MI AIM
Michigan Alliance for Innovation on Maternal Health

IMPLEMENTATION BRIEFING MATERIALS

IN PARTNERSHIP WITH

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
SCOPE

The Michigan Alliance for Innovation on Maternal Health (MI AIM) is pleased to provide this Implementation tool kit as a quick reference to national protocols intended to continuously improve patient safety in women’s health care. The enclosed information was designed to promote multidisciplinary collaboration and complement the work currently being conducted within your hospital setting to improve maternal outcomes through continuous quality improvement efforts.

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AIM INITIATIVE

Michigan is dedicated to improving the culture of maternal safety to decrease severe maternal morbidity and mortality through the implementation of early recognition safety bundles and data-driven quality improvement initiatives with providers and within hospitals across the state. The MI AIM initiative builds upon the work that was already being done by the Michigan Health and Hospital Association (MHA) Keystone Center, which has supported and guided Michigan hospitals in the identification of best practices for improving maternal health outcomes. The Michigan AIM program also aligns with one of Michigan’s Infant Mortality Reduction Plan goals to support better health status of women and girls through an enhanced network of support systems to promote maternal and women’s health.

MI AIM is comprised of an active Executive Committee whose members participate on four Task Force groups which were established to accomplish the tasks of the AIM initiative. The Task Force Groups include Data Management; Maternal Mortality; Outreach; and Implementation.

The AIM Work plan and implementation activities are structured on these four Task Force Groups. The MI AIM Executive Committee reports to the Policy and Oversight Committee (POC). The function of the POC is to provide oversight and directions to help the Executive Committee and respective Task Forces accomplish its goals. They serve in the capacity to assist with helping to “move the boulders out of the way,” if there are roadblocks.

OVERARCHING GOAL

Michigan’s women will have timely access to and receive safe, quality healthcare in pregnancy, labor and delivery and achieve optimal health.

EXPECTED OUTCOME

Michigan’s pregnancy related mortality and severe maternal morbidity rate related to hemorrhage and pre-eclampsia/hypertension during 2013-2015 will decrease by 50% by 2020.

AIM OBJECTIVES

- 100% of hospitals will have participated in AIM Baseline Survey by April 30, 2016
- 100% of hospitals will have submitted baseline HDD to MHA by August 2016.
- 100 of hospitals will have a Hemorrhage Cart by December 2017
- 100% of hospitals will have a Hemorrhage protocol in place by December 2017
- 100% of hospitals will have a Hypertension/preeclampsia protocol in place by December 2018
- 100% of hospitals will be performing regular, multidisciplinary simulation (drills) for postpartum hemorrhage by December 2018
MICHIGAN MORTALITY & MORBIDITY DATA

• Maternal mortality in the United States exceeds that of other developed nations and has been increasing in the past few decades. Every year in Michigan, around 25 women die from complications related to pregnancy or childbirth. In addition, for every maternal death, 100 more women suffer from serious complications that put their life at risk. Severe maternal morbidity occurs in nearly 2% of all delivery hospitalizations in Michigan and black women experience complications almost two times more frequently than white women. We believe that perhaps one half of these deaths and severe illnesses may be preventable.

• This has led to Michigan joining a nationwide effort to improve maternal safety and reduce preventable maternal deaths. We have one of the longest continuously active maternal mortality review committees in the country and we believe that by improving the care we offer, we can prevent many more maternal complications and deaths.
SEVERE MATERNAL MORBIDITY (SMM)

CDC DEFINITION

Denominator: All mothers during their birth admission, excluding ectopic pregnancies and miscarriages

Numerator: Among the denominator, all cases with any Severe Maternal SMM Code:

- Acute myocardial infarction
- Acute renal failure
- Adult respiratory distress syndrome
- Amniotic fluid embolism
- Aneurysm
- Cardiac arrest/ventricular fibrillation
- Disseminated intravascular coagulation
- Eclampsia
- Heart failure during procedure or surgery
- Puerperal cerebrovascular disorders
- Pulmonary edema
- Severe anesthesia complications
- Sepsis
- Shock
- Sickle cell anemia with crisis
- Thrombotic embolism
- Blood transfusion
- Conversion of cardiac rhythm
- Hysterectomy
- Temporary tracheostomy
- Ventilation
SAFETY BUNDLES

The two bundles that follow represent a “Michigan-take” on the national protocols and cover briefly, simply, but completely, the minimum of what hospital policies and clinical practice must cover to care appropriately for obstetric hemorrhage and hypertension. These are preceded by a key to early appropriate intervention, early detection of warning signs.

