Surveillance and Prevention with Maternal Mortality Review Committees

Wednesday, June 29, 2022

Meet Our Speakers

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Baylor College of Medicine

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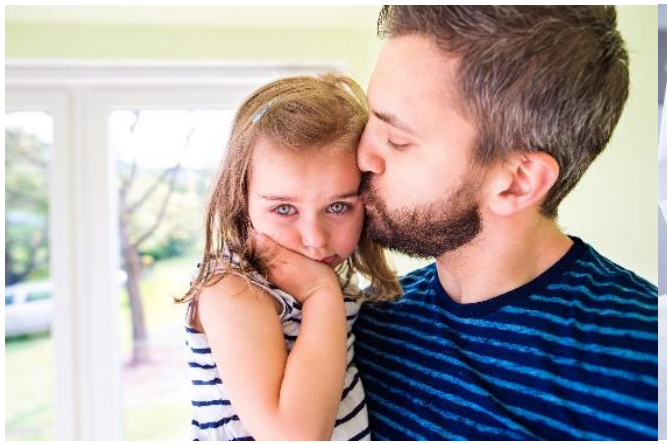
Julie Zaharatos, MPH, Maternal Mortality Prevention Team
CDC Division of Reproductive Health




MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

ERASE MM Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

REVIEW to ACTION WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

The data we have

	National (CDC) – National Vital Statistics System (NVSS)	National (CDC) – Pregnancy Mortality Surveillance System (PMSS)	State and Local Maternal Mortality Review Committees (MMRCs)
Data Source	Death records	Death records, and death records linked birth or fetal death records, additional information as available	Death records, and death records linked birth or fetal death records, medical records, social service records, autopsy, informant interviews, etc.
Time Frame	During pregnancy – 42 days	During pregnancy – 1 year	During pregnancy – 1 year
Source of Classification	ICD-10 codes	Medical epidemiologists	Multidisciplinary committees
Terms	Maternal death	Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related	Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related
Measure	Maternal Mortality Rate - # of Maternal Deaths per 100,000 live births	Pregnancy Related Mortality Ratio - # of Pregnancy Related Deaths per 100,000 live births	Pregnancy Related Mortality Ratio - # of Pregnancy Related Deaths per 100,000 live births
Purpose	Show national trends and provide a basis for international comparison	Analyze clinical factors associated with deaths, publish information that may lead to prevention strategies	Understand medical and non-medical contributors to deaths, inform prioritization of interventions that effectively reduce pregnancy-related deaths

Adapted from: St. Pierre A, Zaharatos J, Goodman D, Callaghan WM. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. *Obstet Gynecol*. 2018;131(1):138–142.

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700

Each year in the U.S., about 700 women die as a result of pregnancy complications

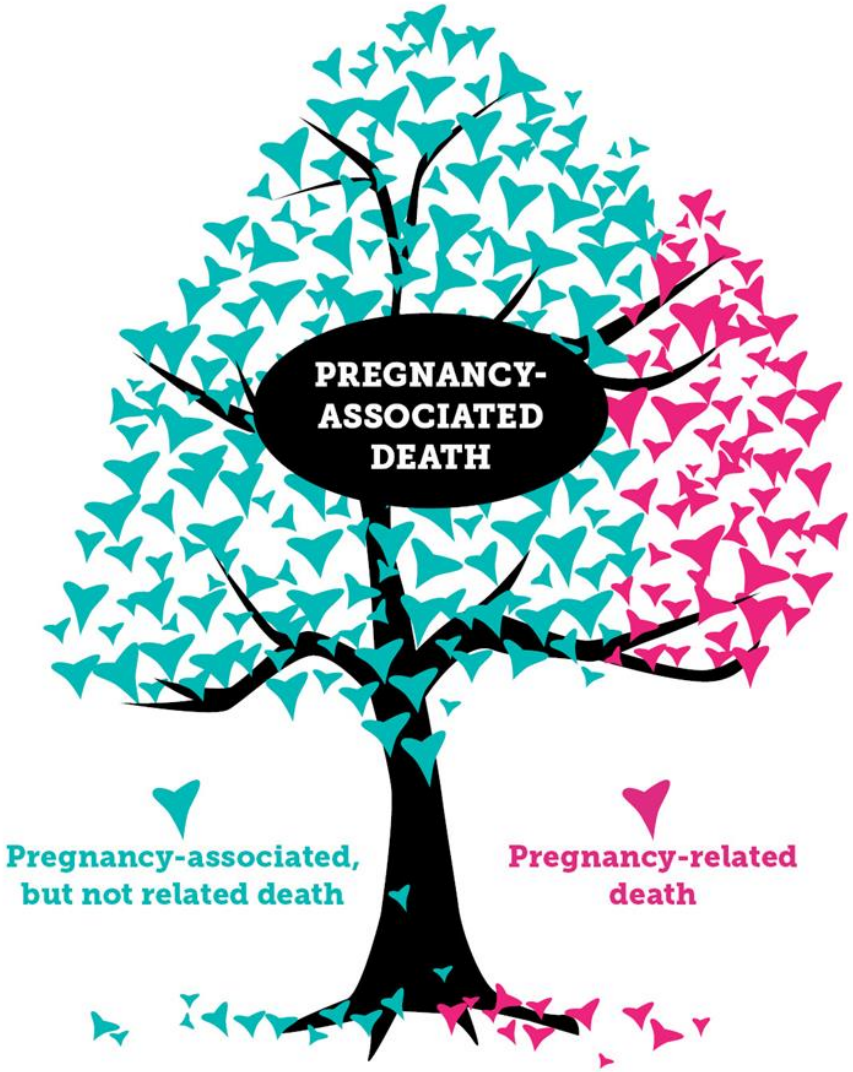
2 – 3x

Black and AI/AN women are 2 – 3 times more likely to die of pregnancy-related causes than white women

Pregnancy-associated death: the death of a person while pregnant or within one year of pregnancy, regardless of cause (may be related or unrelated to pregnancy)

Pregnancy-associated, but not related, death: the death of a person while pregnant, or within one year of pregnancy, from a cause that is unrelated to pregnancy

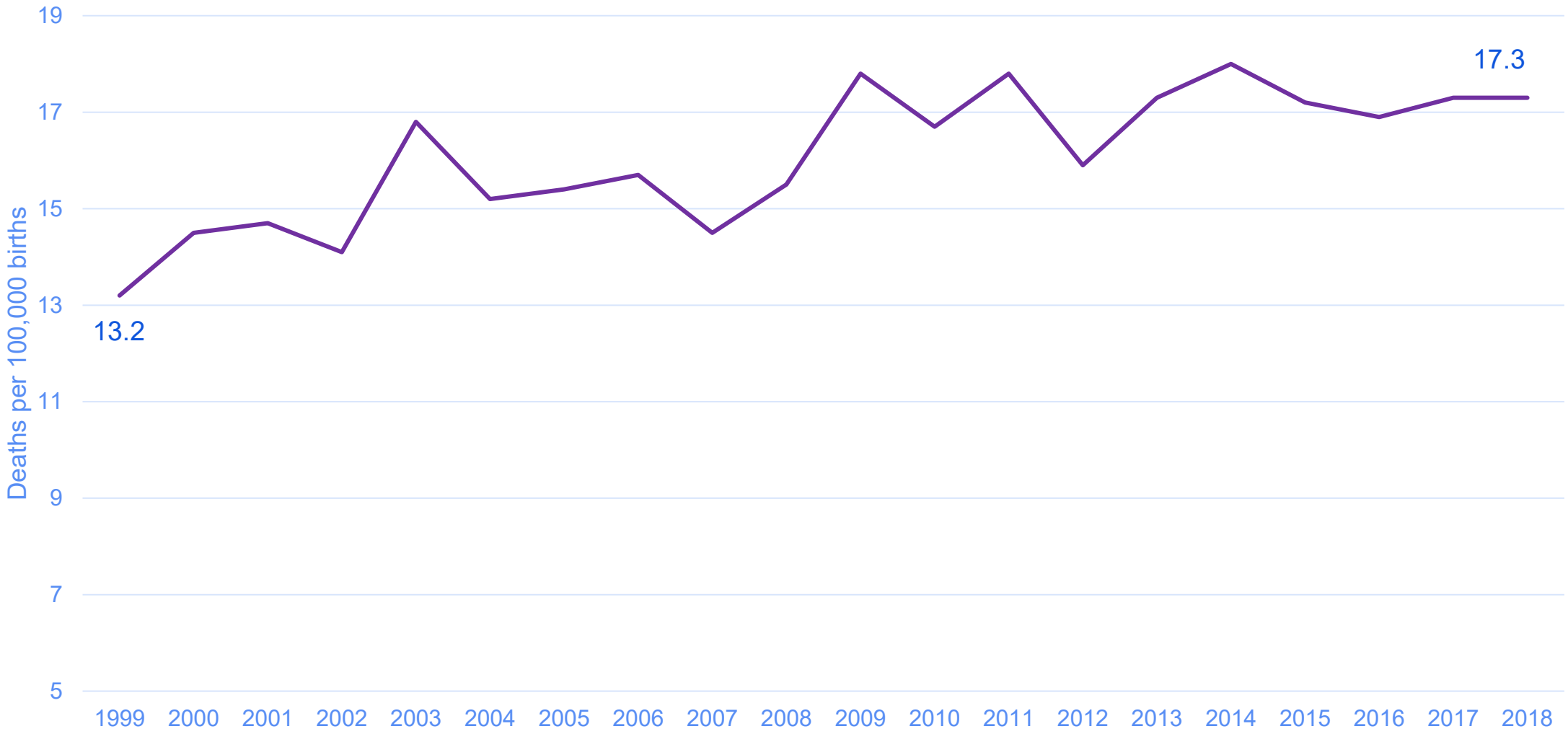
Pregnancy-related death: the death of a person while pregnant or within one year of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy



