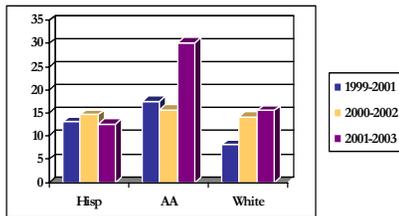


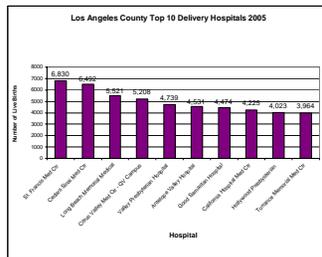
Los Angeles County Maternal Care Quality Improvement Project : Reducing Maternal Hemorrhage: a Multi-Tiered approach

BACKGROUND:

The goal of the Los Angeles County Maternal Care Quality Improvement Project is to reduce the overall incidence of maternal morbidity and mortality by focusing on prevention, recognition, and response to obstetrical hemorrhage (OBH). The project targets obstetrical providers, hospitals, and pregnant women in Los Angeles County at the top 10 delivery hospitals. We have assembled representatives from the American College of Obstetricians and Gynecologists (ACOG), Regional Perinatal Programs of California (RPPC), managed care health plans, community based organizations, local public health departments, key hospitals, and obstetrical providers. Additional partners include the Black Infant Health (BIH) Program, American College of Nurse Midwives, March of Dimes, and other key organizations.



Los Angeles County Maternal Mortality Rates by Ethnicity



Top 10 Delivery Hospitals in Los Angeles County

TIMELINE:

The project is a two year project. It was started October 1, 2008.

The impact of the provider and hospital components will be felt by the beginning of the second year (July 1, 2009). Results of the community and patient education component will be felt by January 1, 2010.

A total of \$198,150 Local Maternal Care Quality Collaborative Grant, funded through Federal Title V MCH Block Grant as well as funds from the State General Fund and Federal Title XIX (Medicaid) is the source of funding for the grant. In addition, the Los Angeles MCAH Program and several of our collaborative partners will contribute a significant amount of in-kind services.

METHODS & GOALS

A three-tiered approach targeting obstetrical providers, hospitals, and pregnant women will be implemented. Collaboration with delivery hospitals will be accomplished through risk management teams, health plans, and RPPC to refine existing hemorrhage protocols, disseminate protocols, and urge implementation of hemorrhage drills, thus enabling implementation of a valid emergency response.

Efforts to improve the accuracy and usefulness of postpartum hemorrhage coding will also be championed by these hospital partners. An early alert system for hospitalized patients at risk for obstetrical hemorrhage will be used to identify high risk women. Our aim is to eventually expand this early alert system to the prenatal care period.

Finally, to inform and educate pregnant women, educational materials related to reducing postpartum hemorrhage risk will be produced.

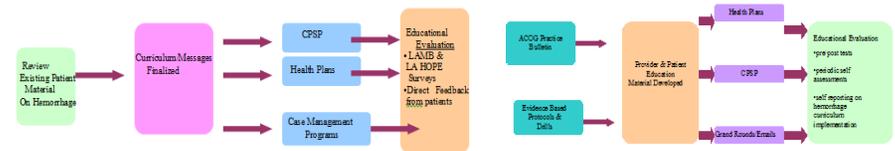


Figure 5. Patient Implementation

Figure 6. Examples for Provider Implementation

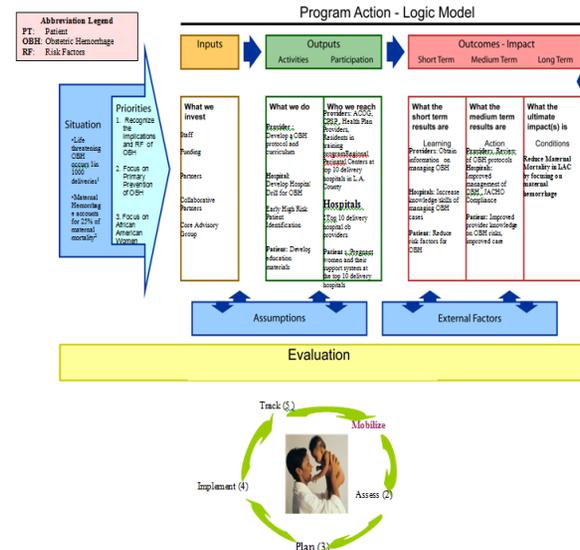


Figure 7. Rapid-Cycle Change Approach to Quality Improvement: MAP IT: Mobilize, Assess, Plan, Implement, Track, Progress