Calligram (noun): a word or phrase or piece of text arranged to form a picture of the subject described.

Hypertension and Hemorrhage calligrams provided by Bob Lorenz, MD (2016)
MATERNAL EARLY WARNING SYSTEM (MEWS)

BACKGROUND

Forty to fifty percent of cases of maternal mortality and severe maternal morbidity are preventable. Delays in identification and treatment are major contributors to preventable adverse outcomes. As of 2010, The Joint Commission required hospitals in the United States to “develop written criteria describing early warning signs of a change or deterioration in a patient’s condition and when to seek further assistance,” and to “have staff seek additional assistance when they have concerns about a patient’s condition.”

_MI AIM recommends adoption of a Maternal Early Warning System1_

OBJECTIVE

All birthing institutions should have an established system for all pregnant and postpartum patients. The system should delineate a method for identification and response. One method is excerpted here:

IDENTIFICATION

The Maternal Early Obstetric Warning Criteria include any of the following:

- Systolic BP (mm Hg) <90 or >160
- Diastolic BP (mm Hg) >100
- Heart rate (beats per min) <50 or >120
- Respiratory rate (breaths per min) <10 or >30
- Oxygen saturation on room air, at sea level, <95%
- Oliguria, mL/hr for 2 hours <35
- Maternal agitation, confusion, or unresponsiveness
- Patient with preeclampsia reporting a non-remitting headache or shortness of breath

These triggers cannot address every possible clinical scenario that could be faced by an obstetric clinician and must not replace clinical judgment. As a core safety principle, bedside nurses should always feel comfortable to escalate their concerns at any point.
RESPONSE

All women who meet any of The Maternal Early Obstetric Warning Criteria should receive prompt bedside evaluation by a physician or other clinician with the ability to activate resources in order to initiate emergency diagnostic and therapeutic interventions as needed. Specific processes to request bedside evaluation should be established at a local level.

Critical components of an effective communication policy should define:
• Who to notify
• How to notify them
• When and how to activate the clinical chain of command in order to ensure an appropriate response

RECOMMENDATIONS

MI AIM recommends adoption of a Maternal Early Obstetric Warning System and the following tools for communication:
• SBAR – Situation, Background, Assessment and Recommendation
• CUS – Concerned, Uncomfortable, Safe

OBSTETRIC HEMORRHAGE BUNDLE

Background—Hemorrhage is the most frequent cause of severe maternal morbidity and preventable maternal mortality and therefore is an ideal topic for the initial national maternity patient safety bundle. *Obstet Gynecol.* 2015 Nov;126(5):1111

REACHIBILITY:

1. Hemorrhage cart available and accessible to include:
2. Vaginal retractors; long weighted speculum
   - Long instruments (needle holder, scissors, Kelly clamps, sponge forceps)
   - Intrauterine balloon
   - Banjo curette
   - Bright task light
   - Intrauterine balloon
   - Procedural instructions (balloon, B-Lynch, arterial ligations)
   - #1 chromic or plain catgut suture & reloadable needle for B-Lynch sutures

| RISK ASSESSMENT: ADMISSION | | | |
|----------------------------|--|--|
| MEDIUM RISK | HIGH RISK |
| Prior cesarean, or uterine surgery or multiple laparotomies | Placenta previa, low lying placenta |
| Multiple gestation | Suspected placenta accrete, percreta, increta |
| > 4 previous births | Platelets < 70,000 |
| EFW>4000gms | Active bleeding (greater than show) on admit |
| History of previous post-partum hemorrhage | Known coagulopathy |
| Large uterine fibroids | > 2 medium risk factors |
| Obesity (BMI>40) | |
| Hematocrit < 30 & other risk factors | |
| Platelets < 100,000 | |

| RISK ASSESSMENT: INTRAPARTUM | | | |
|----------------------------|--|--|
| MEDIUM RISK | HIGH RISK |
| Prolonged second stage | New active bleeding |
| Magnesium sulfate | > 2 medium risk factors (admission & intrapartum) |
| Chorioamnionitis | |
| Prolonged oxytocin >24 hours | |
3. Medications:
   • Oxytocin (Pitocin) 10-40 units per 500-1000mL solution
   • Misoprostol (Cytotec)
   • 15-methyl PGF$_2$$\alpha$ (Hemabate, Carboprost)
   • Methylergonovine (Methergine)

Tranexamic acid is a relatively inexpensive anti-fibrinolytic drug that has been useful for prevention and treatment of bleeding in various clinical settings, such as surgery and trauma. A recent large international randomized clinical trial of over 20,000 women with post-partum hemorrhage showed benefits of reduction in mortality without increase in adverse effects. Though currently under review by US scientific professional organizations, administration of tranexamic acid upon diagnosis of PPH, ideally within three hours of delivery may be considered. One gram (10 mL of a 100mg/mL solution) is infused over 10 to 20 minutes, as infusion >1 mL/minute can cause hypotension.