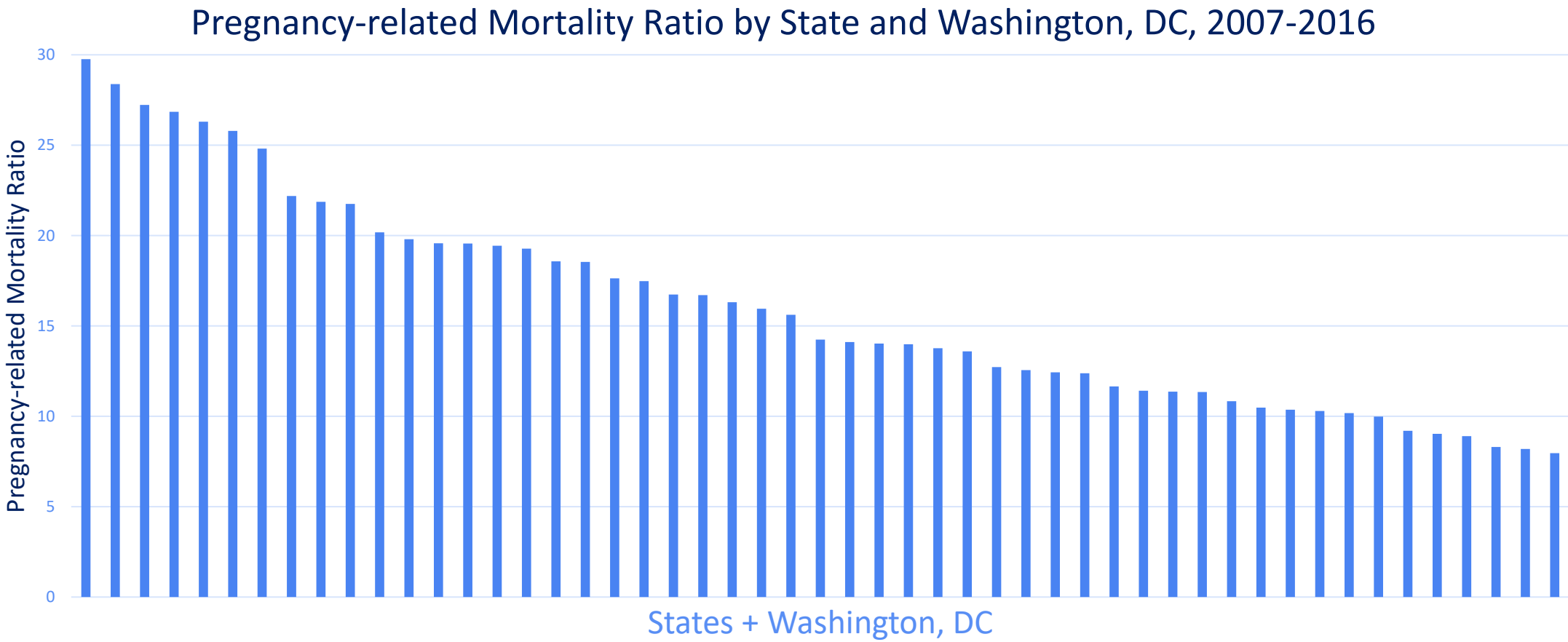
https://reviewtoaction.org/content/mmria-committee-facilitation-guide

Graphic sourced from: South Dakota Department of Health https://doh.sd.gov/statistics/maternalmortality.aspx

Pregnancy-Related Mortality, PMSS, 1999-2018: Not Improving



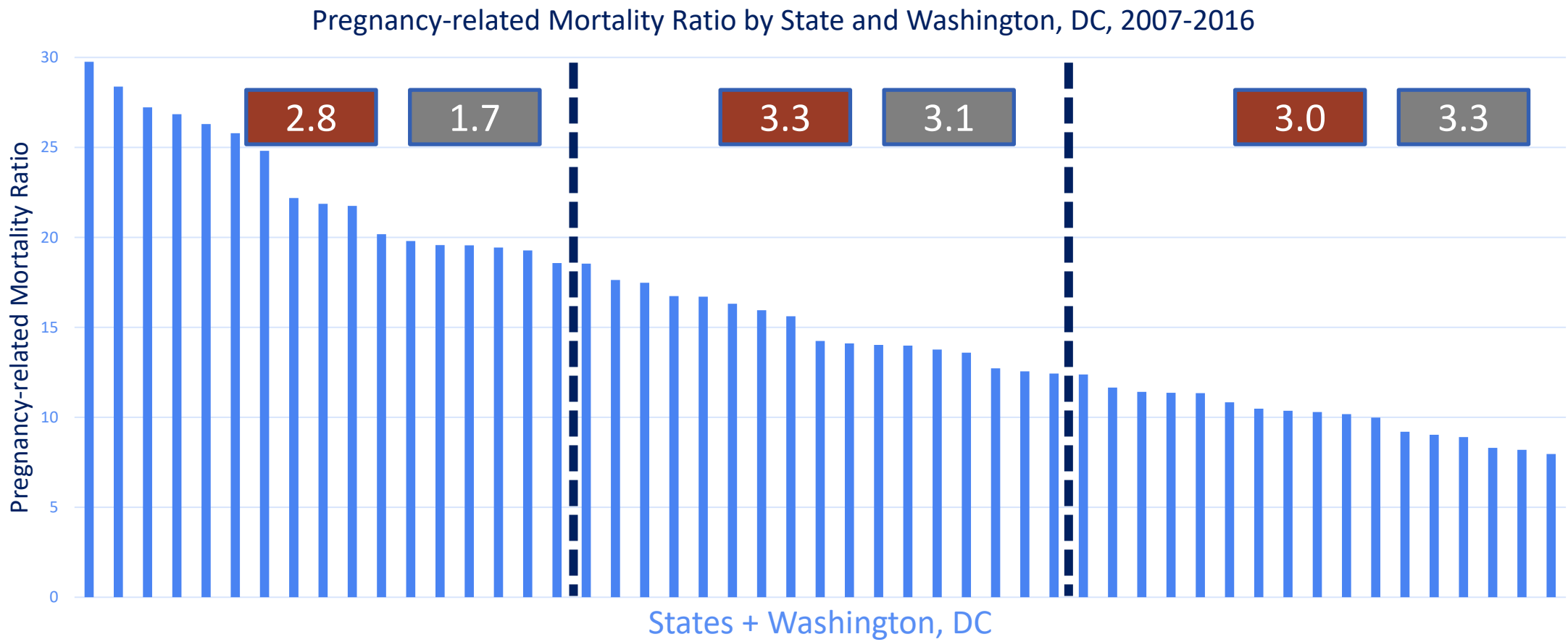
PMSS: State Variation



PMSS: State Variation

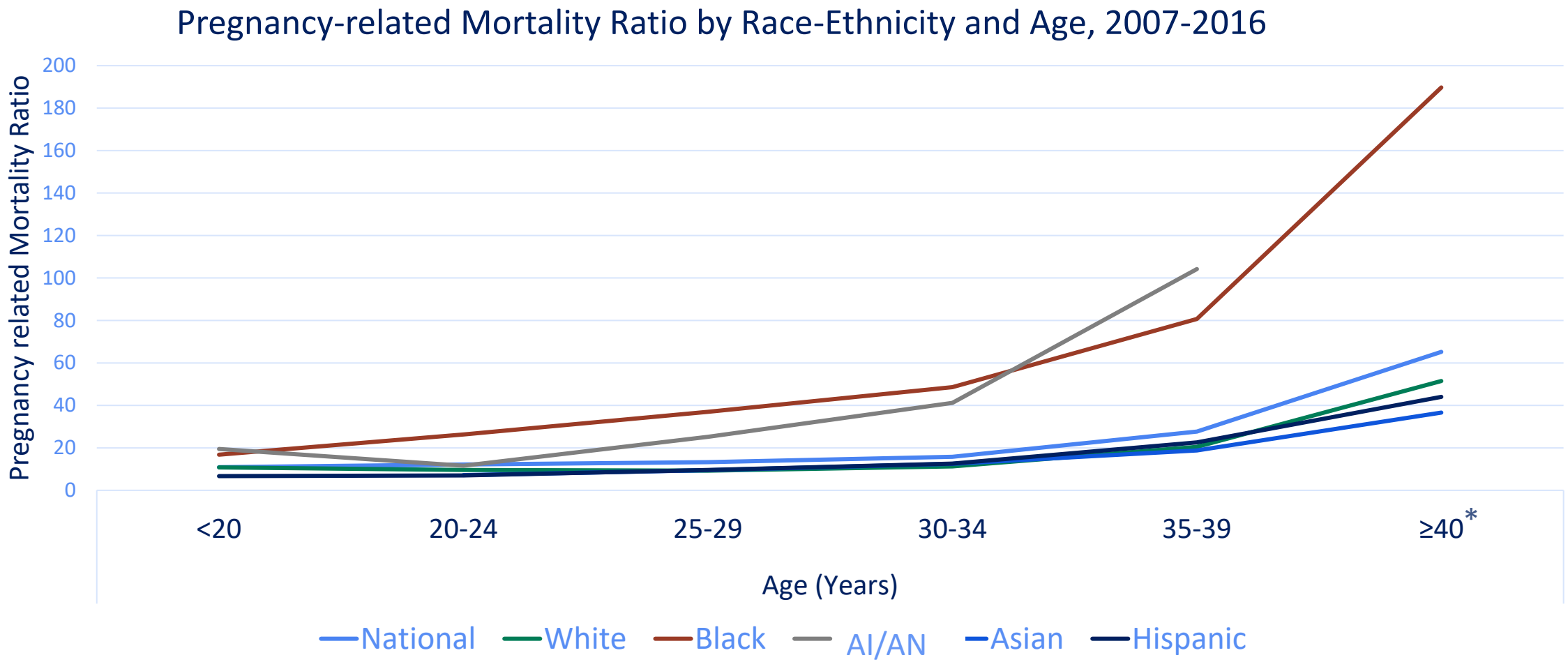
Black PRMR ÷ White PRMR

Native PRMR ÷ White PRMR



Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765

PMSS: by age grouping



Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765

*≥40 for AI/AN due to suppression rules

PMSS: by timing of death in relation to pregnancy

31%
During pregnancy

36%
During delivery and
up to 1 week afterward

33%
1 week to
1 year after

Jurisdiction-level Maternal Mortality Review Committees provide local maternal mortality data

	State and Local Maternal Mortality Review Committees (MMRCs)
Data Source	Death certificates and death certificates linked to birth or fetal death certificates, medical records, social service records, autopsy, informant interviews, etc.
Time Frame	During pregnancy – 1 year
Source of Classification	Multidisciplinary committees
Terms	Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related
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Adapted from: St. Pierre A, Zaharatos J, Goodman D, Callaghan WM. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. *Obstet Gynecol*. 2018;131(1):138–142.

Maternal Mortality Review IS NOT

- A mechanism for assigning blame or responsibility for any death
- A research study
- Peer review
  - It does not disclose facility or providers involved
- An institutional review
- A substitute for existing mortality and morbidity inquiries

Berg, C., Danel, I., Atrash H., Zane, S. Bartlett, L. (Eds.). Strategies to reduce pregnancy-related deaths: From identification and review to action. Atlanta: Centers for Disease Control and Prevention; 2001

Maternal Mortality Review IS

- Ongoing anonymous and confidential process of data collection, analysis, interpretation and action
- Systematic process guided by policies, statutes, rules, etc.
- Intended to move from data collection to prevention activities

