MI-AIM
Orientation Manual for Outreach and Implementation
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Dear Reader:

On behalf of everyone at Michigan AIM, we want to thank you for volunteering to assist in reducing maternal morbidity and mortality. We look forward to working with you to improve the care of women and support our colleagues in their efforts with one of the teams below:

**Data**
Kayla Vanden Esschert, Megan Black, Sarah Lyon-Callo

**Maternal Mortality**
Bob Lorenz, Frank Anderson, Glenn Copeland

**Outreach**
Jody Jones, Federico Mariona, Cheryl Gibson-Fountain; Amy Zaagman; Dotun Ogunyemi, Lisa Kane-Low, Megan Diebel

**Implementation**
Mary Shubert, Megan Black, Dotun Ogunyemi, Sam Watson

Again, thank you for your participation.

Sincerely yours,

Robert J. Sokol, M.D.

Lynette Biery, PA-C, MSc
AIM Program Overview

The Alliance for Innovation on Maternal Health (AIM) Program is a national partnership of organizations poised to reduce severe maternal morbidity by 100,000 events and maternal mortality by 1,000 deaths by 2018. The AIM Core Partnership includes: American College of Nurse Midwives (ACNM), American College of Obstetricians and Gynecologists (ACOG), Association of Maternal and Child Health Programs (AMCHP), Association of State and Territorial Health Officials (ASTHO), Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN), California Maternal Quality Care Collaborative (CMQCC), Society of Maternal-Fetal Medicine (SMFM), The Health Resources and Services Administration Maternal and Child Health Bureau (HRSA-MCHB)

Background

Over the next 4 years, the AIM Program will provide intensive technical assistance and implementation support to eight states with the highest rates of maternal morbidity and mortality in our nation. These eight states will be chosen according to three priority criteria: high acuity, data infrastructure and capacity, and leadership engagement.

Simultaneously with this eight state cohort, the AIM Program will engage with interested states and birth facilities to ensure continuous and effective capacity-building of system factors to reduce the overall U.S. maternal morbidity and maternal mortality.

The purpose of the AIM Program is to equip, empower and embolden every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider in the U.S to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices. The AIM Program is designed to complement current maternal safety initiatives in progress, as well as drive continuous quality improvement on a state and birth facility level through:

- Alignment of national, state, and hospital level efforts to improve maternal health and safety
- Integration of system based improvement initiatives to reduce adverse maternal outcomes
- Harmonization of data-driven rapid cycle and continuous quality improvement processes
- Access to evidence-based resources to streamline maternal safety bundle implementation

Brief Overview

State MCH Personnel, Health Officials and Hospital Associations

- Title V MCH Services Block Grant: AIM provides evidence-based strategies to impact National Performance Measures and National Outcomes Measures
AIM OVERVIEW

- **Infant Mortality Collab:** AIM reinforces the understanding that healthy maternal outcomes reduces infant mortality
- **Maternal Mortality Review Committees:** AIM is a powerful vehicle to implement MMR recommendations
- **Healthy Start Programs:** AIM promotes improved postpartum care strategies

Maternity Care Providers, Perinatal Quality Collaboratives, Hospital Network/Systems, and Birth Facilities

- AIM equips stakeholders with strategies to address racial disparities within peripartum care
- AIM aligns with efforts to reduce the number of high risk births in low resource birth facilities
- AIM facilitates a multidisciplinary and multi-stakeholder team-based approach to improve maternal safety
- AIM supports the Joint Commission (TJC) requirement for hospitals to perform a multidisciplinary in-depth review of severe maternal events
- AIM utilizes rapid cycle and continuous quality improvement processes to improve maternal safety practices

**Michigan’s Goals**

**Overarching Goal:** Engage physicians, nurse midwives, nurse leaders and administrators among all participating MI AIM sites.

**Expected Outcomes:** Network AIM physicians, nurse midwives, nurse leaders and senior hospital administrators among all participating MI AIM sites with emphasis on continued and consistent participation.

1. Improved access and collection of data from all labor and delivery units
2. Create regional teams to provide resources to birthing centers for OB Hemorrhage and Maternal Hypertension Bundles
3. Utilize dashboards to monitor progress in real time
4. Educate physicians and nurses in related specialties, first responders, allied health associates on safety bundles
5. Increase AIM funding
6. Network with state organizations to share AIM message and solicit funding from private and public sources
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

