)?	Hospital	Once	●Perinatal Nurse Manager ●Designated QI Leader	*Major complications will be defined by each facility based on volume, with a minimum being The Joint Commission Severe Maternal Morbidity Criteria*
S4: Hemorrhage Cart	**Report Completion Date** Does your hospital have OB hemorrhage supplies readily available, typically in a cart or mobile box?	Hospital	Once	●Perinatal Nurse Manager ●Designated QI Leader	
S5: Unit Policy and Procedure	**Report Completion Date** Does your hospital have an OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that provides a unit-standard approach using a stage-based management plan with checklists?	Hospital	Once	●Perinatal Nurse Manager ●Designated QI Leader	
S6: EHR Integration	**Report Completion Date** Were some of the recommended OB Hemorrhage bundle processes (i.e. order sets, tracking tools) integrated into your hospital's Electronic Health Record system?	Hospital	Once	●Perinatal Nurse Manager ●Designated QI Leader	*It can be any part of the Obstetric Hemorrhage bundle (i.e. orders, protocols, documentation)*

Process Measures (P)	Description	Data Source	Frequency	Data Coordinator Options	*Notes*
P1: Unit Drills	**Report # of Drills and the drill topics** **P1a:** In this quarter**,** how many OB drills (In Situ and/or Sim Lab) were performed on your unit for any maternal safety topic? **P1b**: In this quarter, what topics were covered in the OB drills?	Hospital	Quarterly	●Perinatal Nurse Manager ●Designated QI Leader	
P2: Provider Education	**Report estimate in 10% increments (round up)** **P2a**: At the end of this quarter, what cumulative proportion of OB physicians and midwives has completed (within the last 2 years) an education program on Obstetric Hemorrhage? **P2b**: At the end of this quarter, what cumulative proportion of OB physicians and midwives has completed (within the last 2 years) an education program on the Obstetric Hemorrhage bundle elements and the unit-standard protocol?	Hospital	Quarterly	●Perinatal Nurse Manager ●Designated QI Leader	***see AIM eModules*** ●*This is meant to be an informal estimate by nursing leadership similar to the CDC mPINC survey to assess breastfeeding practices.* ●*Cumulative means "Since the onset of the project, what proportion of the staff have completed the educational program?"*
P3: Nursing Education	**Report estimate in 10% increments (round up)** **P3a**: At the end of this quarter, what cumulative proportion of OB nurses has completed (within the last 2 years) an education program on Obstetric Hemorrhage? **P3b**: At the end of this quarter, what cumulative proportion of OB nurses has completed (within the last 2 years) an education program on the Obstetric Hemorrhage bundle elements and the unit-standard protocol?	Hospital	Quarterly	●Perinatal Nurse Manager ●Designated QI Leader	***see AIM eModules*** ●*This is meant to be an informal estimate by nursing leadership similar to the CDC mPINC survey to assess breastfeeding practices.* ●*Cumulative means "Since the onset of the project, what proportion of the staff have completed the educational program?"*
P4: Risk Assessment	**Report estimate in 10% increments (round up)** At the end of this quarter, what cumulative proportion of mothers had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team?	Hospital	Quarterly	●Perinatal Nurse Manager ●Designated QI Leader	*This is meant to be an informal estimate by nursing leadership similar to the CDC mPINC survey to assess breastfeeding practices.*

P5: Quantified Blood Loss	**Report estimate in 10% increments (round up)**In this quarter, what proportion of mothers had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques?	Hospital	Quarterly	●Perinatal Nurse Manager●Designated QI Leader	●*This is meant to be an informal estimate by nursing leadership similar to the CDC mPINC survey to assess breastfeeding practices.* ●*Formal measurement can include any method beyond visual estimate alone, such as under-buttock drapes with gradations, weighing clots and sponges, suction canisters with gradations, etc.*

Outcome Measures (O)	Description	Data Source	Frequency	Data Coordinator Options	*Notes*
O1: Severe Maternal Morbidity	**Denominator**: All mothers during their birth admission, excluding ectopics and miscarriages **Numerator:** Among the denominator, all cases with any SMM code	HDD File (ICD-9/ICD-10)	Quarterly (if available), otherwise annual	●Texas Department of State Health Services ●Designated Data Coordinating Body/Hospital System	*see **AIM SMM Codes List*** *The SMM Outcome Measures will also be calculated on an annual basis by major Race/Ethnicity: **NH white, NH black, Hispanic, NH AI/AN, NH API(NH=Non-Hispanic)** Each state will determine which race groups to report, but the first 3 are required.*
O2: Severe Maternal Morbidity (excluding cases with only a transfusion code) among All Delivering Women	**Denominator:** All mothers during their birth admission, excluding ectopics and miscarriages **Numerator:** Among the denominator, all cases with any non-transfusion SMM code	HDD File (ICD-9/ICD-10)	Quarterly (if available), otherwise annual	●Texas Department of State Health Services ●Designated Data Coordinating Body/Hospital System	*see **AIM SMM Codes List*** *The SMM Outcome Measures will also be calculated on an annual basis by major Race/Ethnicity: **NH white, NH black, Hispanic, NH AI/AN, NH API(NH=Non-Hispanic)** Each state will determine which race groups to report, but the first 3 are required.*

O3: Severe Maternal Morbidity among Hemorrhage Cases	**Denominator:** All mothers during their birth admission, excluding ectopics and miscarriages, meeting one of the following criteria: • Presence of an Abruption, Previa or Antepartum hemorrhage diagnosis code • Presence of transfusion procedure code without a sickle cell crisis diagnosis code • Presence of a Postpartum hemorrhage diagnosis code **Numerator:** Among the denominator, all cases with any SMM code	HDD File (ICD-9/ICD-10)	Quarterly (if available), otherwise annual	●Texas Department of State Health Services ●Designated Data Coordinating Body/Hospital System	*see **AIM SMM Codes List***
O4: Severe Maternal Morbidity (excluding cases with only a transfusion code)) among Hemorrhage Cases.	**Denominator:** All mothers during their birth admission, excluding ectopics and miscarriages, meeting one of the following criteria: • Presence of an Abruption, Previa or Antepartum hemorrhage diagnosis code • Presence of transfusion procedure code without a sickle cell crisis diagnosis code • Presence of a Postpartum hemorrhage diagnosis code **Numerator:** Among the denominator, all cases with any non-transfusion SMM code	HDD File (ICD-9/ICD-10)	Quarterly (if available), otherwise annual	●Texas Department of State Health Services ●Designated Data Coordinating Body/Hospital System	*see **AIM SMM Codes List***

TexasAIM Plus Obstetric Hemorrhage Quality Measures: Data Details

Data details will be provided prior to phasing in these measures.