Maternal Mortality Review Committees*

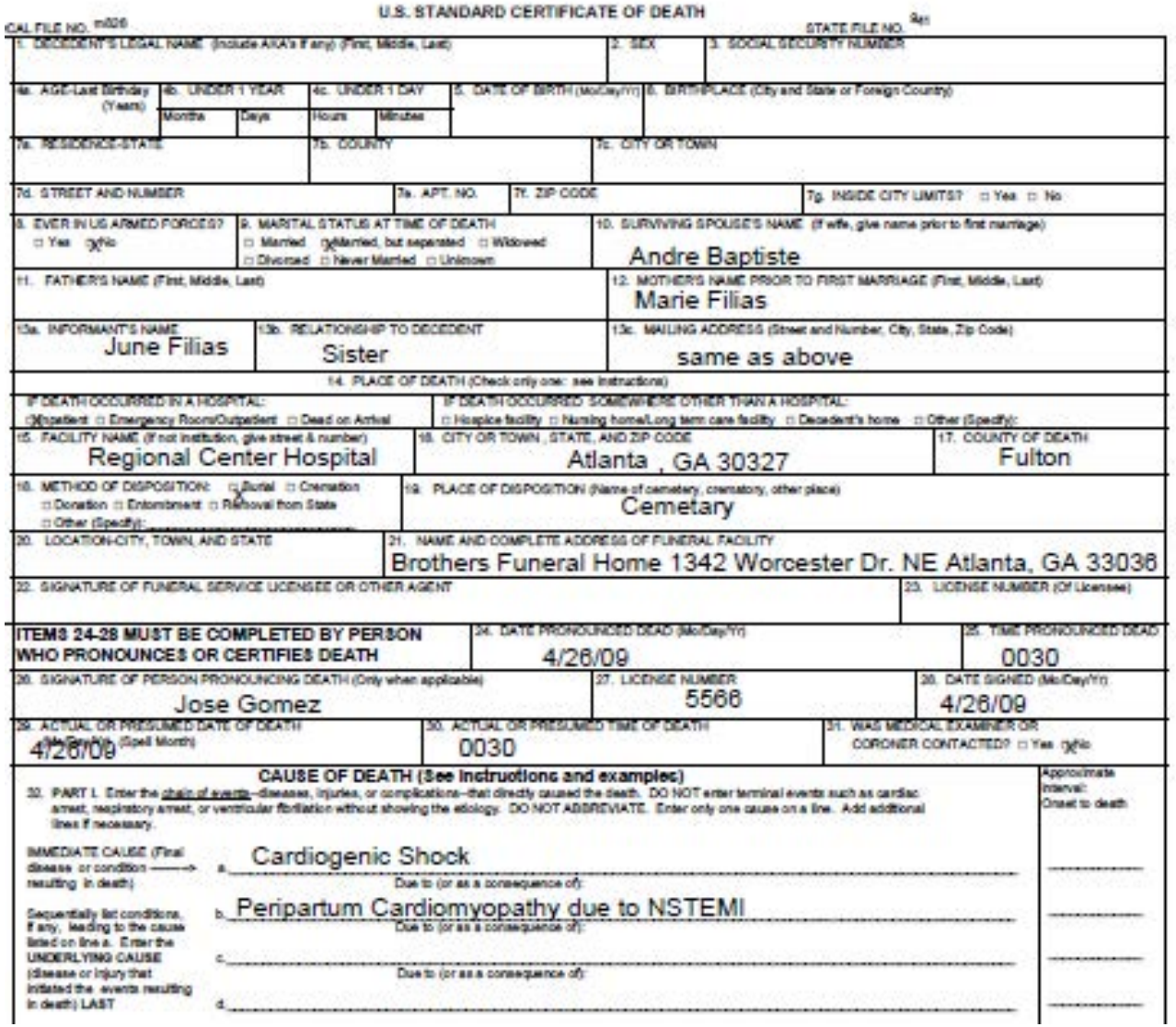
MMRCs gather data from multiple sources to determine

- pregnancy-relatedness,
- underlying cause,
- preventability,
- contributing factors and
- recommendations for action.

*To connect with an MMRC near you visit https://www.reviewtoaction.org/tools/networking-map

Identifying pregnancy-associated deaths

Maternal Mortality Review Committees (MMRCs) rely on death certificates, birth certificates and fetal death certificates to identify pregnancy-associated deaths



U.S. STANDARD CERTIFICATE OF DEATH

CAL FILE NO. m026 — STATE FILE NO. 94

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) | 2. SEX | 3. SOCIAL SECURITY NUMBER

4a. AGE-Last Birthday (Years) | 4b. UNDER 1 YEAR: Months, Days | 4c. UNDER 1 DAY: Hours, Minutes | 5. DATE OF BIRTH (Mo/Day/Yr) | 6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE-STATE | 7b. COUNTY | 7c. CITY OR TOWN

7d. STREET AND NUMBER | 7e. APT. NO. | 7f. ZIP CODE | 7g. INSIDE CITY LIMITS? ☐ Yes ☐ No

8. EVER IN US ARMED FORCES? ☐ Yes ☒ No | 9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☒ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown | 10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage): Andre Baptiste

11. FATHER'S NAME (First, Middle, Last) | 12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Marie Filias

13a. INFORMANT'S NAME: June Filias | 13b. RELATIONSHIP TO DECEDENT: Sister | 13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): same as above

14. PLACE OF DEATH (Check only one: see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☒ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):

15. FACILITY NAME (If not institution, give street & number): Regional Center Hospital | 16. CITY OR TOWN, STATE, AND ZIP CODE: Atlanta , GA 30327 | 17. COUNTY OF DEATH: Fulton

18. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify): | 19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place): Cemetary

20. LOCATION-CITY, TOWN, AND STATE | 21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY: Brothers Funeral Home 1342 Worcester Dr. NE Atlanta, GA 33036

22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT | 23. LICENSE NUMBER (Of Licensee)

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr): 4/26/09 | 25. TIME PRONOUNCED DEAD: 0030

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable): Jose Gomez | 27. LICENSE NUMBER: 5566 | 28. DATE SIGNED (Mo/Day/Yr): 4/26/09

29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month): 4/26/09 | 30. ACTUAL OR PRESUMED TIME OF DEATH: 0030 | 31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☒ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition ——> resulting in death)

a. Cardiogenic Shock

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

b. Peripartum Cardiomyopathy due to NSTEMI

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval: Onset to death

Abstracting and reviewing pregnancy-associated deaths

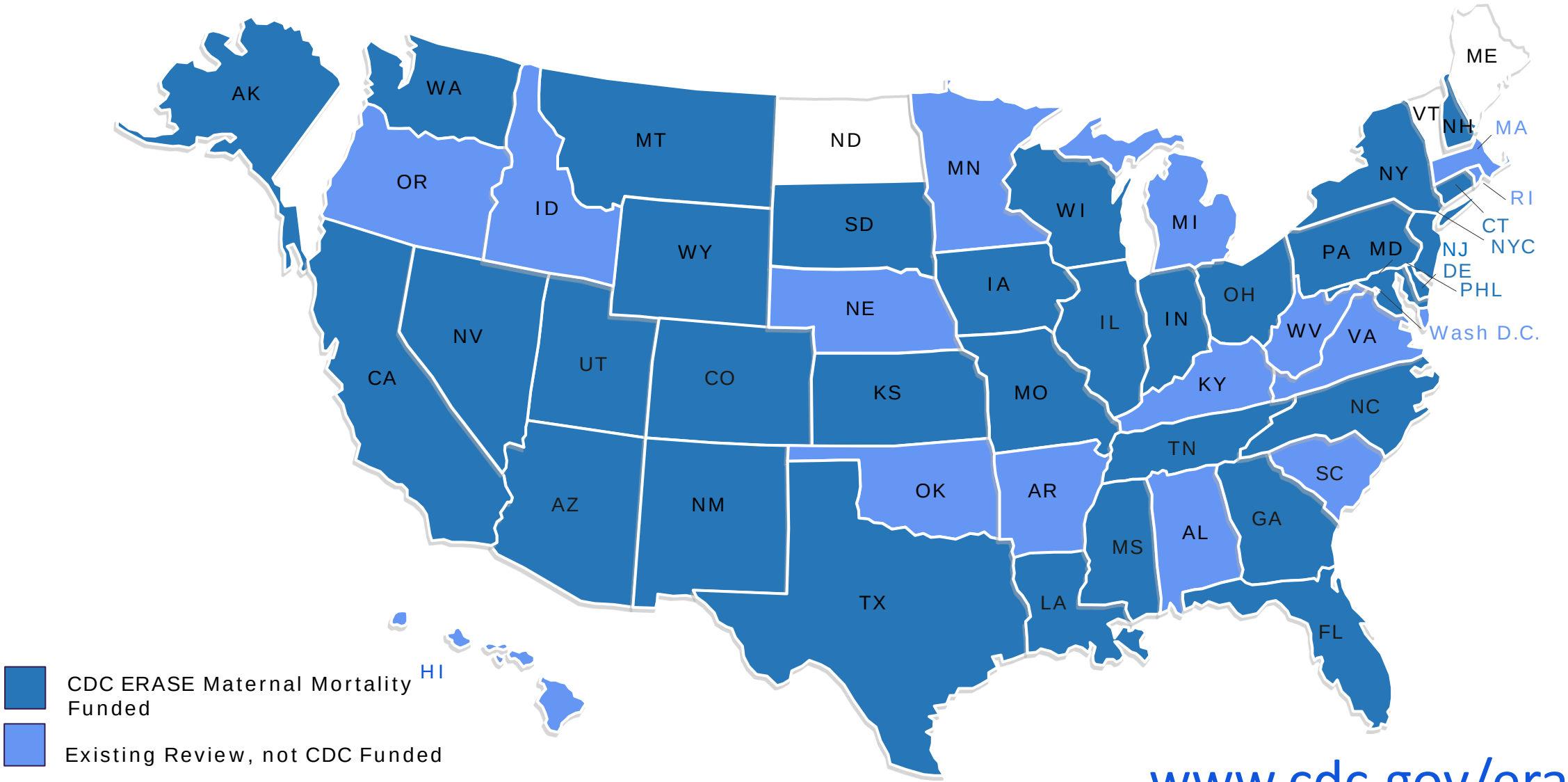
- Significant medical and social history
- Prenatal care
- ED visits / hospitalizations
- Screening / treatment / referral
- Access to care (available/accessible)

MMRIA

MMRIA is a CDC data system that provides a **common data language** for MMRCs, facilitating their functions and **promoting a national approach**.