**READINESS:**
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

<table>
<thead>
<tr>
<th>Medium Risk</th>
<th>High Risk</th>
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<tbody>
<tr>
<td>Prior cesarean, or uterine surgery or multiple</td>
<td>Placenta previa, low lying placenta</td>
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<td>laparotomies</td>
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<tr>
<td>Multiple gestation</td>
<td>Suspected placenta accrete, percreta, increta</td>
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<td>&gt; 4 previous births</td>
<td>Platelets &lt; 70,000</td>
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<td>EFW&gt;4000gms</td>
<td>Active bleeding (greater than show) on admit</td>
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<tr>
<td>History of previous post-partum hemorrhage</td>
<td>Known coagulopathy</td>
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<tr>
<td>Large uterine fibroids</td>
<td>&gt; 2 medium risk factors</td>
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<td>Obesity (BMI&gt;40)</td>
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<tr>
<td>Hematocrit &lt; 30 &amp; other risk factors</td>
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<tr>
<td>Platelets &lt; 100,000</td>
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### Risk Assessment: Intrapartum

<table>
<thead>
<tr>
<th>Medium Risk</th>
<th>High Risk</th>
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<tbody>
<tr>
<td>Prolonged second stage</td>
<td>New active bleeding</td>
</tr>
<tr>
<td>Magnesium sulfate</td>
<td>&gt; 2 medium risk factors (admission &amp; intrapartum)</td>
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<tr>
<td>Chorioamnionitis</td>
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<tr>
<td>Prolonged oxytocin &gt;24 hours</td>
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</table>
3. Medications:
   - Oxytocin (Pitocin) 10-40 units per 500-1000mL solution
   - Misoprostol (Cytotec)
   - 15-methyl PGF₂α (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 Acess 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. HYDRAHALAZINE 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
Patient Safety Criteria

MATERNAL EARLY WARNING SYSTEM

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 requires 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 System.

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 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 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 Warning System and the following tools for communication:
- SBAR — Situation, Background, Assessment and Recommendation
- CUS — Concerned, Uncomfortable, Safe


Revised 11/2/2016
Roles and Responsibilities

The primary goal of the Michigan AIM project is full implementation of the ACOG hemorrhage and hypertension safety bundles in all of Michigan’s birthing hospitals. The Michigan AIM Executive Committee and leadership of the Outreach & Implementation Committee recognized that hospitals are at a variety of stages along the path of attaining the full implementation goal and improved efficiency and effectiveness could be achieved if the Outreach & Implementation Committee were split by two key functions – outreach and implementation. Key tasks of the Outreach Committee are the initial engagement of hospital administration and clinical leadership in MI-AIM and technical assistance and guidance in the early stages of safety bundle implementation planning and launch. Key tasks of the Implementation Committee are the technical assistance, best practices, and consultation required to move hospitals to full clinical integration and sustainment of the safety bundles as well as consistent, quality data submission.

Outreach

The primary objectives of Outreach will be identifying and engaging the administrative and clinical leadership of hospitals who have not begun to work on the ACOG safety bundles or are in the early stages of planning for bundle implementation. (These hospitals are assigned positions in the bottom two quartiles.) The Outreach Committee will facilitate phone calls and visits to the hospitals (as needed) to provide guidance and consultation on the clinical, administrative, and data activities required for participation in the MI-AIM Project. The Outreach Committee will use the results of the MI-AIM survey to call and email clinical and/or administrative contacts to begin the engagement process. The Outreach Committee will also use contacts to encourage hospitals that have not completed the survey to do so. Additional tasks are delineated in the table below.

Implementation

The primary objective of Implementation will be contacting the hospitals that have moved into early launch or sustainment of one or both safety bundles. (These hospitals are assigned to the top two quartiles.) This team will provide calls to assist hospitals with the clinical, administrative and technical skills and strategies required to fully implement and sustain both safety bundles. Topics will include – quality improvement methods and best practices, data collection and submission, guidance on clinical issues, and sharing of success outcomes. Additional tasks are delineated in the table below.
The primary goal of the Site Visit is to help Michigan Hospitals reach full implementation of the ACOG hemorrhage and hypertension safety bundles. The site visits will provide information to hospitals that need assistance to incorporate bundles, engage hospital administrators, and/or clarify bundle components.

1. Pre-Visit
   a. Phone Protocol (pg. 12-13)
   b. Prior to visit, send email with attachments: AIM PowerPoint & AIM Briefing Book

2. Day of Visit (attachments)
   a. Provide background and information for Bundles (pg. 3-10)
   b. Current State of Implementation (pg. 14)
   c. Wrap-up
   d. Q & A

3. Follow-up Information
   a. Post Visit Survey/Evaluation
      https://msu.co1.qualtrics.com/jfe/form/SV_9QAM9lG7Plhm14V
   b. Reimbursement form (attachment)

4. Additional Resources
   a. MI AIM Monthly webinars can be found here: http://ihp.msu.edu/ under the MI AIM tab
THE ISSUE

- Every year, about 25 women in Michigan die from complications related to pregnancy or childbirth. In addition, for every woman who dies in childbirth, 100 more suffer severe life-threatening injury, infection or disease – that’s about 2500 young women/mothers per year.