Appendix 3: Sample Driver Diagram Applied to Obstetric Hemorrhage Patient Safety Bundle[6]

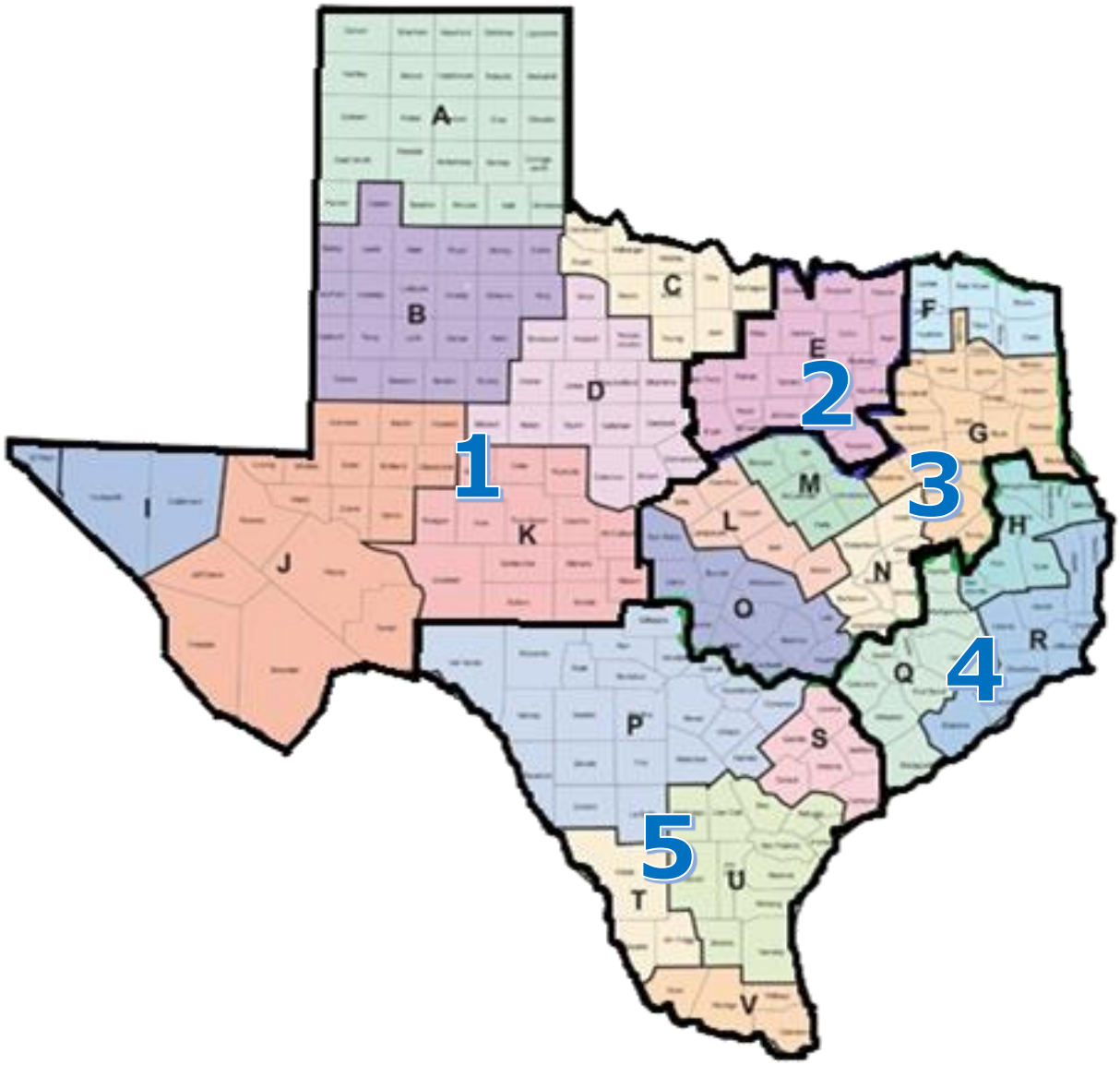
TexasAIM Plus Obstetric Hemorrhage Learning Collaborative

OUTCOME	PRIMARY DRIVERS	SECONDARY DRIVERS	ACTION STEPS
Decrease severe maternal morbidity from OB Hemorrhage by 25% from 2017 to 2020.	Readiness for OB hemorrhage (For Every Unit)	1. Hemorrhage cart available and accessible intrapartum AND postpartum 2. Medications immediately available Obstetric emergency response team in place 3. Establish massive and emergency release transfusion protocols 4. Unit education/Unit drills, including post-event debriefs	1. Establish a multidisciplinary team. 2. Establish an obstetric rapid response team for all obstetric emergencies 3. Research and standardize hemorrhage cart 4. Simulate medication procurement. Identify improvement opportunities and include all stakeholders including Pharmacy 5. Implement communication processes for rapid response obstetric response team 6. Engage a multi-disciplinary team to develop massive and emergency release transfusion protocol 7. Adopt education for OB hemorrhage 8. Identify staff to lead multidisciplinary drills and simulations, including post-event debriefs
	Recognition and prevention of OB hemorrhage (For Every Patient)	1. Assess hemorrhage risk 2. Quantify blood loss 3. Actively manage 3rd stage of labor	1. Identify hemorrhage risk assessment tool. Pilot/PDSA. 2. Identify tools for the reliable quantification of blood loss for vaginal and cesarean delivery (for example, one such tool may be to use and secure under-buttocks drapes) 3. Engage OB providers and nurses on Quantified Blood Loss measurement and develop a shared educational program with standard tools. Pilot/PDSA. Ensure all staff and providers are held accountable by the standard. 4. Secure champions for active management of 3rd stage of labor implementation 5. Pilot/PDSA active management of 3rd stage of labor 6. Develop active management of 3rd stage of labor policy