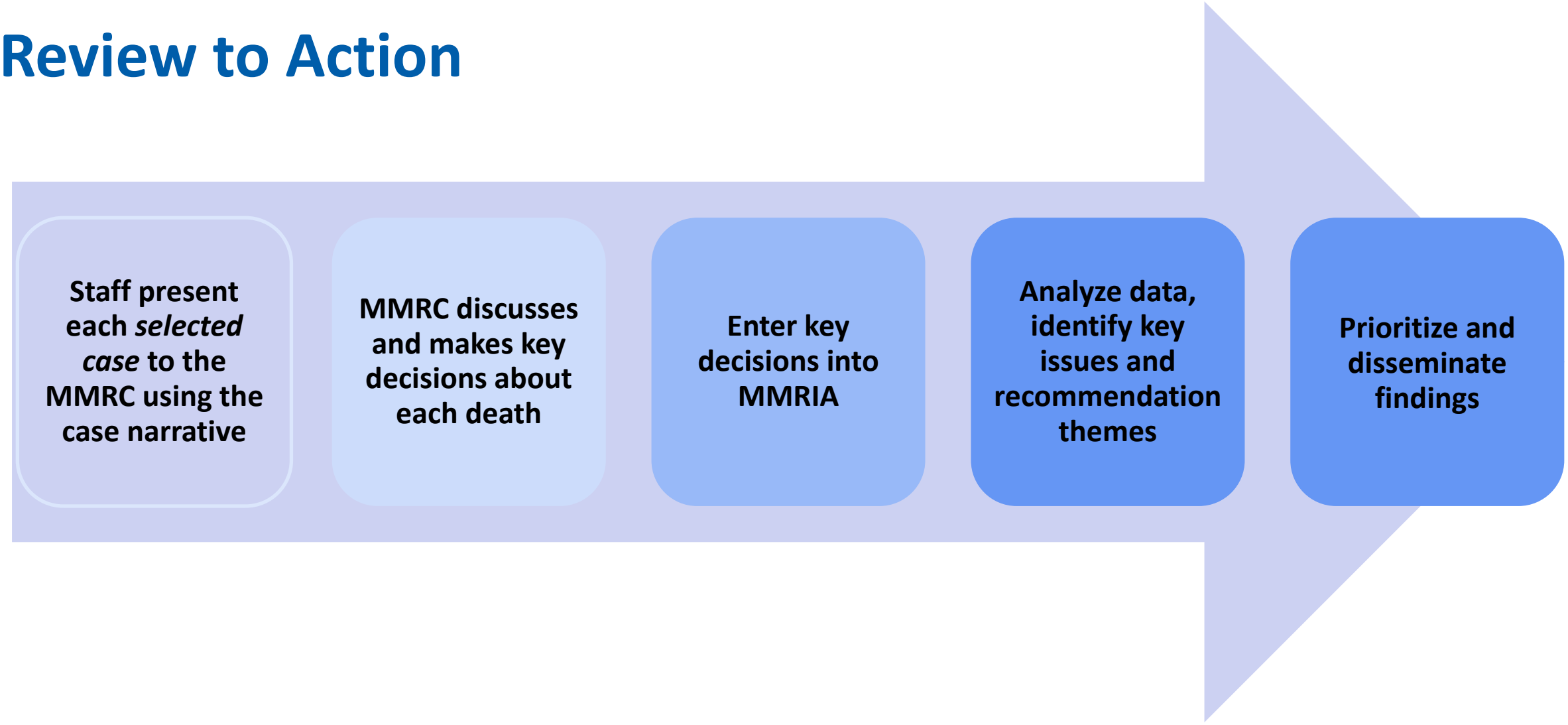
MATERNAL MORTALITY REVIEW INFORMATION APP

Existing Maternal Mortality Review Committees (MMRCs)



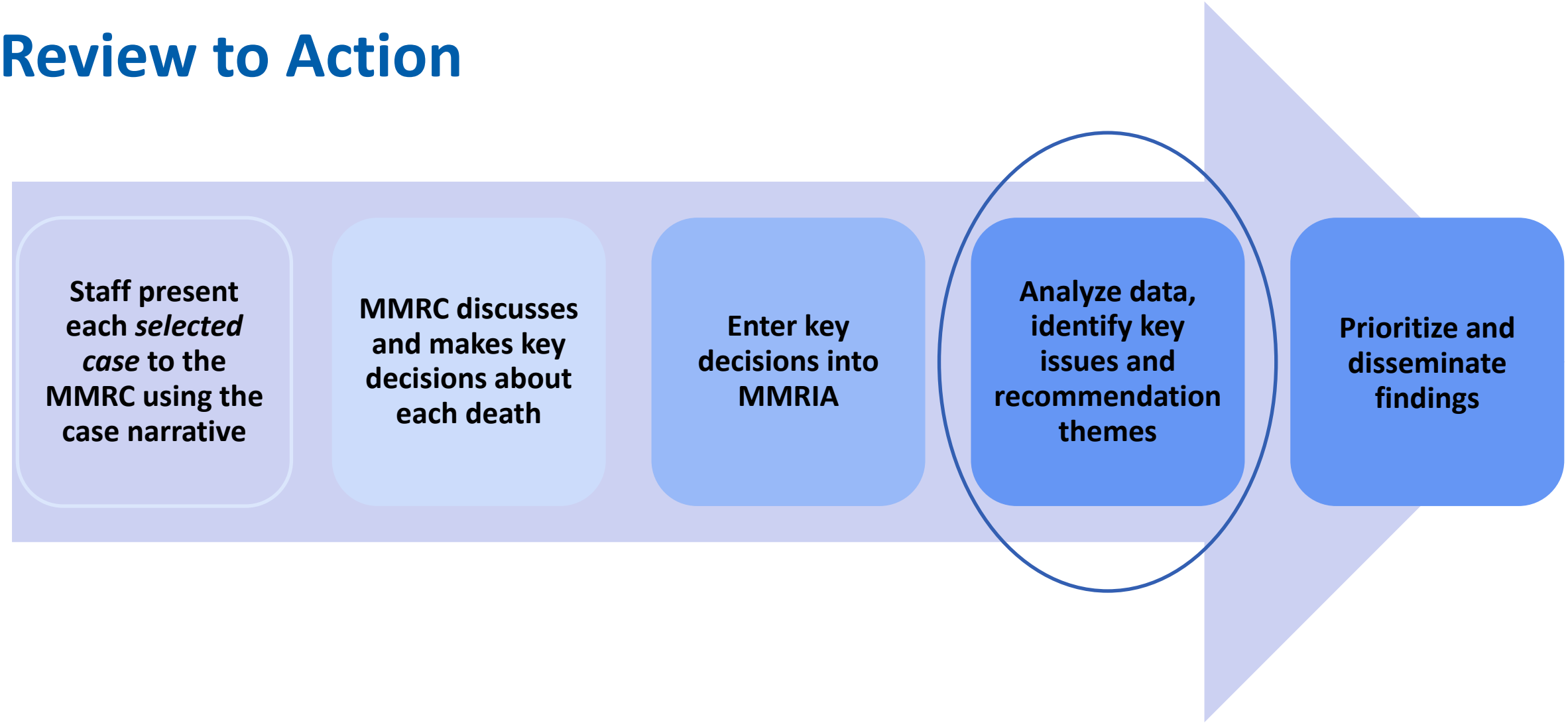
www.cdc.gov/erasemm

Review to Action



Adapted from WA State DOH

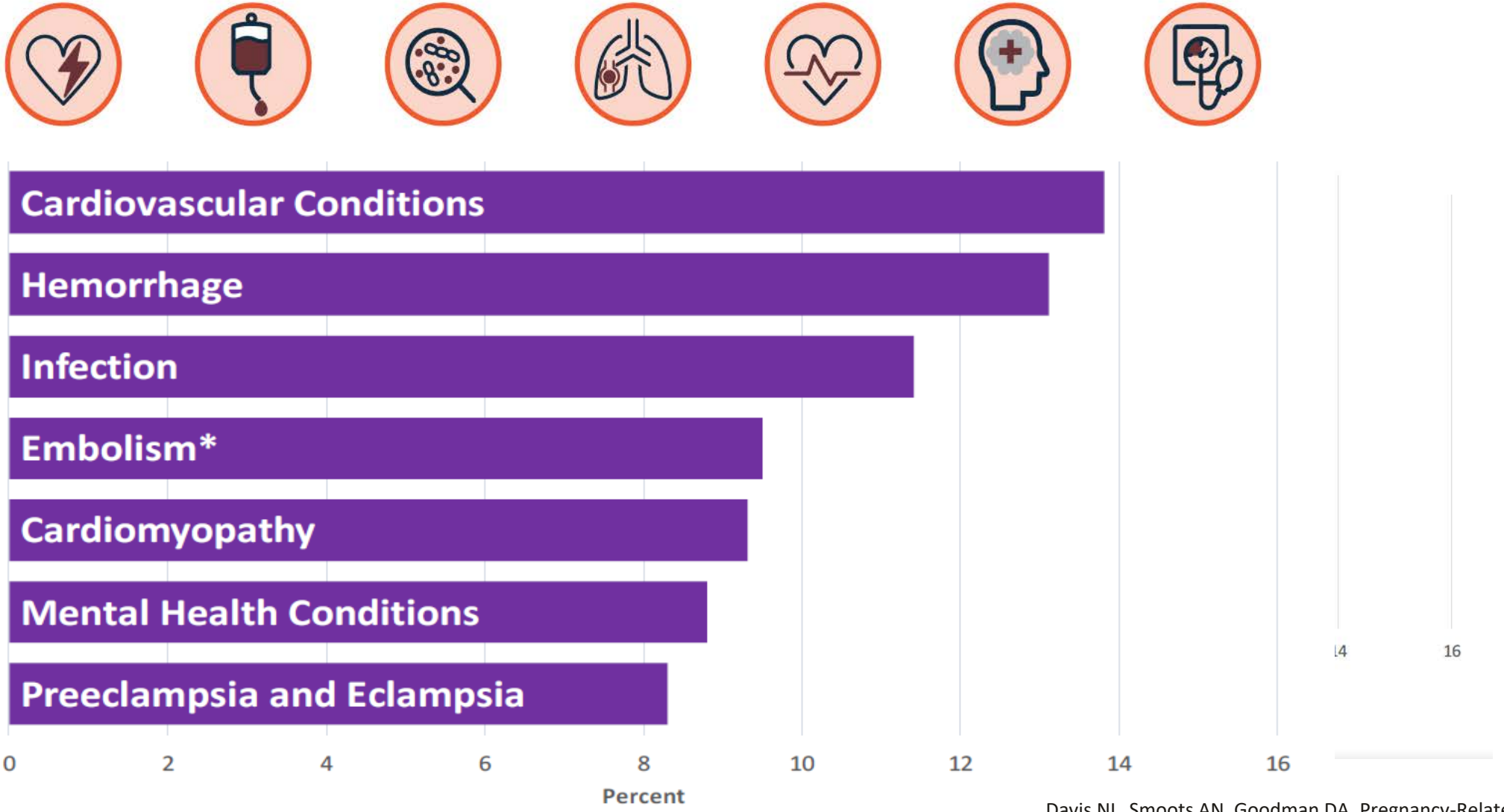
Review to Action



Adapted from WA State DOH

What have we learned from MMRCs?

Leading causes of pregnancy-related deaths

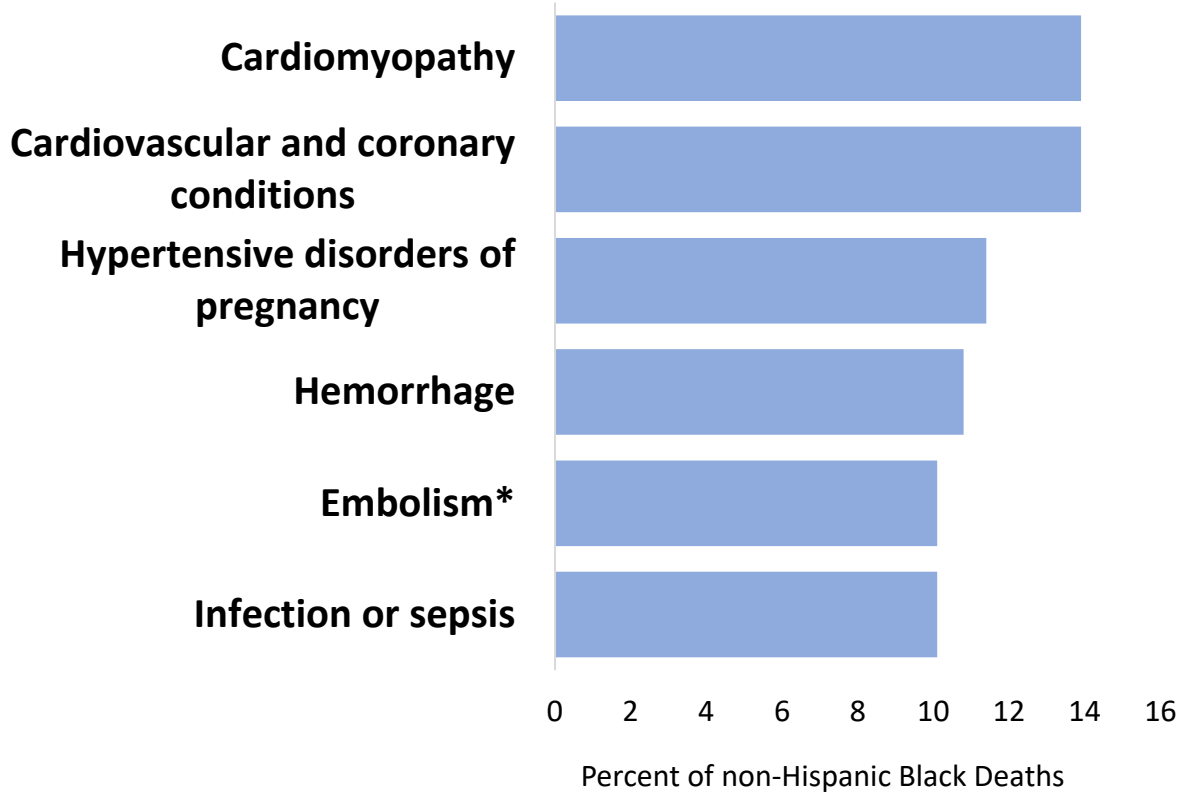


*Embolism includes thrombotic pulmonary or other embolism (i.e., air, septic, or fat). It does not include amniotic fluid embolism.