- The leading causes of pregnancy-related death are hemorrhage, hypertensive preeclampsia, embolism, amniotic fluid embolism, infection, and an exacerbation of pre-existing chronic conditions.
  
  - In the United States, maternal morbidities have increased 50 percent in the past decade and we now rank 64th in the world for maternal mortality – we are one of the very worst of the industrialized countries.
  
  - Michigan’s reported maternal mortality is high, with Detroit having three times the nation’s maternal mortality rate. African-American women have a death rate that is three to four times that of any other racial group. This may well be the highest disparity ratio of any calculated by public health officials. We are very far from health equity.

MICHIGAN CARES

- Michigan is dedicated to improving the culture of maternal safety to decrease maternal morbidity and mortality through the Alliance for Innovation on Maternal Health (AIM) Program.

- The Alliance for Innovation on Maternal Health (AIM) Program is a national partnership of organizations poised to reduce severe maternal morbidity by 100,000 events and maternal mortality by 1,000 deaths by 2018.

- The Michigan Department of Health and Human Services, along with the Michigan Health and Hospital Association (MHA) and Wayne State University have joined more than 30 national and local organizations to significantly reduce severe morbidity and maternal mortality across the state of Michigan. The Michigan initiative is called MI AIM (my aim).

- The MI AIM initiative builds upon the work already being done by the Michigan Health and Hospital Association (MHA) Keystone Center, which has pioneered patient safety interventions across the patient care spectrum, as well as on the work of the state’s Maternal Mortality Committee.

The MI AIM program aligns with Michigan Department of Health and Human Service’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.
Hello Dr Ms this is ........ from the **Alliance for Innovation on Maternal Health** AIM group in Michigan; is this a good time to interrupt you to talk about the AIM project at your center?

**IF NO:**
Can you give me a time to call you back or a way to contact another team member that may be available?

**IF YES:**
I am a member of the Michigan group working on the AIM project.
The reason for my calling is our interest in knowing how the bundles implementation is progressing with your group and if there is anything we can do to assist. The **objective** is to reduce maternal mortality and severe morbidity in the State. We are concentrating on both the hemorrhage (PPH) and the hypertension (HTN) bundles. We should accomplish this conversation in less than 15 minutes.

Your role at the Center?
How long have you been doing it?
Are you currently implementing the bundles?
  - If Yes: are you experiencing any challenges
  - If NO: What are the barriers
Is anyone from your organization participating in the webinars or meetings on line related to the MIAIM project?
Are you close partners with blood bank, anesthesia pharmacy laboratory
**Would you be interested in a site visit from the Michigan AIM group to assist you on your journey?**
If Yes when can we schedule a follow up phone call: Date: Time:
If No
Let me leave you a phone number to contact and an email so we can keep in touch, update the progress, share experiences and continue learning from each other.

Thank you so very much for your time and information.
# Previsit Organizational Support Template

## Hospital Level Previsit Information Gathering:

<table>
<thead>
<tr>
<th>Name of Organization:</th>
<th>Site champion or key leaders:</th>
<th>Name</th>
<th>Contact Information</th>
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## Demographic Date

<table>
<thead>
<tr>
<th>Annual # of births</th>
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<tbody>
<tr>
<td># of providers</td>
</tr>
<tr>
<td># of nurses</td>
</tr>
<tr>
<td>Level of maternal/neonatal care</td>
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</tbody>
</table>

## Process Support

<table>
<thead>
<tr>
<th>EMR Type</th>
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</thead>
<tbody>
<tr>
<td>Provider ordering</td>
</tr>
<tr>
<td>Hard Stops or flags</td>
</tr>
<tr>
<td>Protocol built in EMR Hemorrhage/Hypertension</td>
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## People Support - Key Leaders

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<tr>
<th>Physician</th>
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### Unit Culture/Climate

**Team STEPPS**

- How does your unit respond to change?
- How do you build in sustainability into your programs?
- Is there anything we can do to assist with the change process?

### System Support

**Current Quality Initiatives**

- Data Reporting (or access to KDS)
- Data submission (to KDS)
- Data Reports (from KDS)

**Financial**

- Adequate staff to complete data pull and submission

**Site Identified Needs: Phone interview with site identified leaders**

- What about their implementation is going well
- Strengths have they used in the past for successful implementation of quality improvement project
- What challenges or opportunities reflect their current state of implementation

**Post Phone Call Assessment – Outreach Team**

- Set date and confirm attendance