[6] Based on American College of Obstetricians and Gynecologists. Council on Patient Safety in Women's Health Care Implementing Quality Improvement Projects Toolkit V1, May 2016. Available: http://safehealthcareforeverywoman.org/patient-safety-tools/implementing-quality-improvement-projects/

	Standardized Response to OB Hemorrhage (For Every Hemorrhage)	1. Adopt standard, stage-based hemorrhage management plan with checklists 2. Adopt support program for patients, families, and staff for significant hemorrhages	1. Develop standardized, stage-based hemorrhage management plan with checklists 2. Pilot stage-based management plan in simulations/PDSA after pilot 3. Secure MD and Nurse champions for plan implementation 4. Incorporate plan into EMR (make it easier to do the right thing) 5. Form group representing all stakeholders to develop support program(s) for patients, families, and staff 6. Research resources available for support 7. Pilot/PDSA support components; develop support programs; ensure all populations are represented
	Reporting and systems learning from OB Hemorrhage (For Every Unit) (Facility Culture)	1. Huddle for high risk patients to prepare throughout care 2. Debrief to identify successes and opportunities; create and promote a feedback system of learning. 3. Multidisciplinary review of stage 2/3 hemorrhages 4. Identify and use data collection plan to capture OB hemorrhage events	1. Identify nursing and medical champions for huddle design and implementation 2. Test before implementing huddle/pilot/PDSA after pilot 3. Engage medical, nursing leadership to lead and implement debriefs 4. Engage medical, nursing, administrative leadership to establish multidisciplinary review 5. Implement multidisciplinary review for stage 2 & 3 hemorrhages 6. Investigate data measures and other resources/tools. Identify data champion. 7. Utilize collection plan. PDSA.

Attachment 1
TexasAIM Plus Learning Collaborative Cohort Regions



TexasAIM Plus OBH+ Learning Collaborative Participating Organizations

145 Hospitals Currently Enrolled in TexasAIM Plus Obstetric Hemorrhage Learning Collaborative*

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Abilene Regional Medical Center	TAYLOR	TSA D	Big Country	1
Baptist Hospital of Southeast Texas	JEFFERSON	TSA R	East Texas Gulf Coast RAC	4
Baptist Medical Center	BEXAR	TSA P	Southwest Texas RAC	5
Baylor Scott & White All Saints Medical Center at Fort Worth	TARRANT	TSA E	North Central Texas RAC	2
Baylor Scott & White Centennial	COLLIN	TSA E	North Central Texas RAC	2
Baylor Scott & White College Station	BRAZOS	TSA N	Brazos Valley RAC	3
Baylor Scott & White Frisco	COLLIN	TSA E	North Central Texas RAC	2
Baylor Scott & White Grapevine	TARRANT	TSA E	North Central Texas RAC	2
Baylor Scott & White Hillcrest	MCLENNAN	TSA M	Heart of Texas RAC	3
Baylor Scott & White Irving	DALLAS	TSA E	North Central Texas RAC	2
Baylor Scott & White Lake Pointe	ROCKWALL	TSA E	North Central Texas RAC	2
Baylor Scott & White Lakeway	TRAVIS	TSA O	Capital Area Trauma RAC	3
Baylor Scott & White Marble Falls	BURNET	TSA O	Capital Area Trauma RAC	3
Baylor Scott & White McKinney	COLLIN	TSA E	North Central Texas RAC	2
Baylor Scott & White Round Rock	WILLIAMSON	TSA O	Capital Area Trauma RAC	3
Baylor Scott & White Temple (Scott & White Medical Center)	BELL	TSA L	Central Texas RAC	3
Baylor Scott & White Waxahachie	ELLIS	TSA E	North Central Texas RAC	2
Baylor University Medical Center	DALLAS	TSA E	North Central Texas RAC	2
Bayshore Medical Center	HARRIS	TSA Q	Southeast Texas RAC	4

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Ben Taub General Hospital (Harris Health System)	HARRIS	TSA Q	Southeast Texas RAC	4
Brownwood Regional Medical Center	BROWN	TSA D	Big Country	1
Cedar Park Regional Medical Center	WILLIAMSON	TSA O	Capital Area Trauma RAC	3
CHI St. Luke's Health Brazosport	BRAZORIA	TSA R	East Texas Gulf Coast RAC	4
CHI St. Luke's The Vintage Hospital	HARRIS	TSA Q	Southeast Texas RAC	4
CHI St. Luke's The Woodlands Hospital	MONTGOMERY	TSA Q	Southeast Texas RAC	4
Children's Memorial Hermann Hospital-The Women's Center	HARRIS	TSA Q	Southeast Texas RAC	4
Christus Good Shepherd Medical Center Longview	GREGG	TSA G	Piney Woods RAC	3
Christus Mother Frances Hospital Sulphur Springs	HOPKINS	TSA F	Northeast Texas RAC	3
CHRISTUS Santa Rosa - The Children's Hospital of San Antonio	BEXAR	TSA P	Southwest Texas RAC	5
Christus Santa Rosa Hospital - New Braunfels	COMAL	TSA P	Southwest Texas RAC	5
Christus Santa Rosa Hospital - Westover Hills	BEXAR	TSA P	Southwest Texas RAC	5
Christus Southeast Texas St. Elizabeth	JEFFERSON	TSA R	East Texas Gulf Coast RAC	4
Christus Spohn Hospital Corpus Christi-South	NUECES	TSA U	Coastal Bend RAC	5
Christus Spohn Hospital Kleberg	KLEBERG	TSA U	Coastal Bend RAC	5
Christus St. Michael	BOWIE	TSA F	Northeast Texas RAC	3
Christus Trinity Mother Frances Hospital Tyler	SMITH	TSA G	Piney Woods RAC	3
Cogdell Memorial Hospital	SCURRY	TSA B	BRAC	1
Corpus Christi Medical Center - Bay Area	NUECES	TSA U	Coastal Bend RAC	5
Covenant Children's Hospital	LUBBOCK	TSA B	BRAC	1
Covenant Hospital Levelland	HOCKLEY	TSA B	BRAC	1
Cuero Regional Hospital	DEWITT	TSA S	Golden Crescent RAC	5