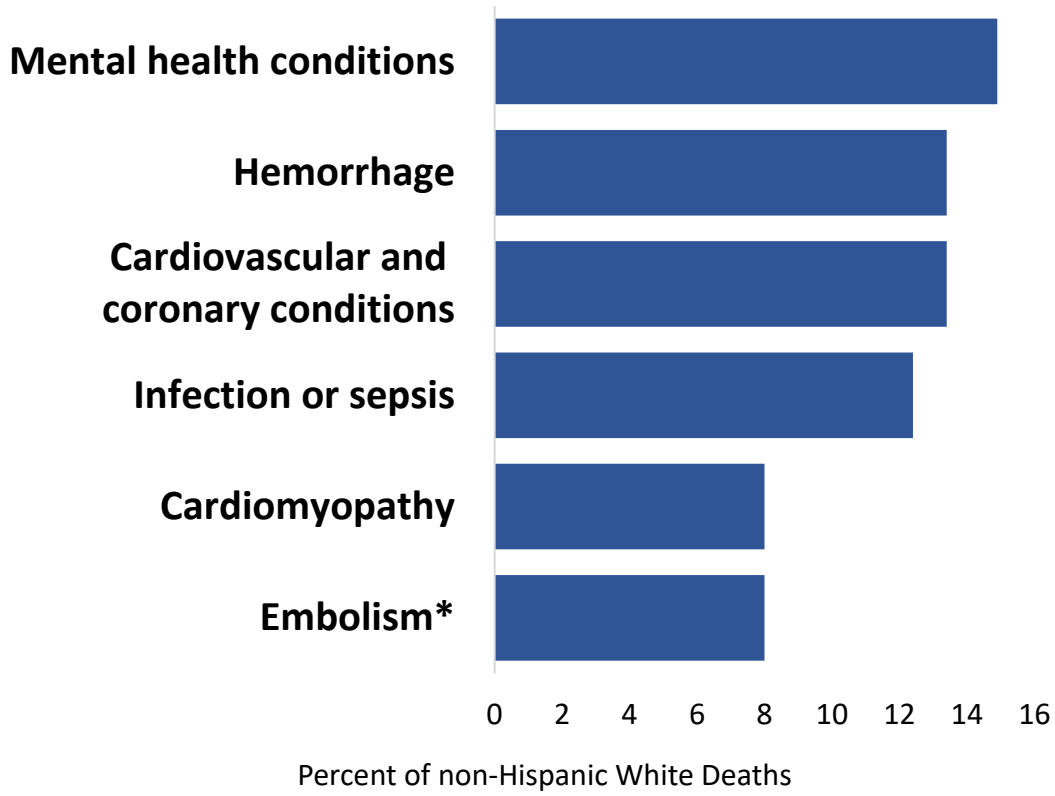
Davis NL, Smoots AN, Goodman DA. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019

Leading causes vary by race-ethnicity: 14 MMRCs

Non-Hispanic Black



Non-Hispanic White



Data Source: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html

Notes: * Embolism – thrombotic pulmonary and other embolisms

Community and Facility

Contributing Factor	Recommendations to Address Contributing Factor
Access to clinical care	Expand office hours; Increase number of providers who accept Medicaid; Increase availability of group prenatal care
Unstable housing	Prioritize pregnant women for temporary housing programs
Lack of/inadequate transportation options	Strengthen/build systems that link persons to affordable transportation; Provide vouchers for non-emergency transportation
Obesity and associated chronic condition complications	Improve access to healthy food options; Improve education and promotion of health eating habits and weight management strategies
Limited experience with OB emergencies	Implement OB emergency simulation training for Emergency Dept. staff; Ensure Emergency Dept staff ask about recent pregnancy history and consult with OB on call if pregnant within prior year
Lack of appropriate personnel or services	Increase access to telemedicine by facilities with no OB onsite; Ensure Medicaid managed care organizations' contracts include sufficient access to high risk care specialists
Lack of guiding protocols	Ensure sepsis, hemorrhage, and mass transfusion protocols are in place and monitor for staff use; Develop/implement relevant patient safety bundles; Implement systems that foster care coordination across providers; Increase use of patient navigators

Patient and Provider

Contributing Factor	Recommendations to Address Contributing Factor
Lack knowledge of warning signs or need to seek care	Improve counseling and increase use of patient education materials on warning signs and when to seek care, such as the AWHONN *Save Your Life* discharge instructions
Non-adherence to medical regimens or advice	Standardize patient education to ensure providers communicate consistent messages; Implement techniques that ensure patient understanding, such as patient "teaching back" to the provider; Make education materials available in clinic and online; Strengthen/expand access to patient navigators, case managers, and peer support; Ensure access/use of interpreter services when needed; Increase home health or social work follow-up services
Missed/delayed diagnosis	Repeat blood pressure measurement in a timely manner (and perhaps manually) when initial blood pressure result is unexpected; Offer/expand non-OB provider education on cardiac conditions in pregnant and postpartum women; Increase the thorough evaluation of patients with pain and shortness of breath
Inappropriate/delayed treatment	Establish polices and protocols that support only performing cesarean deliveries when medically indicated; Implement a maternal early warning system
Lack of continuity of care	Improve care transition protocols and communication between OB providers and primary care providers and specialty care providers

System(s)

Contributing Factor	Recommendations to Address Contributing Factor
Inadequate receipt of care	Develop/expand implementation of policies that ensure women deliver at/are transported to a hospital with a level of maternal care that matches her health risk; Enlist state perinatal quality collaboratives to identify quality improvement procedures and periodic drills/simulation training for birth facilities, including OB emergencies; Design/expand implementation of education initiatives
Case coordination/management	Extend/expand Medicaid eligibility for pregnant women to include 1 year of postpartum care; Create a quality improvement entity to manage outpatient care gaps and implement and monitor care coordination improvements; Develop/implement a postpartum care bundle that integrates services for high risk women; Develop and implement protocols and polices that improve hospital documentation of abnormal test results, follow-up care plans, and condition management plans; Develop a universal electronic health record system that allows sharing medical records within and between hospitals
Guiding policies, procedures, or standards not in place	Develop and implement protocols and policies that increase timely referrals and consultation; Increase (and monitor for) consistency of protocols and policies within healthcare systems

Example of using qualitative analysis for a deeper understanding of MMRIA data on substance use

- MMRIA qualitative analysis showed fragmentation of screening for substance use disorder was commonly noted in case narratives and contributing factors.
- Individuals experienced:
  - Housing instability including homelessness
  - Violence* sometimes across their lifespan
  - Incarceration history
  - Financial instability/unemployment
  - Loss of child/children/pregnancy**

Only 50% of pregnancy-associated drug overdose deaths had substance use documented in the prenatal records

*Violence includes intimate partner violence, domestic violence, personal and familial violence including physical and sexual abuse, and childhood trauma.
**Loss of child/children/pregnancy: defined as the death or loss child including stillbirth and induced termination or spontaneous loss of pregnancy, removal of a child by Child Protective Services, or loss of child to custody issues.

Identifying, Documenting, and Addressing Bias

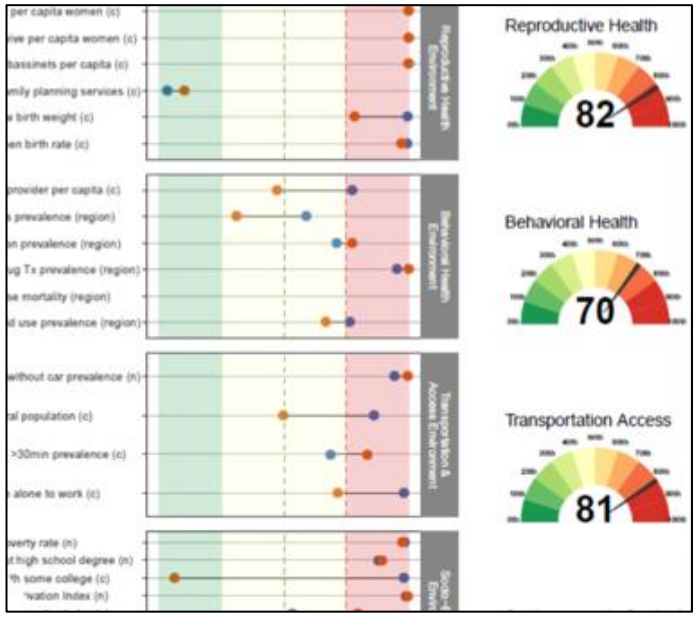
Discrimination: treating someone **more or less favorably** based on the group, class or category they belong to resulting from **biases, prejudices,** and **stereotyping**. It can manifest as differences in **care, clinical communication** and shared **decision-making**.

Interpersonal Racism: discriminatory interactions between individuals resulting in differential assumptions about the **abilities, motives,** and **intentions** of others and differential actions toward others based on their race. It can be **conscious** as well as **unconscious**, and it includes acts of **commission** and acts of **omission**. It manifests as lack of **respect, suspicion, devaluation, scapegoating**, and **dehumanization**.

