

**Los Angeles County Department of Public Health:  
Leading the Way to Improving the Quality and  
Safety of Peripartum Health**



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**Background:  
Maternal Mortality**

- ❖ Healthy People 2020 maternal mortality  
Target: 11.4 maternal deaths per 100,000 live births
- ❖ Los Angeles County 2001 to 2003  
maternal mortality  
-14.5 deaths per 100,000 live births  
-African American 30 deaths per  
100,000 live births
- ❖ 75% of deaths are preventable, with  
obstetric hemorrhage being the most  
preventable cause of death



**2006**



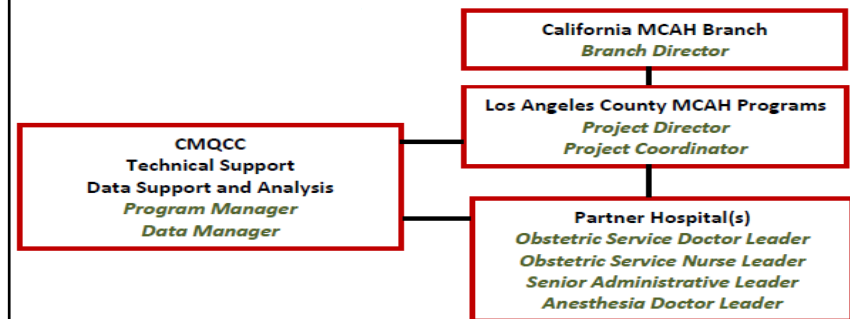


## Background: Obstetric Hemorrhage

- ❖ Worldwide one of the most common causes of maternal death
- ❖ In California, one of the five leading causes of death
- ❖ 70% of these tragic deaths stood a good to strong chance of being prevented



## Local Maternal Care Quality Improvement





## Los Angeles County Maternal Care Quality Improvement Project

### Goal

Reduce the risk of obstetric hemorrhage for women delivering in partnering hospitals

### Two Broad Aims

#### Patient outcomes:

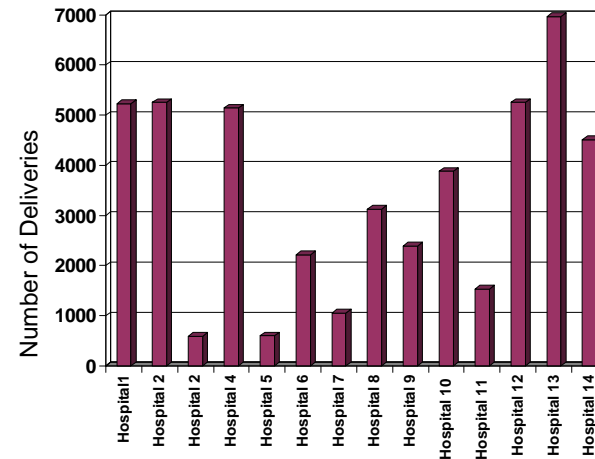
Reducing massive hemorrhage and major complications, including blood product transfusions and peripartum hysterectomies

#### Develop capacity:

Implement a multidisciplinary response to massive hemorrhage



## Los Angeles County 14 Partner Hospitals



2007  
Total Births:  
50,507

Range:  
595  
deliveries  
to  
6969  
deliveries







## Develop Capacity

- ❖ Hemorrhage care algorithm
- ❖ Hemorrhage policy
- ❖ Drills
- ❖ Hemorrhage carts/trays
- ❖ Quality improvement (QI) data collection
- ❖ Monthly webinars
- ❖ Clearinghouse publications, videos, best practices from national and international forums, and sample policies



### Report-Out of May Activities

- Accomplishments
- Challenges
- Current Activities
- Next planned



## Education:





## Accomplishments

- ❖ 100 % of hospitals developed policies for addressing massive obstetric hemorrhage
- ❖ Collaborative hospitals reduced the use of
  - packed red blood cells 12.4% (4.2 units per 1,000 births)
  - all blood products by 18.0% (8.3 units per 1,000 births)
- ❖ 91.0% participating hospitals documented progress implementing the protocol of seven strategies to recognize, respond to, and prevent obstetric hemorrhage



## Accomplishments

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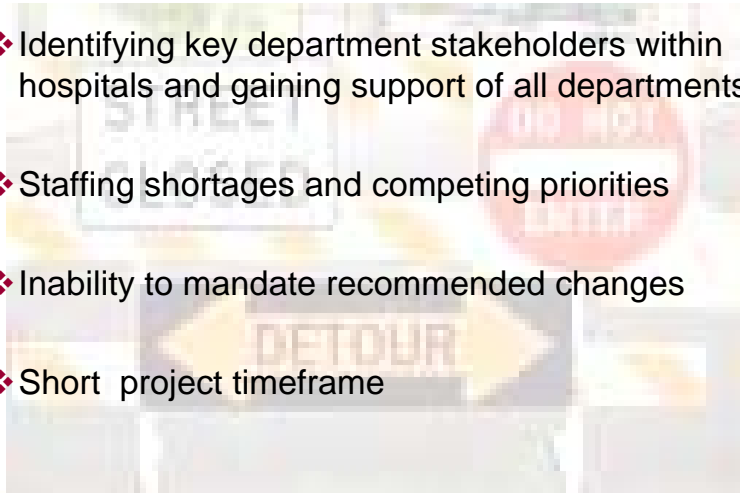
Available on  
<http://www.publichealth.lacounty.gov/mch/>





## Barriers

- ❖ Identifying key department stakeholders within hospitals and gaining support of all departments
- ❖ Staffing shortages and competing priorities
- ❖ Inability to mandate recommended changes
- ❖ Short project timeframe



## Lessons Learned

- ❖ DPH is an excellent mediator for improving QI programs
- ❖ Electronic communication maximize communication and participation
  - ❖ economical
  - ❖ effective
  - ❖ 24/7





*“Thanks so much for allowing us to be part of this great collaborative! You made our successes easy to reach and provided evidence to support the changes we have implemented. Best of luck with your next collaborative group.”*

*-Participating Hospital*



***Thank you!***

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