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Cypress Fairbanks Medical Center	HARRIS	TSA Q	Southeast Texas RAC	4
Del Sol Medical Center	EL PASO	TSA I	Border RAC	1
Doctors Hospital - Laredo	WEBB	TSA T	Seven Flags RAC	5
Fort Duncan Regional Medical Center	MAVERICK	TSA P	Southwest Texas RAC	5
Harlingen Medical Center	CAMERON	TSA V	Lower Rio Grande Valley RAC	5
Hendrick Medical Center	TAYLOR	TSA D	Big Country	1
Hereford Regional Medical Center	DEAF SMITH	TSA A	Panhandle RAC	1
Hill Country Memorial Hospital	GILLESPIE	TSA P	Southwest Texas RAC	5
Houston Methodist Childbirth Center at St. John	HARRIS	TSA Q	Southeast Texas RAC	4
Houston Methodist Childbirth Center at Sugar Land	FORT BEND	TSA Q	Southeast Texas RAC	4
Houston Methodist Childbirth Center at West	HARRIS	TSA Q	Southeast Texas RAC	4
Houston Methodist Childbrith Center at Willowbrook	HARRIS	TSA Q	Southeast Texas RAC	4
Houston Methodist San Jacinto Hospital	HARRIS	TSA Q	Southeast Texas RAC	4
Hunt Regional Medical Center-Greenville	HUNT	TSA E	North Central Texas RAC	2
Huntsville Memorial Hospital	WALKER	TSA Q	Southeast Texas RAC	4
John Peter Smith Health Network	TARRANT	TSA E	North Central Texas RAC	2
Kingwood Medical Center	MONTGOMERY	TSA Q	Southeast Texas RAC	4
Knapp Medical Center	HIDALGO	TSA V	Lower Rio Grande Valley RAC	5
Lake Granbury Medical Center	HOOD	TSA E	North Central Texas RAC	2
Laredo Medical Center	WEBB	TSA T	Seven Flags RAC	5
Las Palmas Medical Center	EL PASO	TSA I	Border RAC	1
Longview Regional Medical Center	GREGG	TSA G	Piney Woods RAC	3

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Lyndon Baines Johnson General Hospital	HARRIS	TSA Q	Southeast Texas RAC	4
Medical Center Health System	ECTOR	TSA J	Texas "J" RAC	1
Medical City Alliance	TARRANT	TSA E	North Central Texas RAC	2
Medical City Dallas	DALLAS	TSA E	North Central Texas RAC	2
Medical City Lewisville	DENTON	TSA E	North Central Texas RAC	2
Medical City Plano	COLLIN	TSA E	North Central Texas RAC	2
Medina Regional Hospital	MEDINA	TSA P	Southwest Texas RAC	5
Memorial Hermann Hospital Katy	HARRIS	TSA Q	Southeast Texas RAC	4
Memorial Hermann Hospital Memorial City	HARRIS	TSA Q	Southeast Texas RAC	4
Memorial Hermann Hospital Northeast	HARRIS	TSA Q	Southeast Texas RAC	4
Memorial Hermann Hospital Southeast	HARRIS	TSA Q	Southeast Texas RAC	4
Memorial Hermann Hospital Southwest	HARRIS	TSA Q	Southeast Texas RAC	4
Memorial Hermann Hospital Sugar Land	FORT BEND	TSA Q	Southeast Texas RAC	4
Memorial Hermann Hospital The Woodlands	MONTGOMERY	TSA Q	Southeast Texas RAC	4
Memorial Hermann Pearland Hospital	BRAZORIA	TSA R	East Texas Gulf Coast RAC	4
Memorial Medical Center	CALHOUN	TSA S	Golden Crescent RAC	5
Methodist Charlton Medical Center	DALLAS	TSA E	North Central Texas RAC	2
Methodist Children's Hospital (Women's Pavillion at Methodist)	BEXAR	TSA P	Southwest Texas RAC	5
Methodist Dallas Medical Center	DALLAS	TSA E	North Central Texas RAC	2
Methodist Mansfield Medical Center	TARRANT	TSA E	North Central Texas RAC	2
Methodist Richardson Medical Center	COLLIN	TSA E	North Central Texas RAC	2
Methodist Stone Oak Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Metroplex Health System-Sue Mayborn Women's Center	BELL	TSA L	Central Texas RAC	3

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Metropolitan Methodist Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Moore County Hospital District	MOORE	TSA A	Panhandle RAC	1
Navarro Regional Hospital	NAVARRO	TSA E	North Central Texas RAC	2
North Central Baptist Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Northeast Baptist Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Northwest Texas Hospital	POTTER	TSA A	Panhandle RAC	1
Oakbend Medical Center	FORT BEND	TSA Q	Southeast Texas RAC	4
Odessa Regional Medical Center	ECTOR	TSA J	Texas "J" RAC	1
Palestine Regional Medical Center	ANDERSON	TSA G	Piney Woods RAC	3
Pampa Regional Medical Center	GRAY	TSA A	Panhandle RAC	1
Parkland Memorial Hospital	DALLAS	TSA E	North Central Texas RAC	2
Permian Regional Medical Center	ANDREWS	TSA J	Texas "J" RAC	1
Peterson Regional Medical Center	KERR	TSA P	Southwest Texas RAC	5
Metropolitan Methodist Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Moore County Hospital District	MOORE	TSA A	Panhandle RAC	1
Navarro Regional Hospital	NAVARRO	TSA E	North Central Texas RAC	2
North Central Baptist Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Northeast Baptist Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Northwest Texas Hospital	POTTER	TSA A	Panhandle RAC	1
Oakbend Medical Center	FORT BEND	TSA Q	Southeast Texas RAC	4
Odessa Regional Medical Center	ECTOR	TSA J	Texas "J" RAC	1
Palestine Regional Medical Center	ANDERSON	TSA G	Piney Woods RAC	3
Pampa Regional Medical Center	GRAY	TSA A	Panhandle RAC	1
Parkland Memorial Hospital	DALLAS	TSA E	North Central Texas RAC	2