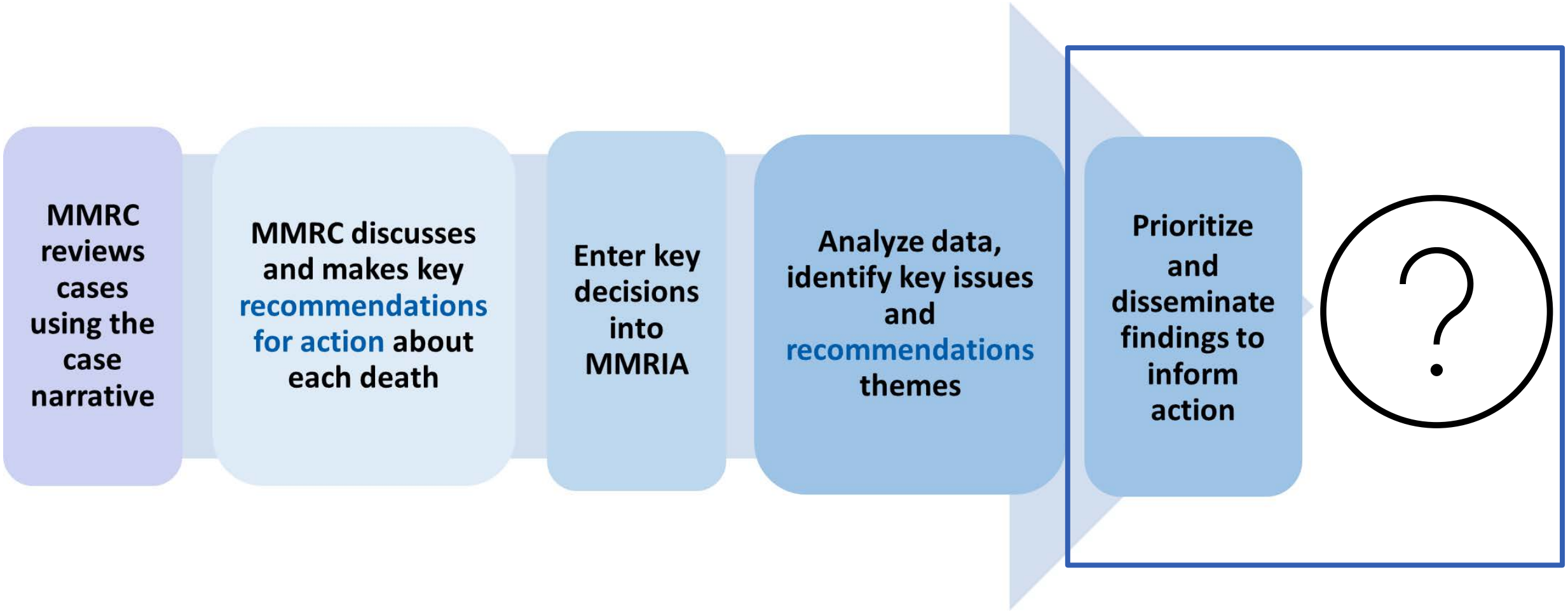
Structural Racism: the systems of power based on **historical injustices** and **contemporary social factors** that systematically **disadvantage people of color** and **advantage white people** through **inequities** in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.

Community Vital Signs dashboards for additional context

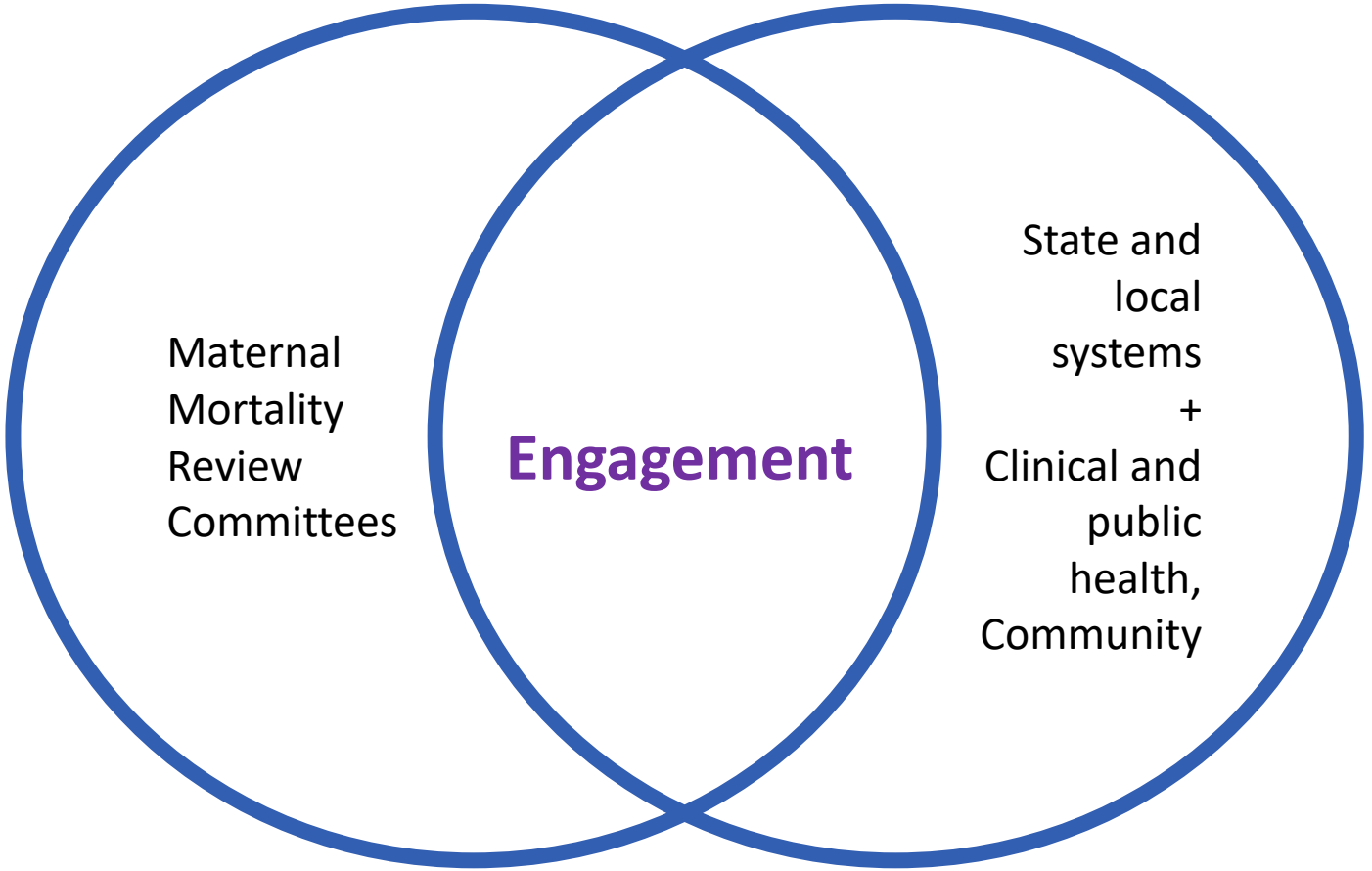
- Community Vital Signs dashboard data supports maternal mortality reviews by comparing community health indicators where the pregnant or postpartum person lived to those of all pregnant or postpartum persons in the same state or in the US.
- Community Vital Signs dashboards for MMRIA users expected by Fall 2022 through partnership with HHS Office of Minority Health and Emory University.



Review to Action



Moving Data to Action to Prevent Maternal Mortality



In partnership with clinical and public health and community leadership and organizations, the recommendations from MMRCs can inform strategies to prevent maternal mortality within a state and local context.

MMRC reviews cases using the case narrative

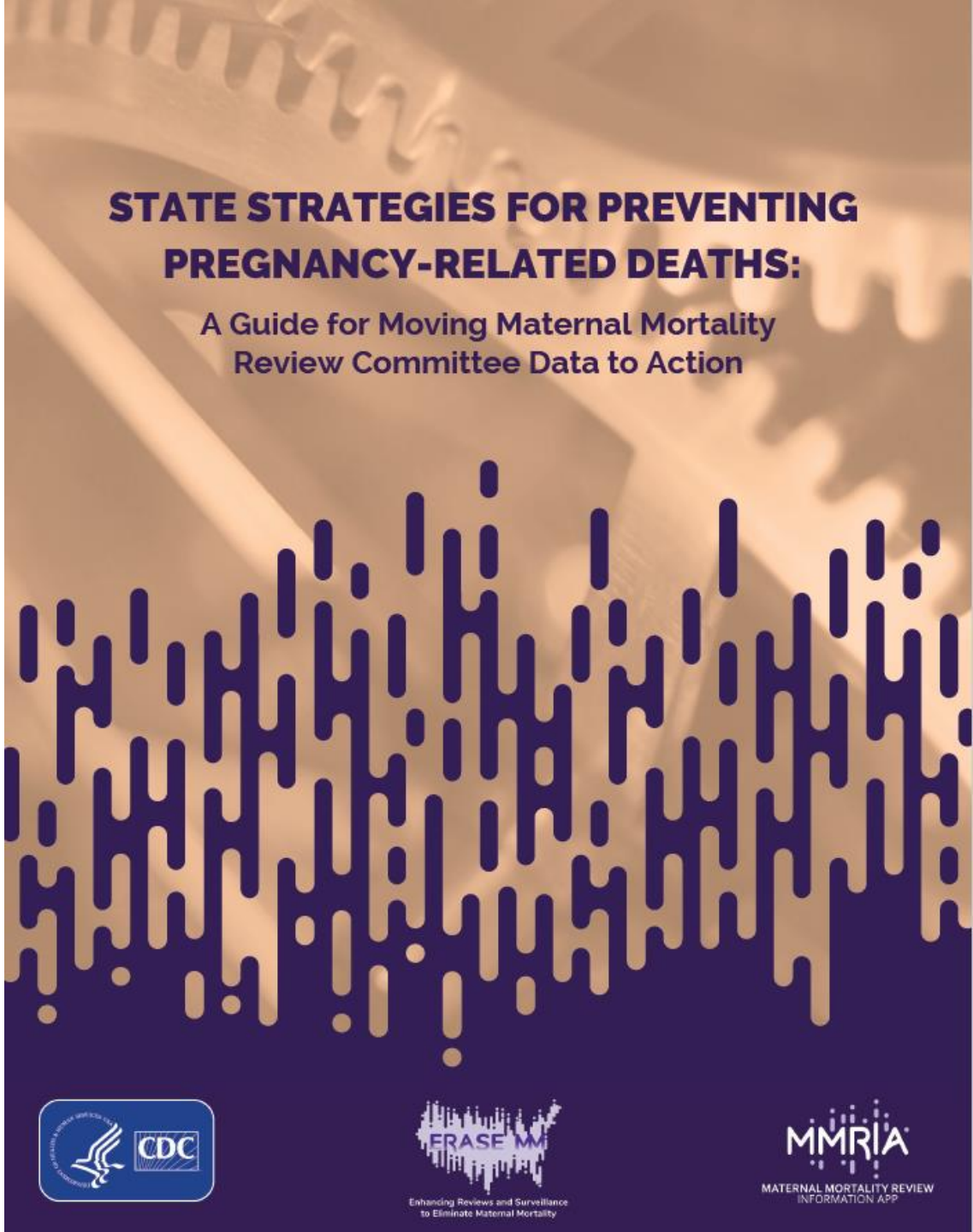
MMRC discusses and makes key recommendations for action about each death

