

# AWHONN PPH Project Application

Completion of this application is required for consideration into AWHONN's Postpartum Hemorrhage Quality Improvement Learning Collaborative. Hospitals must be located in the District of Columbia, Georgia, or New Jersey in order to participate. You must complete this application on-line at one time (you can't save your form and go back at a later date to complete it). Feel free to print this web page to use as a reference when compiling your information.

Selection of hospitals into the collaborative is based upon receiving a completed application in a timely and complete manner. Applications that are not complete will not be reviewed.

For questions about the application, please contact Ben Scheich (bscheich@awhonn.org).

Completed applications are due by February 14, 2014.

**Hospital Name \***

**Hospital Address Address \***

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

**Is your hospital part of a hospital system? \***

- Yes  
 No

**If your hospital is part of a hospital system, please provide the name of the hospital system**

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## Nurse Quality Improvement (QI) Contact Information

Name and credentials of the nurse co-leading the quality improvement project

**First Name \***

**Last Name \*****Credentials****Title \*****Email of nurse leading the quality improvement project \*****Phone Number of the nurse leading the quality improvement project \***

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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## OB Physician QI Contact Information

Name and credentials of the OB physician co-leading the quality improvement project

**First Name \*****Last Name \*****Credentials****Title \*****Email of OB physician leading the Quality improvement project \*****Phone Number of the OB physician leading the quality improvement project \***

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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## Blood Bank Director QI Contact Information

## Name and credentials of the blood bank director co- leading the quality improvement initiative

**First Name \***

**Last Name \***

**Title \***

**Credentials**

**Email of blood bank director leading the quality improvement project \***

**Phone Number of the blood bank director leading the quality improvement project \***

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## Anesthesiology Physician QI Contact Information

### Name and credentials of the anesthesiology physician co- leading the quality improvement project

**First Name \***

**Last Name \***

**Title \***

**Credentials**

**Email of anesthesiology physician leading the quality improvement project \***

**Phone Number of the anesthesiology physician leading the quality improvement project \***

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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**Chief Executive Officer or Vice President co-leading the quality improvement initiative**

**Name and credentials of senior leader for the quality improvement initiative**

**First Name \***

**Last Name \***

**Title \***

**Credentials**

**Email of the senior leader leading the quality improvement project \***

**Phone Number of the senior leader leading the quality improvement project \***

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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**Who is the primary contact person at your hospital for this project? \***

**Email of primary contact \***

**Phone Number of primary contact \***

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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**Hospital Demographics for Calendar Year 2012**

Please provide the racial/ethnic distribution percentage for mothers giving birth at your hospital (all answers must

add to 100%). Your admissions department may be able to assist you with these numbers.

**Hispanic \***

**White (not Hispanic) \***

**Black or African American (not Hispanic) \***

**American Indian or Alaska Native \***

**Asian/Pacific Islander \***

**Other/Unknown \***

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## Hospital Demographics for Calendar Year 2012

Please provide your best estimate of the distribution percentage of insurance for mothers giving birth at your hospital (all answers must add to 100%). Your financial department may be able to assist you with these numbers.

**Medicaid \***

**Commercial or Private Insurance \***

**Military or Federal Government \***

**Self Pay \***

**Other/Unknown \***

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## Hospital Demographics for Calendar Year 2012

Please provide the following about your hospital

**Please provide the total number of mothers who gave birth for calendar year 2012 \***

**What percentage of mothers gave birth via primary cesarean (as a percentage of total mothers giving birth) in calendar year 2012? \***

**What percentage of mothers gave birth via repeat cesarean (as a percentage of total mothers giving birth) in calendar year 2012? \***

**In 2012, how many women had greater than or equal to 4 units of blood transfused during the birth hospitalization?**

**Note: This question is not required but you will receive more points in your application if you provide this data element**

**In 2012, how many women had an ICU admission during the birth hospitalization?**

**Note: This question is not required but you will receive more points in your application if you provide this data element**

**What are the top 3 reasons why you want to participate in AWHONN's PPH Project? \***

**Rate your hospital's experience in leading obstetric quality improvement efforts.**

**Note: We will not be penalizing your hospital if you do not have expertise in quality improvement**

- Unknown
- Very high level of skill at implementing quality improvement projects
- High level of skill at implementing quality improvement projects
- Moderate level of skill at implementing quality improvement projects
- Low level of skill at implementing quality improvement projects
- Very low level of skill at implementing quality improvement projects

**List the topics for recent quality improvement projects, if applicable**

**AWHONN's PPH Project will require the following:**

- 1. Completion of the baseline survey.**
- 2. Travel for two of your hospital staff to a one day kickoff meeting and a one day wrap-up meeting. It will be free to attend these meetings but any travel/hotel costs must be covered by the hospital.**
- 3. Monthly participation on PPH Project conference calls by at least one person at your hospital**
- 4. Monthly data collection submitted to AWHONN within the time frame specified.**

**Is your hospital willing to comply with the above? \***

- Yes
- No

**Please provide any other comments you want us to know about your application**

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## Letters of support

A sample letter of support template is available at <http://www.pphproject.org/apply.asp>

**Attach a signed letter of support from your hospital's senior leadership. \***

No file selected.

**Attach a signed letter of support from your hospital's physician leadership or OB physician leadership. \***

No file selected.

**Attach a signed letter of support from your hospital's women's services nurse leadership. \***

No file selected.

**Attach a signed letter of support from your hospital's blood bank services leadership.**

No file selected.

**Attach a signed letter of support from your hospital's anesthesia services leadership.**

No file selected.