Groups Announce Ambitious Maternal Health Initiative
Oklahoma Prepared to Respond with Postpartum Hemorrhage Management Toolkit

Read the news release from ACOG and SMFM and find out how Oklahoma is already prepared to address one component of this initiative.

Washington, DC (May 10, 2013)-- The American College of Obstetricians and Gynecologists (The College) and the Society for Maternal-Fetal Medicine (SMFM) are pleased to announce the Maternal Health Initiative, a large multi-group collaborative effort aimed at reducing maternal morbidity and mortality in the US by 50% as well as reducing the racial and ethnic maternal health disparities.

“The US ranks 50th in maternal deaths worldwide, far below Canada, Japan, and many western European countries,” said Jeanne A. Conry, MD, PhD, president of The College and assistant physician in chief at The Permanente Medical Group in Roseville, CA. “If we are to cut maternal morbidity and mortality by 50%, then one of the things we must do is address women's overall health and their reproductive and contraceptive choices. With ever-increasing rates of chronic diseases such as obesity, hypertension, and diabetes among reproductive-age women, we need to stress contraception and planning pregnancies to optimize maternal outcomes.”

At its recent Annual Clinical Meeting in New Orleans, The College, in close collaboration with SMFM, convened a group of over 100 stakeholder representatives for the Maternal Health Initiative, including the American Academy of Family Physicians, American College of Nurse Midwives, Association of Women’s Health, Obstetric and Neonatal Nurses, Health Services and Resources Administration, Society for Obstetric Anesthesia and Perinatology, US Centers for Disease Control and Prevention, as well as hospitals, birth centers, and blood banks. This group participated in discussions regarding specific steps all birthing facilities should implement to reduce maternal risks and improve birth outcomes.

Reducing maternal morbidity and mortality can be achieved by improving women's health across their reproductive years through improved access to contraception planning and by ensuring safety in maternity care. The Maternal Health Initiative stakeholders committed to work together to establish, at every facility that provides maternity care in the US, protocols that address the leading causes of maternal harm or death, including hemorrhage, hypertension, thromboembolism, cardiac disease, sepsis, and obesity. “Implementing these protocols at each maternity facility nationwide will reduce the risk of pregnancy complications and enable each facility to respond more effectively when complications occur,” said Brian M. Mercer, MD, president of...
SMFM and chair of ob-gyn at MetroHealth Medical Center in Cleveland, OH.

In addition, the Maternal Health Initiative stakeholders are developing a list of symptoms and warning signs that require rapid responses so that serious complications can be identified and treated quickly. The Maternal Health Initiative collaborators are committed to initiating these ambitious efforts before the end of this year.

Oklahoma Ahead of the Game

Oklahoma’s maternal death rate of 27 per 100,000 births is almost double the national average of 14.5 per 100,000. According to the Oklahoma Maternal Mortality Review program, hemorrhage is identified as the cause in 17% of these deaths. Between 1994 and 2006 the incidence of postpartum hemorrhages increased by 26% in the United States.

Organizations such as The Joint Commission (TJC), Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI) support the use of standardized protocols to provide safe, reliable care to patients. This is especially true in low volume, high risk situations like postpartum hemorrhage. Recent studies indicate that late recognition of severity of blood loss leading to delayed emergency management is the main cause of morbidity and mortality among women with postpartum hemorrhage. In response to the current status of postpartum hemorrhage as the second leading cause of maternal death, Oklahoma hospitals expressed an interest in having a protocol based on best practices and consistent processes.

Through the leadership of the Oklahoma Perinatal Nurses Forum and with support and funding by Physicians Liability Insurance Company, OU Health Sciences Center, and Oklahoma State Department of Health an interdisciplinary and interagency committee was formed to develop the Postpartum Hemorrhage Toolkit and Education Module. All birthing hospitals in the state are invited to join a cost-free initiative to decrease the morbidity and mortality associated with postpartum hemorrhage. This state-wide initiative includes a printed tool kit, online education, and regional hospital training. The last half-day training session is July 11th in Lawton, Oklahoma.

Oklahoma has become one of the leading states in implementing perinatal quality improvement activities. We have an opportunity to lead the way in the Maternal Health Initiative's goal of reducing maternal mortality and severe maternal morbidity by 50% by starting NOW to improve outcomes for mothers who experience postpartum hemorrhage. Please join this collaborative effort by implementing this program in your birthing facility. More information can be found at www.oumedicine.com/pphm. Questions? Call 405-271-7777 or e-mail barbara-koop@ouhsc.edu

Perinatal Quality Conference featuring Dr. Elliott Main – Going Beyond Every Week Counts

Please save the dates of August 28 and August 29. We will be hosting a CME activity in Tulsa at the Schusterman Center in the evening on August 28. Dr. Elliott Main, California Maternal Quality Care Collaborative Medical Director and expert on all things having to do with perinatal quality care, will provide a short presentation and a Q&A session with medical providers. On August 29, we will host a day-long meeting to discuss a broad range of topics surrounding perinatal care, including EWC, in OKC at the Moore Norman Technology Center South Penn campus. Dr. Main will be the featured speaker at this meeting. Clinicians and administrators from any Oklahoma birthing hospital are welcome to attend. We will provide a more detailed agenda at a later date. We will also host an evening CME meeting on August 29 in OKC for medical providers featuring a presentation and Q&A session with Dr. Main.