Tranexamic acid should not be mixed with blood or given through a line with blood, or mixed with solutions containing penicillin. It should not be given to patients with subarachnoid hemorrhage or active intravascular clotting (disseminated intravascular coagulation). The dose should be reduced in patients with renal insufficiency, venous or arterial thrombosis, or ureteral bleeding.

REFERENCE:

4. Establish an Obstetrical Rapid Response Team to include:
   • Obstetrician
   • Nursing (team coordinator)
   • Anesthesia
   • Blood Bank
   • Pharmacy
   • Advanced pelvic surgeon when available
5. Massive Transfusion Protocol
6. Educate unit on quantifying blood loss and hemorrhage protocols
7. Implement simulations, drills and debriefs
RECOGNITION AND PREVENTION:
1. ALL pregnant women admitted for delivery will be prospectively risk-assessed for PPH on ADMISSION & INTRAPARTUM

Blood available according to risk – Medium: TYPE & SCREEN High: TYPE & CROSS
Tools to assist with quantifying blood loss: MI AIM recommends under buttock drapes

2. Protocol for active management of the third stage of labor: Include administration of uterotonic agents, controlled cord traction, and uterine massage after placenta delivery

RESPONSE:

Stage 1: Blood loss > 500 mL vaginal OR blood loss > 1000 mL cesarean with normal vital signs and lab values

Stage 2: Continued Bleeding (EBL up to 1500mL OR > 2 uterotonics) with normal vital signs and lab values

Stage 3: Continued Bleeding (EBL > 1500mL OR > 2 RBCs given OR at risk for occult bleeding/coagulopathy OR any patient with abnormal vital signs/labs/oliguria)

Stage 4: Cardiovascular Collapse (massive hemorrhage, profound hypovolemic shock, or amniotic fluid embolism)

MANAGEMENT TIPS (MAINTAIN DOCUMENTATION OF ACTIONS AND TIME):
1. Double IV Access gauge 16 if possible.
2. Increase oxytocin infusion 10 to 40 U / 500 or 1,000 ML , drip for 4 hours
3. Continue uterine massage and Insert Foley
4. Methergine 0. 2 mg IM IF no maternal hypertension. May be repeated in 2 hours
5. CALL FOR BLOOD Initiate first unit of PRBC
6. Hemabate  250 mcg IM
7. Cytotec* may use 800-1000 mcg. Rectal OR 600 mcg p.o OR 800 mcg sublingual IF no asthma
8. Alert O.R, communicate PLAN. (PP curettage, BAKRI, sutures, hysterectomy, other)
9. Secure ICU bed if appropriate
10. PPH FOLLOW UP Monitor clinical status, consider po meds for next 3 days,(methergine 0.2 mg q-6-8 hrs) if no contraindications Check with pediatrician if breast feeding

REPORTING:
- Huddle for high risk patients with post event debriefs
- Multidisciplinary review of all serious hemorrhages
MATERNAL HYPERTENSION BUNDLE

OBJECTIVE:
Risk reduction and safe clinical outcomes for women with preeclampsia or eclampsia require appropriate and prompt management of severe range systolic and diastolic blood pressures. Introducing standardized, evidence-based clinical guidelines for preeclampsia and eclampsia has been demonstrated to reduce adverse maternal outcomes.