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Permian Regional Medical Center	ANDREWS	TSA J	Texas "J" RAC	1
Peterson Regional Medical Center	KERR	TSA P	Southwest Texas RAC	5
Reeves County Hospital	REEVES	TSA J	Texas "J" RAC	1
Resolute Health	COMAL	TSA P	Southwest Texas RAC	5
Rice Medical Center	COLORADO	TSA Q	Southeast Texas RAC	4
Rio Grande Regional Hospital	HIDALGO	TSA V	Lower Rio Grande Valley RAC	5
Rolling Plains Memorial Hospital	NOLAN	TSA D	Big Country	1
San Angelo Community Medical Center	TOM GREEN	TSA K	Concho Valley RAC	1
Seton Medical Center	TRAVIS	TSA O	Capital Area Trauma RAC	3
Seton Medical Center Harker Heights	BELL	TSA L	Central Texas RAC	3
Seton Medical Center Hays	HAYS	TSA O	Capital Area Trauma RAC	3
Shannon Medical Center	TOM GREEN	TSA K	Concho Valley RAC	1
St. David's Medical Center	TRAVIS	TSA O	Capital Area Trauma RAC	3
St. David's North Austin Medical Center	TRAVIS	TSA O	Capital Area Trauma RAC	3
St. David's Round Rock Medical Center	WILLIAMSON	TSA O	Capital Area Trauma RAC	3
St. David's South Austin Hospital	TRAVIS	TSA O	Capital Area Trauma RAC	3
St. Luke's Baptist Hospital	BEXAR	TSA P	Southwest Texas RAC	5
Texas Children's Hospital Pavillion for Women	HARRIS	TSA Q	Southeast Texas RAC	4
Texas Health Arlington Memorial Hospital	TARRANT	TSA E	North Central Texas RAC	2
Texas Health Harris Methodist Hospital Alliance	TARRANT	TSA E	North Central Texas RAC	2
Texas Health Harris Methodist Hospital Cleburne	JOHNSON	TSA E	North Central Texas RAC	2
Texas Health Harris Methodist Hospital Fort Worth	TARRANT	TSA E	North Central Texas RAC	2
Texas Health Harris Methodist Hospital H-E-B	TARRANT	TSA E	North Central Texas RAC	2

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Texas Health Harris Methodist Hospital Southwest Fort Worth	TARRANT	TSA E	North Central Texas RAC	2
Texas Health Harris Methodist Hospital Stephenville	ERATH	TSA E	North Central Texas RAC	2
Texas Health Huguley Hospital- Fort Worth South	TARRANT	TSA E	North Central Texas RAC	2
Texas Health Presbyterian Hospital Allen	COLLIN	TSA E	North Central Texas RAC	2
Texas Health Presbyterian Hospital Dallas	DALLAS	TSA E	North Central Texas RAC	2
Texas Health Presbyterian Hospital Denton	DENTON	TSA E	North Central Texas RAC	2
Texas Health Presbyterian Hospital Plano	COLLIN	TSA E	North Central Texas RAC	2
Texoma Medical Center	GRAYSON	TSA E	North Central Texas RAC	2
The Hospitals of Providence (THOP) East Campus	EL PASO	TSA I	Border RAC	1
The Hospitals of Providence Memorial Campus	EL PASO	TSA I	Border RAC	1
Titus Regional Medical Center	TITUS	TSA F	Northeast Texas RAC	3
Tomball Regional Hospital	HARRIS	TSA Q	Southeast Texas RAC	4
United Regional Health Care System	WICHITA	TSA C	North Texas RAC	1
University Hospital	BEXAR	TSA P	Southwest Texas RAC	5
University Medical Center El Paso	EL PASO	TSA I	Border RAC	1
University Medical Center Lubbock	LUBBOCK	TSA B	BRAC	1
University Texas Medical Branch- Angleton Campus	BRAZORIA	TSA R	East Texas Gulf Coast RAC	4
University Texas Medical Branch Galveston	GALVESTON	TSA R	East Texas Gulf Coast RAC	4
University Texas Medical Branch- League City Campus	GALVESTON	TSA R	East Texas Gulf Coast RAC	4
UT Health East Texas Athens	HENDERSON	TSA G	Piney Woods RAC	3
Valley Baptist Medical Center - Brownsville	CAMERON	TSA V	Lower Rio Grande Valley RAC	5

Hospitals Enrolled in TexasAIM Plus OBH+ Learning Collaborative as of August 16, 2018	County	Trauma Service Area	Regional Advisory Council	COHORT
Valley Baptist Medical Center- Harlingen	CAMERON	TSA V	Lower Rio Grande Valley RAC	5
Wadley Regional Medical Center- Stewart Family Hospital	BOWIE	TSA F	Northeast Texas RAC	3
William P. Clements Jr. University Hospital-UT Southwestern	DALLAS	TSA E	North Central Texas RAC	2
Wise Regional Health System	WISE	TSA E	North Central Texas RAC	2

An additional 37 hospitals (not listed here) are participating in the TexasAIM Basic Obstetric Hemorrhage Bundle Implementation.

