

SESSION SUMMARY

This session highlighted lessons learned from Minnesota birthing facilities that participated in the MNPQC *Obstetrical Hemorrhage Community of Learning (OBH COL)*. Representatives from three diverse birthing settings shared their experiences strengthening obstetrical hemorrhage practices, including successes, challenges, and strategies for sustainable improvement through a panel and case-based discussion.

HEMORRHAGE DEFINITIONS:

Obstetric hemorrhage (OBH) is excessive or significant bleeding from the genital tract (a cumulative blood loss of 1,000 mL or more) that can occur during early pregnancy, late pregnancy, or after childbirth. Source: ACOG Practice Bulletin 137 (2017)

- QBL: Quantitative Blood Loss
- EBL: Estimated Blood Loss
- PPH: Postpartum Hemorrhage

WHY A RELIABLE RESPONSE MATTERS:

OBH remains a leading cause of preventable maternal morbidity and mortality.

Source: Minnesota Maternal Mortality Report (2017 - 2021)

Patient outcomes can be influenced by how well a system is prepared to respond under pressure. OBH requires early recognition and a coordinated, rapid team response, making preparedness especially important. The level of care may look different across urban, rural, and community birth settings, but the setting alone should not determine protocols and best practices.

Standardization is a safety strategy. Move beyond simply having a plan to having a team that knows the plan, their role, and has practiced using it.

BACKGROUND OF MNPQC'S OBH COL:

Program Duration: September 2025 - April 2026

Purpose: To increase the proportion of Minnesota birthing facilities with the training, standardized protocols, and resources needed to effectively identify, prevent, and manage obstetric hemorrhage.

Updated as of September 2026

KEY TAKEAWAYS:

Twin Cities Midwifery | Community Birth Setting

- **Approaches to OBH:** Care plans are developed with clients during prenatal visits, using risk handouts and informed consent. The team maintains strong transfer relationships with hospitals and EMS.
- **COL Lessons Learned:** Before the COL, QBL was weighed when time allowed, or if heavy blood loss was suspected. The team now weighs QBL whenever possible, documenting if blood loss is EBL or QBL.
- **Recommendations:** Community transfers may involve different professionals, making clear communication essential to ensure teams are prepared to work together effectively.

Essentia Health Virginia | Rural Setting

- **Approaches to OBH:** The nearest higher-level care facility is over an hour away, prompting the facility to develop an OBH cart and protocol in 2020–21. The protocol includes an alert system directing staff to a medication and supplies guide for rapid response.
- **COL Lessons Learned:** The facility had strong team debriefing practices following hemorrhage events. Through the COL, the need for an additional debrief with the family was identified.
- **Recommendations:** When transfers are necessary, seek help first, then continue the response protocol. A warm handoff summarizing actions taken helps ensure continuity of care.

Hennepin Healthcare (HCMC) | Urban Setting

- **Approaches to OBH:** A provider completes a PPH risk assessment at admission, which is added to the OBTraceVue Dashboard and activates a PPH Risk Banner. When transfusion is needed, one nurse is assigned to the rapid infuser. Emergency Department, OR, and anesthesia teams participate in regular Birth Center simulations to strengthen response readiness.
- **COL Lessons Learned:** Reinforced visibility of risk information and bi-monthly review of data. PPH risk assessment in the RN flowsheet in November 2026.
- **Recommendations:** Even resource-rich systems face competing priorities. Teams should advocate for their needs and directly involve stakeholders. Remember that OBH events can also be traumatic for staff.

IS YOUR FACILITY READY TO IMPLEMENT AN OBSTETRICAL HEMORRHAGE PROTOCOL?

Ask yourself:

1. Is the right equipment available and easy to access?
2. Do staff know who does what, when, and how?
3. Are escalation of care pathways clear?
4. Are actions standardized across shifts and staff?
5. Do teams practice the response before an emergency occurs, such as through a simulation?
6. Does the team identify and address gaps after an event through debriefing with the care team and family?

SESSION MODERATOR & FEATURED PANELISTS:

- **Rachel Pilliod, MD** | Allina Health (Moderator)
- **Cindy Kvilvang, RN, BSN** | Essentia Health Virginia Hospital (Panelist)
- **Kate Saumweber Hogan, CPM, LM** | Twin Cities Midwifery (Panelist)
- **Alina Bailey, MSN, BA, RN, PHN** | Hennepin Healthcare (Panelist)

RESOURCES:

- **The American College of Obstetricians and Gynecologists (ACOG) has created guidance** related to obstetrical hemorrhage that can be accessed below:
 - [ACOG's Obstetric Hemorrhage Bundle](#)
 - [ACOG's Postpartum Hemorrhage](#) | Practice Bulletin Number 183
- **Hemorrhage Toolkits:**
 - [California Maternal Quality Care Collaborative \(CMQCC\) Hemorrhage Toolkit](#): Available to help healthcare providers implement the latest evidence and best practices. CMQCC recently completed its second revision of the Improving Health Care Response to Obstetric Hemorrhage Toolkit.
 - [Alliance for Innovation on Maternal Health \(AIM\) Hemorrhage Toolkit](#): This toolkit was revised in 2022 and incorporates respectful care and actionable steps that can be adapted to a variety of facilities. This toolkit supported the MNPQC in developing its Obstetrical Hemorrhage COL curriculum.
- [Learn more about MNPQC's Obstetrical Hemorrhage COL](#): This webpage provides an overview of the program and describes the program's goal, participating birthing facilities, how success was tracked and measured, and a toolkit provided to each care team to support their engagement.
- **Interested in more learning opportunities focused on Obstetrical Hemorrhage?**
 - [Register for MNPQC's Perinatal Improvement Summit](#) on October 27, 2026.
 - Hemorrhage-Focused Breakout Sessions offered at the Summit:
 - **Driving Change: Strategies to Improve Postpartum Hemorrhage Rates**: Presented by Stephanie Fieldseth, RN, BSN | Jill Adams, RN, BSN
 - **Step Up Together Action Collaborative: Improving Home Birth & Birth Center to Hospital Transfer Through Interdisciplinary Simulation**: Presented by Kate Saumweber Hogan, CPM, LM | Amy Romano, MBA, MSN, CNM, FACNM | Charles Sloan III, Nationally Registered Paramedic | Ann Forster Page, DNP, APRN, CNM, FACNM

ADDITIONAL DETAILS

If you have questions about this session snapshot or would like to request access to the session slides, please contact the QI Team: QI@minnesotaperinatal.org.

Learn more about this ECHO Series. [Visit our ECHO webpage](#).

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