*American College of Obstetricians and Gynecologists. Hypertension in pregnancy. 2013*

READINESS:
1. Adopt protocols for severe preeclampsia/eclampsia management
   a. *MI AIM recommends Severe Hypertension in Pregnancy Checklist, ACOG Safe Motherhood Initiative*
2. Ensure timely evaluation of pregnant and postpartum hypertension
3. Immediate access to medications used for severe hypertension and eclampsia in the unit
   b. *MI AIM recommends labetalol, hydralazine, nifedipine, for blood pressure management; magnesium sulfate, lorazepam, diazepam for seizure management*
4. Implement Unit based drills with post drill debriefs

RECOGNITION:
2. After severe range blood pressure check BP: every 10 minutes for 1 hour, every 15 minutes for next hour, every 30 minutes for next hour, every hour for 4 hours
3. Obtain baseline labs: CBC, Platelets, LDH, Liver Function Tests, Electrolytes, BUN, creatinine, Urine protein
4. Standard response to:
   a. Vital signs – Maternal early warning signs
   b. CNS – headaches, visual disturbance
   c. Hepatic – > 2-fold elevation in transaminases, epigastric pain
   d. Blood – platelets < 100,00/mm3, hemolysis
   e. Renal – Creatinine > 1.1 mg/dl or doubled
   f. Respiratory – Pulmonary edema
5. Prenatal and postpartum patient education
RESPONSE:

1. Notification primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
2. After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)
3. Medication algorithms

HYPERTENSION MEDICATIONS

A. LABETALOL ALGORITHM
   IF NO IV ACCESS: Use oral labetalol 200 mg, repeat in 30 minutes.

   INTRAVENOUS
   Labetalol 20 mg IV push 2 min. Repeat BP in 10 min. IF BP still syst ≥160 OR diast ≥110
   Labetalol 40 mg IV push 2 min. Check BP in 10 min. IF BP still syst ≥160 OR diast ≥110
   Labetalol 80 mg IV push 2 min. Check BP in 10 min. IF BP still syst ≥160 OR diast ≥110
   Labetalol 80 mg IV push 2 min. Check BP in 10 min. IF BP below threshold repeat BP in 10 min.*
   • IF syst ≥ 160 OR diast ≥ 110 HYDRALAZINE 10 mg IV push in 2 minutes REPEAT BP in 20 minutes
   • IF syst ≥ 160 OR diast ≥ 110

   *Maximum Labetalol 220 mg in 24 hrs. NO labetalol if maternal pulse below 60 bpm.
   Emergency consultation: Discuss, document, delivery plans. Follow consultant’s recommendation for additional antihypertensives.
   • IF viable fetus, initiate surveillance appropriate for gestational age, per local protocol.

B. HYDRALAZINE ALGORITHM
   INTRAVENOUS
   Hydralazine 5 or 10 mg IV push in 2 min. Repeat BP in 20 min. IF BP still syst ≥160 OR diast ≥110
   Hydralazine 10 mg IV push in 2 min. Repeat BP in 20 min. IF BP still syst ≥160 OR diast ≥110*
   • IF BP below threshold continue BP monitoring.
   • IF BP still syst ≥160 OR diast ≥110, LABETALOL 20 mg IV push in 2 min Repeat BP in 10 min.
   • IF BP still syst ≥160 OR diast ≥110, LABETALOL 40 mg IV push AND consult.

   Continue care as per the steps described above.
   *Maximum Hydralazine 25 mg in 24 hours

C. NIFEDIPINE ALGORITHM:
   May start this algorithm if there is no IV access
   • Oral NIFEDIPINE 10 mg Repeat BP in 20 min. IF BP still syst ≥160 OR diast ≥110
   • Oral NIFEDIPINE 20 mg IF below threshold continue BP monitoring
   • IF BP still syst ≥160 OR diast ≥110 Oral NIFEDIPINE 40 mg* AND consult
SEIZURE PROPHYLAXIS

A. MAGNESIUM SULFATE ALGORITHM:
   - IV bolus of 4-6 grams in 100 ml over 20 minutes, followed by IV infusion of 1-2 grams per hour
   - Continue for 24 hours postpartum
   - If no IV access, 10 grams of 50% solution IM (5 g in each buttock)
   - Contraindications: pulmonary edema, renal failure, myasthenia gravis

B. ANTICONVULSANTS ALGORITHM:
   - For recurrent seizures or when magnesium is C/I:
     - Lorazepam: 2-4 mg IV x 1, may repeat x 1 after 10-15 min
     - Diazepam: 5-10 mg IV every 5-10 min to max dose 30 mg
     - Phenytoin: 15-20 mg/kg IV x 1, may repeat 10 mg/kg IV after 20 min if no response.
       Avoid with hypotension, may cause cardiac arrhythmias.
     - Keppra: 500 mg IV or orally, may repeat in 12 hours. Dose adjustment needed if renal impairment