Attachment 2
TexasAIM Plus OBH+ Learning Collaborative Schedule

Action Item	Anticipated Time Frame
APPLICATION	
☐ Complete the TexasAIM Intake Assessment Survey	Within 2 weeks of submission of Enrollment form, signed by CEO
PRE-WORK (See Pre-Work Packet, Attachment 4. Pre-work Packet)	
☐ Attend the Orientation Meeting at the June 4th in-person kick off Leadership and Orientation Summit or make-up virtual orientation session	June 2018 August 2018
☐ Sign up for AIM Collaborative Knowledgebase (Resource Library) and Review AIM eModules for Obstetric Hemorrhage and MEWS	June 2018
☐ Review AIM Maternal Early Warning Tools	June 2018 & ongoing
☐ Review Measurement Strategy (**Appendix 2: Measurement Strategy**)	June 2018 & ongoing
☐ Review pre-work packet	August 2018
☐ Attend/View Welcome and Pre-work Call	August 16, 2018
☐ Register and Attend Data Portal & Basecamp Orientation Call	August 29. 2018 10:00 AM CST or August 30, 2018 2:00 PM CST (Repeat)
☐ Complete a readiness self-assessment survey on your facility's progress toward implementing the Obstetric Hemorrhage +AIM Bundle	September 2018
☐ Form an improvement team and submit completed Improvement Team Roster	September 2018
☐ Submit registration for Learning Session 1	TBA, September 2018
☐ *Texas Collaborative for Healthy Mothers and Babies MEWS Webinar*	*September 2018 (date to be announced)*
☐ Register and attend Quality Improvement Basics Webinar	October 09, 2018 10:00 AM CST
☐ Develop a hospital improvement team aim statement aligned with the overall Collaborative aim	October 2018
☐ Create Team Storyboard	October 2018

LEARNING SESSIONS AND ACTION PERIODS	
1st Collaborative Cohort Learning Sessions (Regional Locations TBD)	October/November 2018 (Dates TBA ASAP)
Action Period 1 Monthly All Teams All Come Action Period Calls Additional team communications and technical assistance opportunities as scheduled	Each month between LS1 and LS2
Optional TexasAIM All Team, All Levels Networking Session: *Texas Collaborative for Healthy Mothers and Babies Summit (in Austin)* *Registration is open @ tchmb.org/2019conference*	*January 29-30, 2019*
2nd Collaborative Cohort Learning Sessions (Regional Locations TBD)	Spring 2019 (Dates TBD)
Action Period 2 Monthly All Teams All Come Action Period Calls Additional team communications and technical assistance opportunities as scheduled	Each month between LS2 and LS3
Optional TexasAIM All Team, All Levels Networking Session: *Texas Department of State Health Services Life Course Conference (Location TBD)*	*Date TBD (June 2019)*
3rd Collaborative Cohort Learning Sessions (Locations TBD)	Fall 2019 (Dates TBD)
Action Period 3 Monthly All Teams All Come Action Period Calls Additional team communications and technical assistance opportunities as scheduled	Fall 2019-February 2020

Attachment 3. Improvement Methodology Terms[3]

Aim: A written, measurable and time-sensitive statement of the expected results of an improvement process.

Change Concept: A general idea for changing a process. Change concepts are usually at a high level of abstraction, but evoke multiple ideas for specific processes. "Simplify," "reduce handoffs," and "consider all parties as part of the same system," are all examples of change concepts.

Cycle or PDSA Cycle: A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:

Plan - a specific planning phase
Do - a time to try the change and observe what happens
Study - an analysis of the results of the trial
Act - devising next steps based on the analysis
This PDSA cycle will naturally lead to the "Plan" step of a subsequent cycle.

Implementation: Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

Key Changes: The list of essential process changes that will help lead to breakthrough improvement.

Measure: An indicator of change. Key measures should be focused, clarify your team's aim and be reportable. A measure is used to track the delivery of proven interventions to patients and to monitor progress over time.

Model for Improvement: An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

Spread: The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on Diffusion of Innovation (Everett Rogers, 1995).

Test: A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

[3] Institute for Healthcare Improvement. 2004. A Glossary of Common Improvement Methodology. http://www.ihi.org/NR/rdonlyres/103C4A5D-2F43-44BE-9051-7734B7ABC322/1067/Glossary1.pdf

Attachment 4. Pre-work Packet

Pre-work Defined

Pre-work consists of activities your improvement team will need to complete before **Learning Session 1 (LS1) in October/November 2018**. Learning Sessions will be held in each of five regions in the state. You can use this document to help your team prepare for participation in the TexasAIM Plus Obstetric Hemorrhage (OBH+) Learning Collaborative. Use the following checklist to track your pre-work activities. If you have questions or require clarification on particular activities, please contact TexasAIM@dshs.texas.gov.

Facility LS1 Pre-work Checklist

			Supporting Materials
Within 2 weeks of enrollment	☐ Work with your team to Complete the TexasAIM Intake Assessment Survey	In consultation with team; Required	Access survey https://www.surveymonkey.com/r/NKFXGD8
Ongoing	☐ Review Orientation Packet/Charter, Pre-work	All Team	Orientation Packet, Pre-work Packet
June 4, 2018 (make up in August & archived for later viewing)	☐ Attend TexasAIM Orientation/Kick-off Summit or make-up virtual orientation webinar session	Team Lead and Physician Champion All Team welcome	Access make-up virtual orientation webinar session
Ongoing	☐ Review AIM+ OB Hemorrhage Bundle and National AIM modules and resources on quality improvement, hemorrhage and MEWS	All Team	https://safehealthcareforeverywoman.org/aim-program/ Orientation Packet (throughout) Attachment 2 of Orientation Packet
Ongoing	☐ Review Measurement Strategy	Data Lead Team Lead	Orientation Packet, **Attachment 2**
August 16, 2018 10:00 AM CST or after	☐ Attend/View Welcome and Pre-work Call	Team Lead All Team welcome	Register/View recording here
August 29. 2018 10:00 AM CST or August 30, 2018 2:00 PM CST	☐ Register and Attend Data Portal & Basecamp Orientation Call	Data Lead Team Lead	Register or view recording (archived after call): August 29. 2018 August 30, 2018 (Repeat)