Timing of Events
August 28 - Evening CME Event, Tulsa
August 29 - Day-long Meeting for hospital teams, OKC
August 29 - Evening CME Event (Repeated), OKC
A 32 y/o woman, G2 P1001 at 39 4/7 weeks is admitted for medical induction of labor secondary to a diagnosis of insulin-dependent diabetes mellitus. She is a White’s classification GDM. Her pregnancy to date is otherwise uncomplicated with appropriate glycemic control noted. The fetus was diagnosed with a cardiac valve defect by perinatal diagnostics; antenatal surveillance leading up to her induction of labor was reassuring. Initial SVE reveals a cervix that is 2 cm dilated, 50% effaced, -2 station, mid-position, and soft. The EFW is approximately 3500 grams. Maternal vital signs are WNL. The fetus is in the cephalic presentation and has a Category I tracing on admission. Uterine contractions are irregular and palpate mild. She is induced with mechanical cervical dilation via Foley bulb and oxytocin. She is GBS negative. After several hours of oxytocin administration per hospital protocol the fetal tracing is as follows:

At the next tracing, the woman has progressed to complete cervical dilation and effacement. The fetal vertex is noted to be at -1 station, and the fetus is allowed to passively descend into the pelvis. Oxytocin is continued although resuscitation measures are initiated. The fetal heart rate tracing is as follows:

Describe the FHR and uterine activity in each tracing using 2008 NICHD terminology.
What are your actions?
What are your concerns or reassurances?
Comments

The first tracing demonstrates a FHR baseline of 140, moderate FHR variability, accelerations, and absence of decelerations. This is a Category I fetal tracing indicating the fetal acid-base status is normal at the time of the tracing. Oxytocin was appropriately continued. The second tracing picks up approximately 2 hours prior to delivery and is a Category II fetal tracing. The uterine contractions are not clearly delineated, but there appear to be late decelerations. Fetal heart rate variability is nearly absent. This is a Category II tracing but is nearly Category III. The patient has entered the second stage of labor by this time.

Discussion

It is important to recognize that a fetal heart rate tracing is a dynamic and evolving process. Additionally, CEFM is not a perfect science as demonstrated above. One would have expected this infant to deliver with depressed APGAR scores and a less reassuring umbilical cord arterial blood gas, given the Category II fetal tracing several hours preceding delivery. Some practitioners may have considered the FHR variability on the low end of minimal (defined as 5 bpm or less but still detectable) and classified this tracing as a Category II. Others may have believed that it was absent (undetectable) therefore making this a Category III tracing. In the clinical setting there can be honest disagreement among care providers on exactly what to call a given fetal heart rate characteristic, but all involved should recognize the evolution of a deteriorating strip and take actions to ameliorate the suspected fetal hypoxemia. If resuscitative measures do not improve the FHR tracing then immediate delivery should be initiated. Despite the overall positive outcome in this particular case, one point of discussion is the lack of recognition of an abnormal fetal tracing and the improper use of oxytocin. Additionally, after review of the case, it was discovered that there was inadequate communication of the fetal heart rate tracing between physicians and nursing. This scenario represents a near miss in which a potential adverse outcome was avoided by happenstance. Regarding perinatal patient safety, fail-safes must be in place to prevent adverse outcomes. Specific to the case presented, the fail-safes should have been:

1) Recognition of an abnormal fetal heart rate tracing. This is a critical first-step to avoiding perinatal adverse outcomes.
2) Proper utilization of an oxytocin administration policy that would have seen to discontinuation of the oxytocin while resuscitative measures were being performed.
3) Formal and properly formatted communication between physicians and nursing regarding the patient and the fetal heart rate tracing.

Labor and delivery is a high-risk environment that requires high reliability to avoid adverse outcomes. Simple steps can be taken that will significantly reduce the likelihood of adverse events.

Outcome

The patient delivered approximately 2 hours from the time of the last tracing provided by spontaneous vaginal delivery. The infant had APGARs of 8 and 9 at 1 and 5 minutes. Umbilical cord arterial blood gases were reassuring with a pH of 7.23 and a base excess of -3.4. The infant required stimulation and suction after delivery. The mother was discharged postpartum day 2 and the infant had a protracted NICU admission secondary to the congenital heart defect.