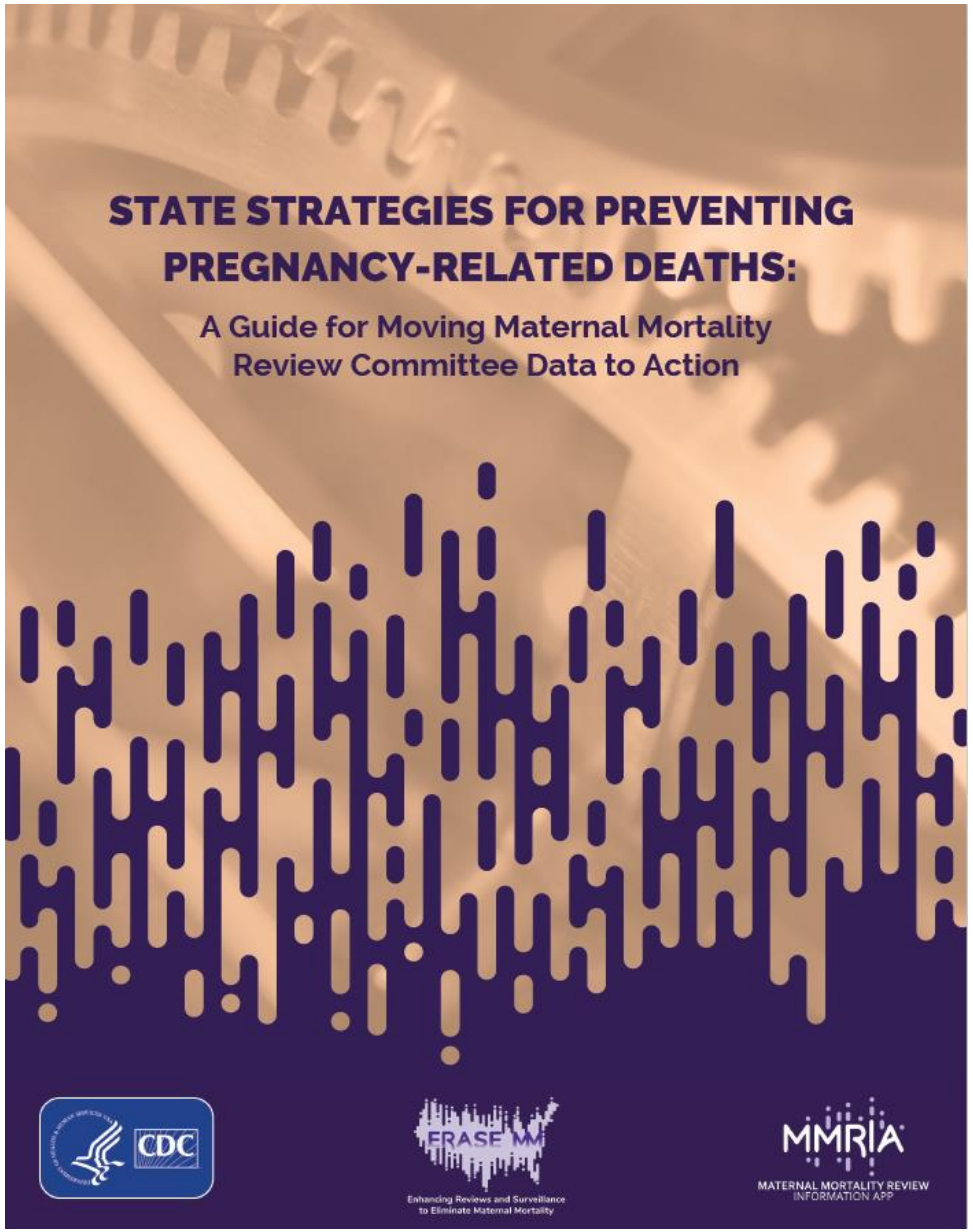
Enter key decisions into MMRIA

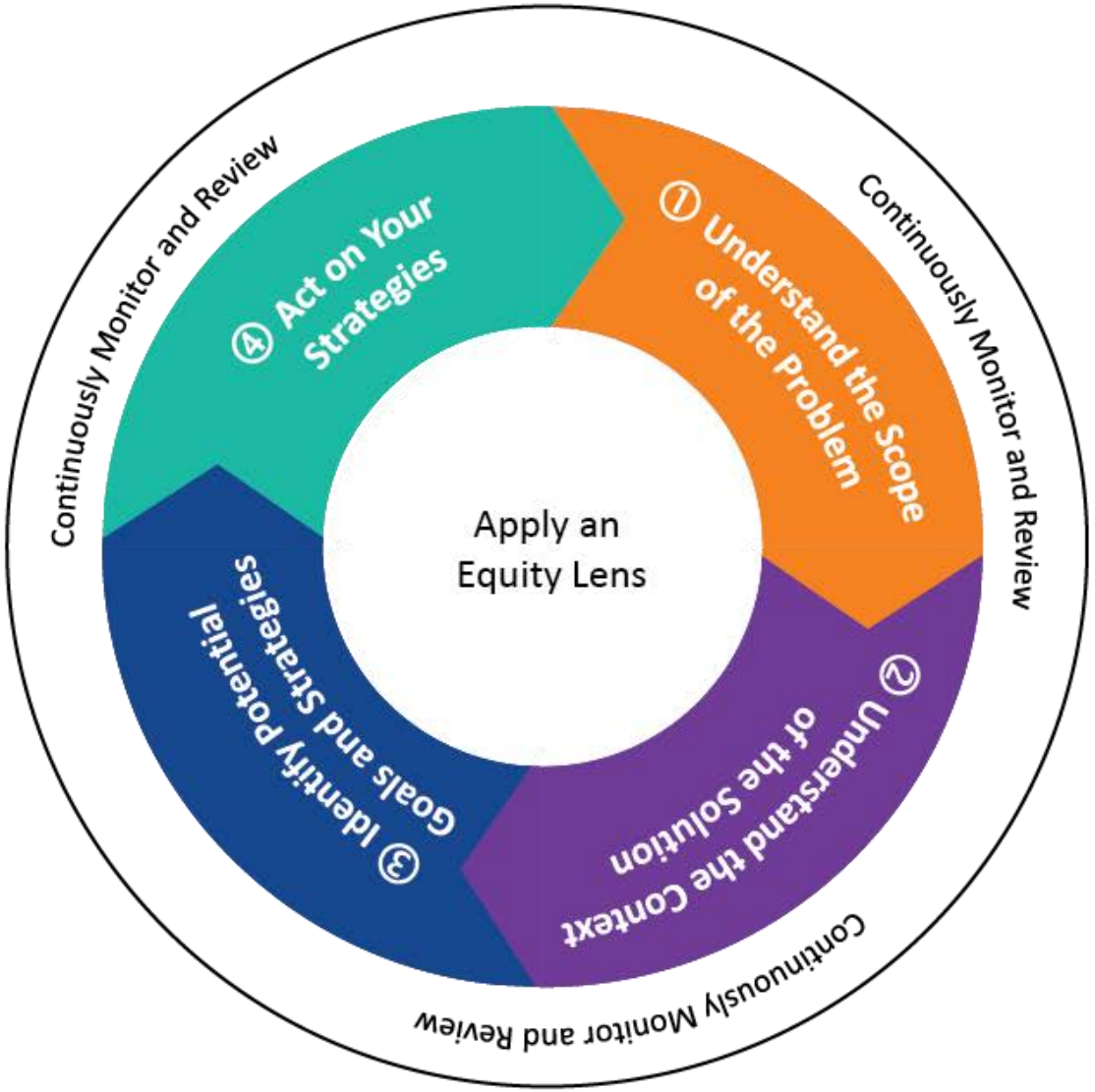
Analyze data, identify key issues and recommendations themes

Prioritize and disseminate findings to inform action

https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths/state-strategies.html

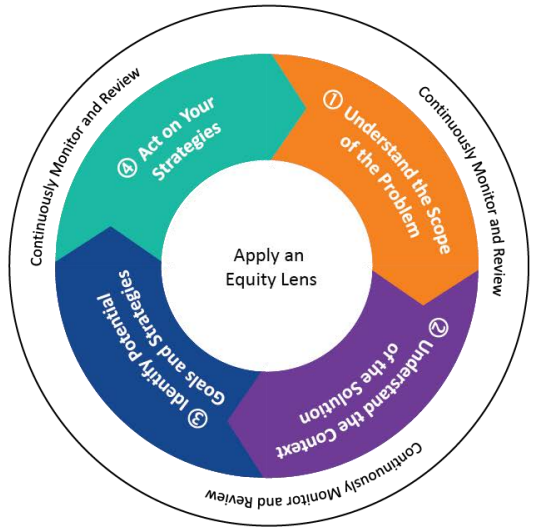






https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths/state-strategies.html

The 4 Iterative Steps.



Step 1. Use Data to Understand the Scope of the Problem

- Identify and review complementary information, such as from PRAMS

Step 2. Understand the Context of the Solution

- Based on who, what, when of MMRC recommendations assess current activities, partnerships, and resources

Step 3. Identify Potential Goals and Strategies

- Provides 5 example goals and strategies based on CDC experiences with MMRCs and MMRC data

Step 4. Act on Your Strategies

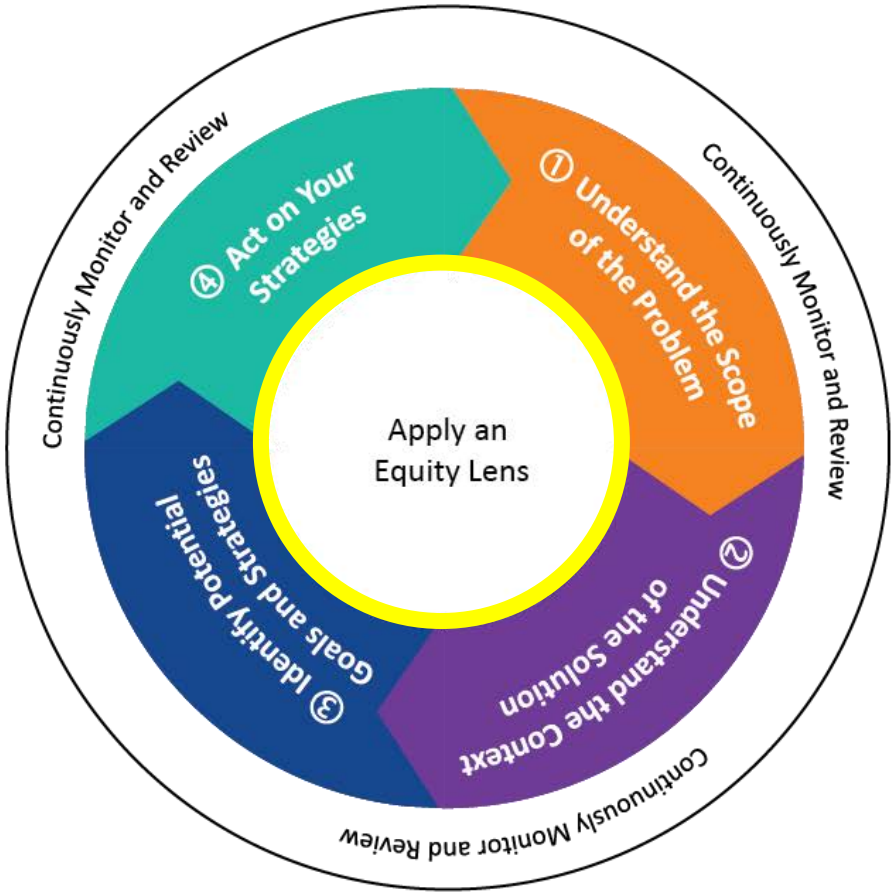
- Covers assessing strategies for fit, implementation planning, and evaluation

https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths/state-strategies.html