POSTPARTUM MANAGEMENT

- Measure BP every 4 hours after delivery until stable
- Do not use NSAIDs for women with elevated BP
- Persistent SBP ≥ 160 or DBP ≥ 110 should be treated within 1 hour
- Treat HTN: SBP ≥ 150 or DBP ≥ 100 on at least two occasions at least 4 hours apart
- Do not discharge patient until BP is well controlled for at least 24 hours
- Outpatient follow-up: within 3-5 days or again in 7-10 days after delivery (if symptoms)

MI AIM RECOMMENDATIONS

1. Eclampsia Checklist, ACOG Safe Motherhood Initiative
2. Establishing policy for transfer of stable patients according to ACOG Levels of Maternal Care and consultation

REPORTING

1. Huddle for high risk patients with post event debriefs
2. Multidisciplinary review of all severe hypertension/eclampsia cases
3. MI AIM endorses development of a perinatal quality team at each center
THE JOINT COMMISSION SEVERE MATERNAL MORBIDITY REVIEWS

DEFINITIONS

- MITransfusion of 4 or more units of blood (revised to > 4 units of RBCs)
- Admission of a pregnant or postpartum woman to an ICU.
- Sentinel event: “a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, or severe temporary harm”

EXAMPLES

1. A G4P3 woman with known placenta accreta underwent cesarean birth during which profound, bleeding occurs, requiring 4 units of packed red blood cells. She was monitored in the ICU overnight with a subsequent unremarkable postpartum stay and was discharged.

   Comment: Since this woman received four units of packed red blood cells and required ICU admission, this case meets the criteria for severe maternal morbidity and should undergo a multidisciplinary review. Although there may be identification of areas for improvement (these might include interventional radiology or consult with gynecologic oncology for additional surgical experience), this does not meet the criteria for a Joint Commission sentinel event because the patient’s underlying condition (placenta accreta) would be expected to result in this type of blood loss. Nevertheless, there may be areas for improvement to be identified.

2. G1P0 woman with gestational diabetes and preeclampsia was admitted for a medically indicated induction of labor.

   Her cervix was long and closed, a long induction ensued, and after 36 hours of oxytocin induction with an epidural and two hours of pushing, she had a vaginal birth. After spontaneous delivery of an intact placenta, she hemorrhaged profusely. She required 6 units of packed red blood cells and was transferred to the ICU in unstable condition.

   Comment: This case also meets the definition for severe maternal morbidity and should undergo multidisciplinary review. Furthermore, this outcome is not due to the patient’s underlying medical condition and therefore meets the criteria for a Joint Commission sentinel event.

SEVERE MATERNAL MORBIDITY (SMM) REVIEW

- All cases of SMM should undergo a multidisciplinary review analysis, resulting in an action plan for improvement, when appropriate.
- If the case of severe maternal morbidity meets the definition for a Joint Commission Sentinel Event, the case should be referred for Root Cause Analysis Process
• Multidisciplinary committee at facility to review could include: Obstetrical providers (obstetricians, family physicians, midwives); Anesthesia providers, Obstetric care nurses, quality improvement analysists, administrators. Consider including patient advocate, Pharmacist, blood bank and IT staff.
• If small center, consider partnering with regional perinatal center or outsourcing the review.
• Facility leadership and coordinating team should develop system for detection of SMM cases in real time
• SMM case should have initial brief timely review to determine if it meets a sentinel event status
• If sentinel event should proceed to the Root Cause Analysis process immediately since this has to be completed within 90 days
• Data should be extracted with standard template by trained extractor in preparation for review (http://safehealthcareforeverywoman.org)
• All SMM cases reviewed regularly possibly quarterly by the SMM multidisciplinary committee
• Report and action plan are developed, implemented and monitored

“A review of the more common causes of severe maternal morbidity is likely to provide a more clinically relevant measure of the standard of maternal care.”