September 2018	☐ Continue to develop your hospital's improvement team ☐ Complete Team Roster	Team Lead All Team	Orientation Packet, Pre-work Packet
September 2018	☐ Complete a readiness self-assessment survey on your facility's progress toward implementing the Obstetric Hemorrhage +AIM Bundle	Data Lead Team Lead	Pre-work packet, Team
September 2018 (TBA)	☐ Register up to 6 core Team members for Learning Session 1	All Attending LS1 required	Registration link to be provided
October 09, 2018 10:00 AM CST	☐ Register and attend Quality Improvement Basics Webinar	Team Lead Data Lead All Team welcome	Register or view recording (archived after call)
Before your regional cohort's LS1 (Oct/Nov)	☐ Develop a hospital improvement team aim statement aligned with the overall Collaborative	Team Lead All Team	Orientation Packet, Pre-work Packet
Before your regional cohort's LS1 (Oct/Nov)	Formalize your team: ☐ Review collaborative goals/ expectations with team ☐ Establish and share hospital's goals/expectations with team	All Team	Orientation Packet, Pre-work document, Orientation make up recording and handouts; Welcome Call recording and handouts, QI Basics recording and handouts
Before your regional cohort's LS1 (Oct/Nov)	☐ Develop a Storyboard & bring to LS Day 1	All Team	Refer to Pg. 4-5

Participate in a Data Portal & Basecamp Orientation Call webinar

These 30" webinar calls will orient you to the National AIM Data Portal and the TexasAIM virtual communication tool, Basecamp. These tools will be essential to your team's participation and success in the Collaborative. The Measurement Strategy will also be discussed. Team Leaders and Data Managers must attend one of the sessions or view the recording. "Live" attendance is highly recommended so that your questions may be addressed.

August 29. 2018, 10:00 AM CST

August 30, 2018, 2:00 PM CST (Repeat)

Participate in the Quality Improvement Basics Webinar

Facilitated by Karen Kendrick, Director of Texas Hospital Association's Clinical Initiatives, this webinar will provide some of the basic theory and tools used throughout the course of this Collaborative. Team Leaders are should attend and all team members are encouraged to participate.

October 09, 2018, from 10:00 to 11:00 AM CST

Orientation Packet (Charter) and Pre-work Review

The Orientation Packet, which serves as a the TexasAIM OBH+ Learning Collaborative Charter, and this pre-work document include information and activities that provide an introduction to collaborative work. All team members, leaders and administrators are asked to review this prior to the first learning session:

Orientation Packet/Collaborative Charter

- Background and Overview
- Collaborative Purpose and Aim
- Methods
- Key Drivers of Improvement/Change Package (see page 8, Appendix 1, and Appendix 3)
- Expectations and Support
- Measurement Strategy

Pre-work Document

Facility Checklist and Pre-work Descriptions

If concerns remain around pre-work requirements or if you would like to ask questions of before Learning Session 1, please contact TexasAIM@dshs.texas.gov with your questions or to schedule a call.

Register for the First Learning Session

Learning sessions are a major intervention of the learning collaborative because they convene teams face-to-face to learn from expert faculty and from each other. Through plenary sessions, interactive activities, small group discussions and team meetings held over two days, attendees have the opportunity to:

- Learn from faculty and colleagues
- Receive coaching and hear strategies from expert faculty (topic content, quality improvement methodology, and data collection)
- Gather new information on subject matter and quality improvement
- Share information and create detailed improvement plans
- Complete important team planning work

The Learning Collaborative will involve three Learning Sessions facilitated by TexasAIM (DSHS and THA) and expert faculty. A minimum of 4 and a maximum of 6 team members must attend each of the three Learning Sessions. We ask that each team send:

- The team leader
- A physician or administrator
- A mother partner

Anyone else from your team can fulfill the remaining two slots for the Learning Session. We will require team members traveling to the first Learning Session in October/November to register.

Registration details, dates and locations of regional cohort sessions for Learning Session 1 are in development and will be shared with your as soon as possible.

Develop and Formalize your Improvement Team

Developing a multi-disciplinary team ***(See Orientation Packet, pages 12-13)*** and putting formal team structures (e.g. regular meetings, communications, expectations) in place are critical to your hospital's success with improvement. Formalizing the team is crucial to ensure that all members are aware of their roles and responsibilities and the opportunities provided by participation. Set expectations for your team early and make sure all members are aware of and sign off on the Collaborative goals and expectations.

Develop Individualized Aim Statement

An aim statement is a concise written statement that describes what the team expects to accomplish in the collaborative. It needs to be consistent with the mission, aim and goals of the Collaborative Charter and aligned with the strategic mission and goals of your organization. An effective aim statement is **SMART**:

- **S**pecific
- **M**easureable
- **A**ctionable
- **R**ealistic
- **T**ime-bound

Setting quantitative goals (goals that can be numerically counted or expressed) **helps to:**

- Clarify the aim
- Create healthy tension for change
- Direct data measurement activities
- Identify necessary resources
- Creates motivation for initial changes

Each team will use the below Collaborative Aim as a basis for developing an appropriate individualized aim statement for their facility.

THE TEXASAIM PLUS AIM STATEMENT IS:

3. All Collaborative participants develop and implement a multidisciplinary team response to every massive hemorrhage by January 1, 2020.
4. The proportion of severe maternal morbidity among hemorrhage patients in participating hospitals is reduced by 25% by January 1, 2020.

Your teams' drafted individualized aim statement should take into consideration:

- Strategic objectives of your organization
- Your team's knowledge of the strengths and weaknesses of your maternity care
- The results of your readiness self-assessment
- Existing data

AN EXAMPLE OF AN INDIVIDUALIZED STATEMENT IS:

- By New Years Day 2020, we will reduce severe maternal morbidity throughout the hospital stay from 30% to 22%. We will achieve this by forming a multidisciplinary team (with members from our L&D and postpartum care units) and work to implement evidence-based strategies so that:
- 100% of staff caring for mothers receive training on standardized policies and procedures for readiness, recognition, and response to obstetric hemorrhage.
- 100% of shifts have a rapid response team.
- 100% of births have ongoing objective quantification of actual blood loss and observation of triggers of maternal deterioration during and after delivery.
- 100% staff participate in regular on-site, multidisciplinary hemorrhage drills at a frequency that is adherent with our written policy on obstetric hemorrhage multi-disciplinary simulation drills.
- Documentation of obstetric hemorrhage uses standardized definitions resulting in consistent coding in 100% of hemorrhage events.

