CMQCC
CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE

California Partnership for Maternal Safety

Funded by Merck for Mothers

PROJECT OVERVIEW/FAQs

Why is there a focus on maternal mortality and morbidity in California?

- The US rate of maternal mortality has risen from 7.7 per 100,00 births in 1999 to 15.5 per 100,000 births in 2009. The U.S. now ranks 47th in the world. California maternal mortality reviews show that the majority of deaths from obstetric hemorrhage and preeclampsia are preventable. The overall mortality rate for preeclampsia in California is greater than 2 times that of the UK, largely due to differences in deaths caused by stroke related to severe hypertension.
- Obstetric Hemorrhage and Preeclampsia are common (3-6% of all births) and seen frequently on every California obstetric unit. Together they account for over 70% of cases of severe maternal morbidity. In 2007, there were an estimated 380 major complications from preeclampsia in California requiring an ICU admission. Additionally, there were 3400 mothers with preeclampsia or hemorrhage requiring a prolonged postpartum length of stay.
- There is now a national multi-stakeholder effort to improve these maternal outcomes.

What is the California Partnership for Maternal Safety (CPMS)?

- The CPMS is a multi-year multi-stakeholder project comprised of California nurses, midwives, physicians, hospitals, patient safety specialists, and other clinical care experts working together to improve maternity outcomes.
- The focus in California will be implementation of national safety bundles for obstetric hemorrhage and severe hypertension in pregnancy (preeclampsia) using CMQCC's evidence-based and tested Obstetric Hemorrhage and Preeclampsia Toolkits
- The Safety Bundles call upon hospitals to standardize their own approaches to these OB emergencies and introduce system improvement activities to obstetrics such as preparedness, huddles, debriefs and multi-disciplinary case reviews as now recommended by the Joint Commission.
- ACOG, AWHONN, CNMA, and CHA support this work and its' alignment with national efforts.
- The CPMS is funded by Merck for Mothers, both a national and global initiative focused on improving the health and well-being of mothers during pregnancy and childbirth.

Why does your hospital need to be involved?

- CMQCC's work demonstrates that every birthing facility has room to improve their system's readiness and clinician response to emergency obstetric conditions, particularly postpartum hemorrhage and preeclampsia, the two leading causes of preventable mortality and morbidity.
- Data shows that much work needs to be done in reducing maternal mortality and importantly, maternal morbidities.* We have noted that hospitals that have previously implemented the Hemorrhage toolkit may have already completed certain elements of the safety bundle.
- Your participation in this initiative will help reduce morbidities, improve patient care, and bring about change in California hospitals that will align with current national efforts being undertaken by all major professional organizations.

*The Joint Commission (TJC) has recently expanded Sentinel Events to include severe maternal morbidity. This change will take effect in January 2015. CPMS is designed to minimize cases that will meet TJC criteria.

What will the CPMS offer you?

- An unprecedented opportunity to review and change clinical practices to reflect current evidence-based guidelines.
- QI leadership with obstetric RN and MD mentors working with hospital clusters that are based on hospital system, university network, volume-size or geographic criteria.
- The ability to address hospital systems issues and implement changes that will help reduce the risk of adverse events
- Use of the California Maternal Data Center to collect data associated with maternal mortality and morbidity as well as many other metrics available.
- Implementation models through collaborative efforts to support change within your facility/unit
- 'How to' guidance and mentoring around implementation of toolkit and safety bundles
- Resources, both evidence-based and web-based to support quality improvement efforts

What does hospital participation entail?

- Completion of facility inventory checklist (What does my hospital already have in place/completed?)
- Completion of a short quality improvement readiness assessment questionnaire
- Adoption of safety bundles for postpartum hemorrhage and preeclampsia (customized for each unit) in conjunction with the use of CMQCC's Toolkits to address:
    - Readiness for every unit
    - Recognition for every patient
    - Response for every hemorrhage/preeclampsia
    - Reporting/Systems Learning for every unit
- Participation in CMQCC Maternal Data Center for collection of defined outcome metrics (**no cost**)
- Assemble an OB QI team to implement bundles, work with mentors, and analyze results

What is the difference between this Partnership and CMQCC's other learning collaboratives?

- No cost for joining the Partnership
- Work directly with two mentors and small groupings of hospitals (5-8)
- Monthly check-in phone calls
- Work on implementing elements of safety bundles
- Limited data collection required
- Materials, resources and clinical support from CMQCC
    - Opportunity to join California Maternal Data Center for data collection at no charge

What is the timeframe for the CPMS activities?

Fall 2014

- Introduction of the bundles
- Orientation of implementation model
- Participation in informational conference calls for hospitals to learn about the initiative
- Completion of pre-project 'homework'
- Registration in California Maternal Data Center at those hospitals not yet participating

January 2015- February 2016

- Begin model collaborative projects
- Conference report-out calls with mentors/hospitals/CMQCC
- Assistance from CMQCC to hospitals as needed with planning and first steps towards implementation of the toolkits and safety bundles

Questions? Contact: Valerie Cape, vcape@cmqcc.org or Julie Vasher at jvasher@cmqcc.org

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