Professor Thomas F. Baskett, MB
### TEAMSTEPPS TOOLS & STRATEGIES

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<th>TOOL</th>
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| 1.   | SBAR (Situation, Background, Assessment, recommendation) | Communicating critical information requiring immediate action about patient’s condition | • Situation: chief complaint  
• Background: clinical context  
• Assessment: current problem  
• Recommendation: what to correct the problem |
| 2.   | Call-out | Communicate important critical information | • Informs all team-members simultaneously during emergent situations  
• Help them anticipate next steps  
• Direct responsibility to a specific individual to carry out a task |
| 3.   | Check-back | Closed loop communication to ensure information is received as intended | • Sender initiates the message  
• Receiver accepts message and provides feedback  
• Sender double-checks to ensure that message was received |
| 4.   | Handoff | Transfer of information, authority & responsibility during transitions in care I-PASS | • I - Introduction  
• P - Patient  
• A - Assessment  
• S - Situation  
• S - Safety concerns |
| 5.   | Brief | Sharing the Plan: Short session prior to start to share plan with team | • Who is on the team  
• Members agree on goals  
• Roles and responsibilities are clear  
• Plan of care  
• Team availability during shift  
• Workload sharing  
• Resources availability |
<p>| 6.   | Huddle | Monitoring and Modifying the Plan: | • Ad-hoc meeting to re-establish situational awareness; reinforce plans already in place and assess the need to adjust or modify the plan |</p>
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| 7. Debrief           | How did we do? Reviewing Team Performance: to improve team performance & effectiveness through lessons learned and reinforcement of positive behavior | • Communication clear  
• Roles & responsibilities understood  
• Situation awareness maintained  
• Workload distribution equitable  
• Task assistance used  
• Errors made or avoided  
• What went well  
• What should improve |
| 8. Situation monitoring | Safety rounds to know what is going on                                      | • Status of Patient  
• Team members  
• Environment  
• Progress towards goal |
| 9. Cross monitoring | Error reduction strategy                                                 | • Monitoring actions of other team members  
• Providing safety net within team  
• Mistakes & oversights caught quickly & easily  
• Watching each other’s back |
| 10. I'M SAFE         | Well-being of Team members                                              | • Illness  
• Medication  
• Stress  
• Alcohol or drugs  
• Fatigue  
• Eating & Elimination |
| 11. Task Assistance  | Helping each other with tasks builds a strong team                       | • Protect each other from work overload  
• Offers & request for assistance in context of patient safety  
• Assistance will be actively offered and sought |
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<tr>
<td>12. Feedback</td>
<td>Information provided to team members for the purpose of improving team performance</td>
<td>• Timely, respectful, specific, directed, considerate</td>
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| 13. Two-Challenge Rule | Empowers all team members to Stop the line if they sense or discover essential safety breach | • Speak-up at least twice  
• Team member being challenged acknowledged that concern has been heard |
| 14. Leadership | Effective chain of command                                                | • If a safety issue has not been resolved  
• Team member should be able to access supervisor and chain of command timely, with fear or risk of retaliation |
| 15. CUS      | Assertive statements                                                     | • I’m concerned  
• I’m uncomfortable  
• I’m scared                                                   |
| 16. DESC     | Constructive approach for managing and resolving interpersonal conflicts | **D** - Describe behavior  
**E** - Express concerns  
**S** - Suggest alternatives, seek agreement  
**C** - Consequences strive for consensus |
8 STEPS OF CHANGE

John Kotter

TeamSTEPPS Change Management
Team Strategies & Tools to Enhance Performance & Patient Safety

KEY PRINCIPLES

TEAM STRUCTURE
Identification of the components of a multi-team system that must work together effectively to ensure patient safety

COMMUNICATION
Structured process by which information is clearly and accurately exchanged among team members

LEADERSHIP
Ability to maximize the activities of team members by ensuring that team actions are understood, changes in information are shared, and team members have the necessary resources

SITUATION MONITORING
Process of actively scanning and assessing situational elements to gain information or understanding, or to maintain awareness to support team functioning

MUTUAL SUPPORT
Ability to anticipate and support team members’ needs through accurate knowledge about their responsibilities and workload
The State of Michigan is divided into ten prosperity regions. These regions group hospitals together by geographic location. Each region has a representative with Michigan AIM. Refer to the map below for your organization and regional leader.
### IMPORTANT CONTACTS RESOURCES

The following resources are available for questions related to the Michigan AIM project.

- For bundle implementation and toolkit resources access the information via the internet by following the link. [http://safehealthcareforeverywoman.org/aim.php](http://safehealthcareforeverywoman.org/aim.php)
- For increased understanding of the data submission contact Megan Black at Michigan Hospital Association [mblack@mha.org](mailto:mblack@mha.org)
- For TeamSTEPPS Master Training course and other resources: [https://www.ahrq.gov/teamstepps/instructor/index.html](https://www.ahrq.gov/teamstepps/instructor/index.html)

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<th>Region</th>
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<th>Contact Name 2</th>
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<tbody>
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