In setting your team's individualized aim statement, be sure to do the following:

Efficiently involve senior leaders in development to:

- Provide critical input and feedback on its alignment with your facility's mission
- Give final approval and ensure there is senior leader

buy-in Base your aims on data by:

- Examining data that your team has on hand
- Reviewing information gathered from your baseline assessment exercise

You will continue to refine details of your Individualized Aim Statement during the pre-work phase and will finalize it during Learning Session 1.

Generate a Buzz

Advertise the TexasAIM Plus Obstetric Hemorrhage Learning Collaborative project by posting descriptions including goals, team members list, and dates of the first learning session in related areas (i.e. L&D, maternity, ED, staff lounges, in newsletter, and in internal communications to managers/ directors /administration) to make staff and patients aware of your facility's improvement efforts!

Develop a Storyboard

Each learning session is designed to create an environment conducive to sharing and learning. At the first Learning Session, you will be asked to display a Storyboard that provides other Collaborative teams with background on your facility, team and objectives for this collaborative.

Be sure to efficiently involve senior leaders in Storyboard creation to:

- Solicit critical input and provide awareness during the start-up phase
- Give final approval

We encourage teams to be creative. The purpose of this activity is **not** to create a polished product, but to tell others the story of what you are trying to do. Keep it simple and straightforward- we do not want you to spend a lot of time on this piece, but have fun!

Instructions

Storyboards must be on a three-fold poster board. Tape, glue, scissors and pushpins will be provided at the Learning Session if needed. Teams are responsible for bringing their own storyboard with them.

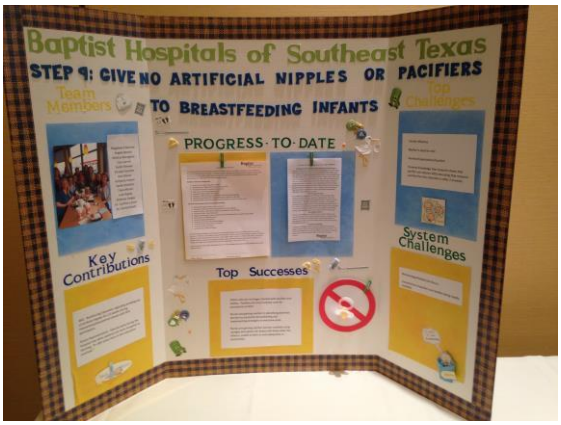
Storyboard Outline Example

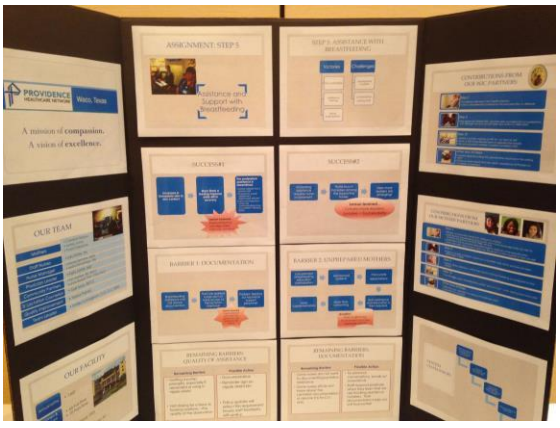
- Name/location of facility
- Brief description of the facility
- Collaborative team members (names, titles, roles)
- Team's individualized aim statement (with numerical goals)
- Number of annual births
- Number of part and full time employees providing maternal care
- Results of your Self-Assessment
- Any changes already made that have promoted maternal health and safety
- Include pictures of team and examples of how project was "advertised" within facility (i.e. project description in lounge)
- Ask 4 people (3 staff and one provider) the question, "I am proud to work at this hospital because…" and include those quotes as part of your storyboard

Display Tips for Storyboard

- Include graphics and pictures
- Include photos (at least of your team)
- Make font size as big as possible
- Keep it basic
- Highlight key messages in color (if you don't have a color printer, use bright highlighters)
- Use clear, understandable titles and labels if you use graphs (i.e. X and Y axes, dates, brief explanation of what it shows, etc.)

Photo examples of storyboards are seen below.





Obstetric Hemorrhage-Readiness Assessment

Requirements-Every Unit	In Place-Consistently Executed	In Place-Not Working	Not In Place	Comments
Hemorrhage cart with supplies, checklist and instruction cards for intrauterine balloons and compressions stitches.				
Immediate access to hemorrhage medications (kit or equivalent).				
Establish a response team-who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services).				
Establish massive and emergency release transfusion protocols (type O negative /uncrossmatched).				
Unit education on protocols, unit-based drills (with post-drill debriefs).				

For each requirement that is not in place and consistently executed, complete an Action Plan

Obstetric Hemorrhage-Recognition & Prevention Assessment

Requirements-Every Patient	In Place-Consistently Executed	In Place-Not Working	Not In Place	Comments
Assessment of hemorrhage risk (prenatal, on admission and at other appropriate times).				
Measurement of cumulative blood loss (formal, as quantitative as possible).				
Active measurement of the 3rd stage of labor (department-wide protocol).				

For each requirement that is not in place and consistently executed, complete an Action Plan

Obstetric Hemorrhage-Response Assessment

Requirements-Every Hemorrhage	In Place-Consistently Executed	In Place-Not Working	Not In Place	Comments
Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists.				
Support program for patients, families and staff for all significant hemorrhages.				

For each requirement that is not in place and consistently executed, complete an Action Plan

Obstetric Hemorrhage-Reporting/Systems Learning Assessment

Requirements-Unit	In Place-Consistently Executed	In Place-Not Working	Not In Place	Comments
Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities.				
Multidisciplinary review of serious hemorrhages for systems issues.				
Monitor outcomes and process metrics in perinatal quality improvement (QI) committee.				

For each requirement that is not in place and consistently executed, complete an Action Plan