



Improving Perinatal Health teleECHO Program Enrollment Checklist

- Complete & return Enrollment Form
- Identify a multidisciplinary team at your hospital to actively champion bundle implementation
- Assure Zoom capability
- Commit to attend at least 80% of the Improving Perinatal Health (IPH) ECHO sessions (at least one member of team on each session)
- Commit to present at least one patient or systems case per team
- Complete the AIM hospital baseline survey
- Commit to upload process measures into AIM data portal on a quarterly basis
- Meet monthly as a hospital team to review your progress and data
- Attend the NMPC annual meeting in Albuquerque on Saturday, 10/26/19 (as many as possible from your team)

The NMPC is partnering with AIM and Project ECHO to implement AIM's OB Hemorrhage bundle for New Mexico hospitals.

The New Mexico Perinatal Collaborative (NMPC) is a nonprofit coalition of stakeholders seeking to improve birth outcomes and the health of New Mexico women and children through the promotion and implementation of best practices in all healthcare settings.

The Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement initiative with the end goal to eliminate preventable maternal mortality and severe morbidity across the United States. It is funded through the federal Health Resources & Services Administration (HRSA)- Maternal and Child Health Bureau (MCHB).

The NMPC will collaborate with _____ (*insert hospital name*), participating on a voluntary basis, to initiate or improve a culture of maternal safety through continuous quality improvement cycles addressing implementation of the AIM OB Hemorrhage Bundle.

The areas of focus:

1. Improve readiness to respond to OB hemorrhage among birthing facilities in New Mexico, as evidenced by adaption of readiness components of the OB Hemorrhage bundle by December 2019;
2. Improve recognition and prevention of hemorrhage among delivering women in New Mexico, as evidenced by adaptation of recognition and prevention components of the OB Hemorrhage Bundle by December 2019;
3. Optimize treatment for women with OB hemorrhage in New Mexico as evidenced by development of an OB hemorrhage checklist by December 2019;
4. Improve data collection for obstetric hemorrhage among New Mexico birthing hospitals as evidenced by reporting process measures through the AIM Data Portal quarterly beginning with enrollment;
5. Optimize support for patients, families, and staff following severe OB hemorrhage events, as evidenced by participation in the IPH teleECHO program sessions and the development of debriefing protocols for significant events.

As part of this initiative, _____ (*insert hospital name*) will receive, free of charge:

1. Access to high quality educational offerings through the IPH teleECHO Program designed to enhance quality improvement capacity and advance quality improvement project work, including free CME;
2. Access to resources, webinars, and other materials to support improvement work on related topics from AIM, ACOG, ACNM, AWHONN, and other professional organizations;
3. Access to the AIM Data Portal to track progress on all topics including run charts, reports, dashboards, and snapshots of the hospital's progress;
4. Support from the NMPC team to overcome barriers;
5. Access to subject matter experts who can assist with improvement questions and recommendations;
6. Access to the listservs and other shared forums to assist improvement teams with barriers and provide encouragement to continue the improvement journey.

Improving Perinatal Health teleECHO Program Enrollment Form

To enroll your birthing hospital, please complete this Enrollment Form and return a scanned copy to Abigail Reese, NMPC Interim Executive Director: areese@salud.unm.edu. Please contact Abigail Reese with any questions at 505-850-3973.

Basic Hospital Information

Hospital Name: _____

Your Hospital Team

Please identify an individual for each role, although some team members may play multiple roles. It is critical that all departments with responsibility for implementation of bundle components be represented.

IMPORTANT: *By being listed below, the individual acknowledges their expected participation in this project.*

Day-to-Day Leader (Key Contact Person)

Name: _____

Title: _____

Telephone: _____

Email: _____

Provider Champion

Name: _____

Title: _____

Telephone: _____

Email: _____

Nursing Champion

Name: _____

Title: _____

Telephone: _____

Email: _____

Data Contact

Name: _____

Title: _____

Telephone: _____

Email: _____

Senior Administrative Leader (Project Sponsor)

Name: _____

Title: _____

Telephone: _____

Email: _____

Additional Team Members (Anesthesia, Lab, Quality, etc.)

Name: _____

Title: _____

Telephone: _____

Email: _____

Acknowledgment of Local Clinical Oversight & Approval

This project seeks to effectively and efficiently implement evidence-based practice in an active clinical care setting. Quality Improvement tests of change that introduce new processes or modify existing processes require assurance of local clinical oversight of the work of the improvement team. This application requires identification of the provider champion who will be responsible for oversight of your institution or practice's implementation of this project. The Provider and/or RN Champions are responsible for gaining approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical or Nursing Officer (as appropriate) for participation in this project.

Please have the Provider or RN Champion complete this section (initial and signature).

_____ I agree to provide medical oversight for the work of the improvement team in my facility or practice.

_____ I have gained approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical or Nursing Officer (as appropriate) for participation in this project.

Signature of Provider or RN Champion: _____

Print Name & Title: _____ Date: _____

Senior Leader Authorization and Support

Please have a Senior Leader confirm the following (using initials) and sign.

_____ This hospital grants permission for the New Mexico Department of Health to access Hospital Inpatient Discharge Data (HIDD) and submit data quarterly to the AIM national database on behalf of the hospital. We understand that the facility level HIDD data will only be available to project leaders from the New Mexico AIM/NMPC team and to our hospital team. All data submitted to the AIM national team will be state-wide aggregate data.

_____ This hospital agrees to submit data quarterly to the AIM national database. We understand that project leaders from NMPC and AIM will have access to view the data reports.

_____ I will support the team and will work with them to remove any barriers and/or provide the resources necessary for them to achieve success.

Signature of Senior Leader: _____

Title: _____

Print Name: _____ Date: _____