All Steps—
Apply an Equity Lens

Applying an equity lens means taking **deliberate** steps to

- Be sure every mother's life is valued equally
  - Ensuring respectful care, client centered care, and a diverse workforce
- Understand the impacts of historical trauma and the role of inequitable institutional structures
  - Expanding insurance coverage, paid family leave policies, and earned income tax credits
- Consider patient and community perspectives
  - Engaging communities in prevention, and recognizing and building upon community assets

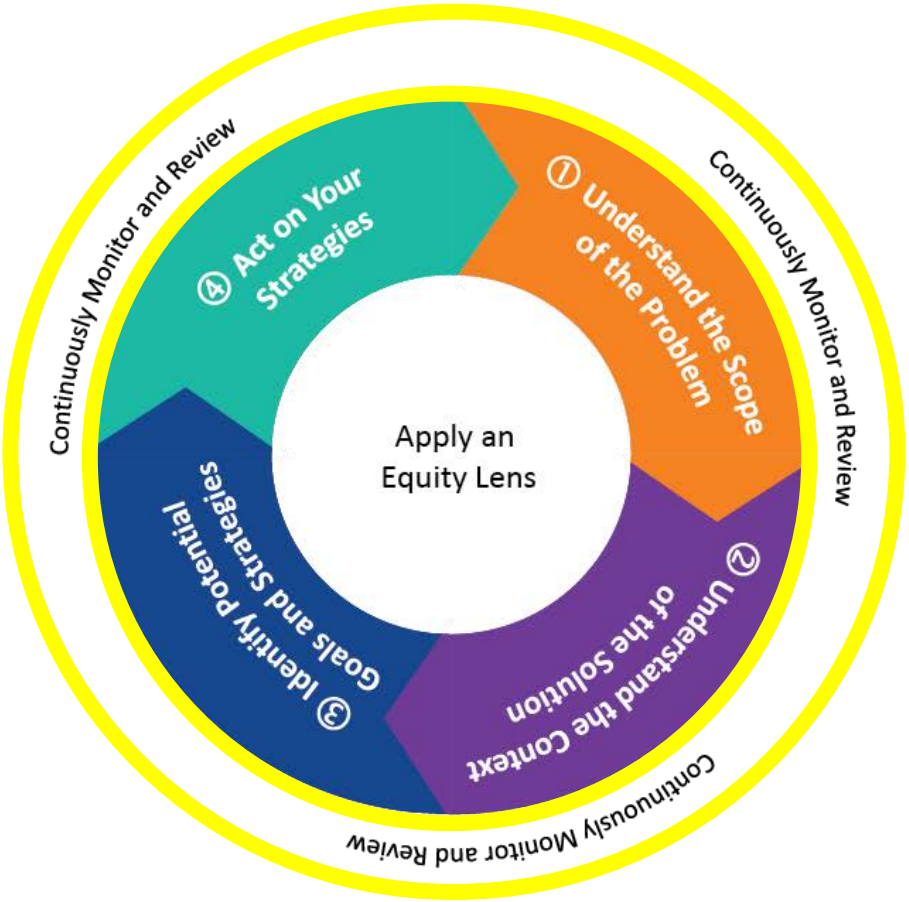


https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths/state-strategies.html

All Steps—
Continuously Monitor and Review

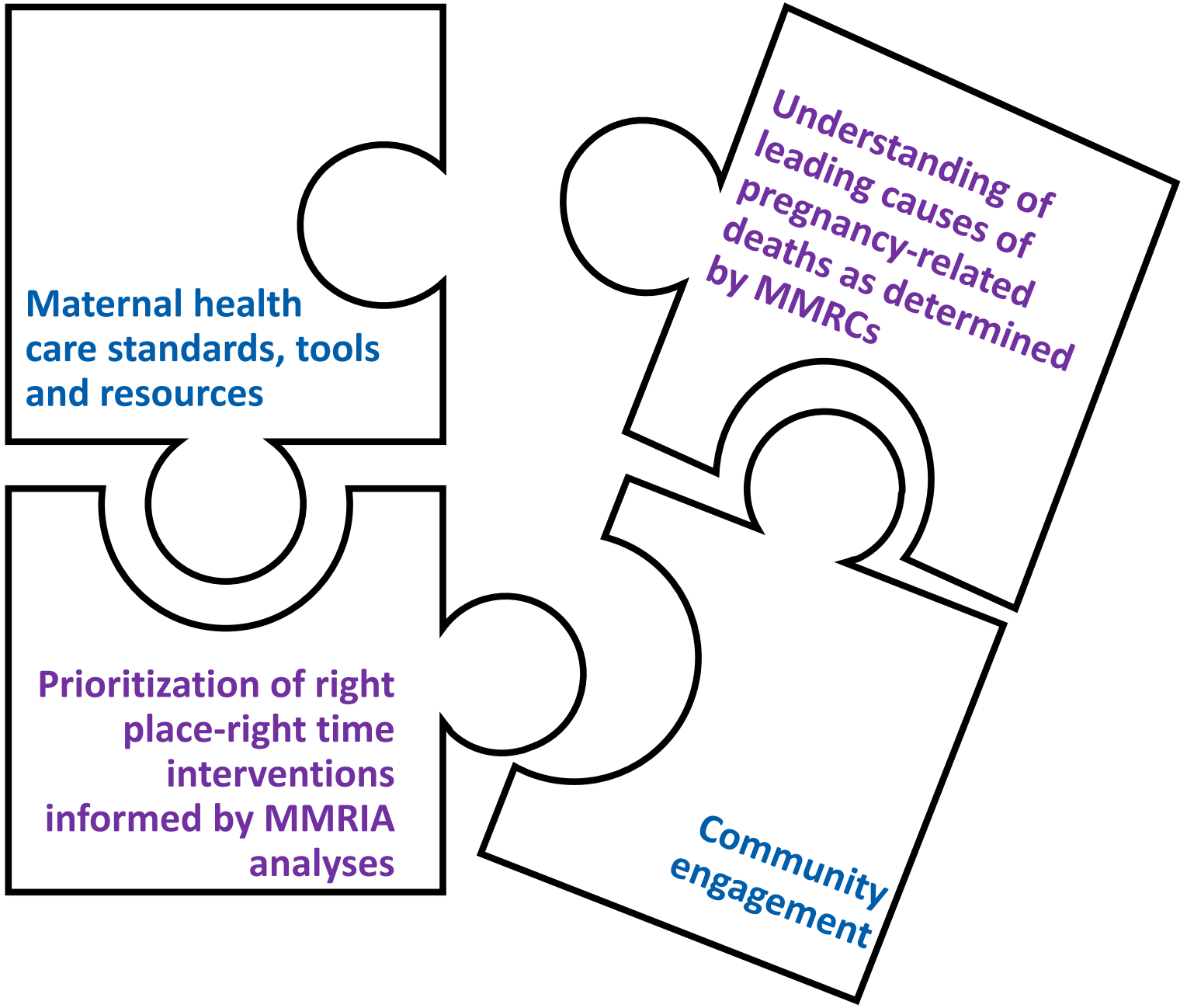
Throughout the process, it is important to **systematically** examine progress:

- Data from population-based data sources can be used for process and outcome evaluation
- Community and organizational factors and resources may be inputs for the implementation plans
- Assessing whether the strategies selected for action are having the intended effect (evaluation) contributes to the evidence-base
- Stratifying indicators for process evaluations by race/ethnicity can identify which factors need directed attention to close the disparity gaps



https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths/state-strategies.html

Data informing action



Data to make a difference—MMRCs are a cornerstone of action, connecting data-informed strategies to improve outcomes and save the lives of moms

MMRIA
MATERNAL MORTALITY REVIEW INFORMATION APP

REVIEW to ACTION
WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

Acknowledgements

Arizona
Colorado
Delaware
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Thank you!

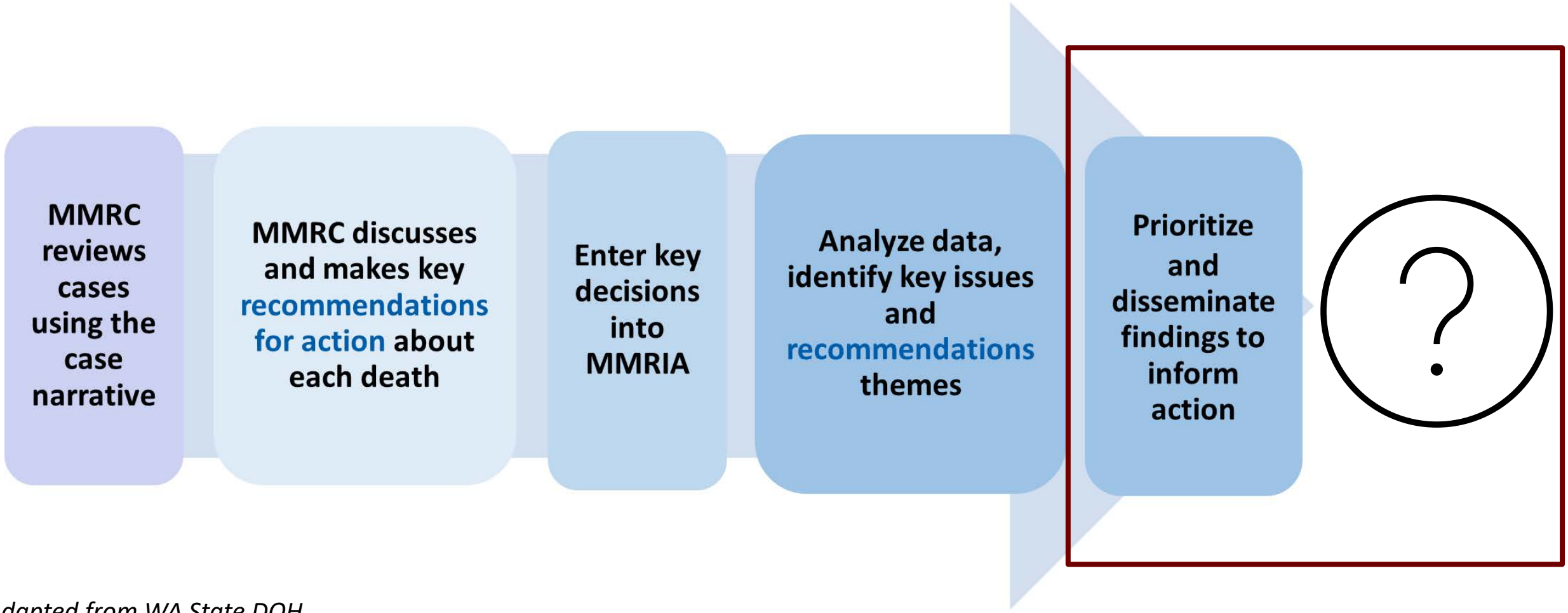
For more information, visit www.cdc.gov/erasemm or contact: erasemm@cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Surveillance and Prevention with Maternal Mortality Review Committees

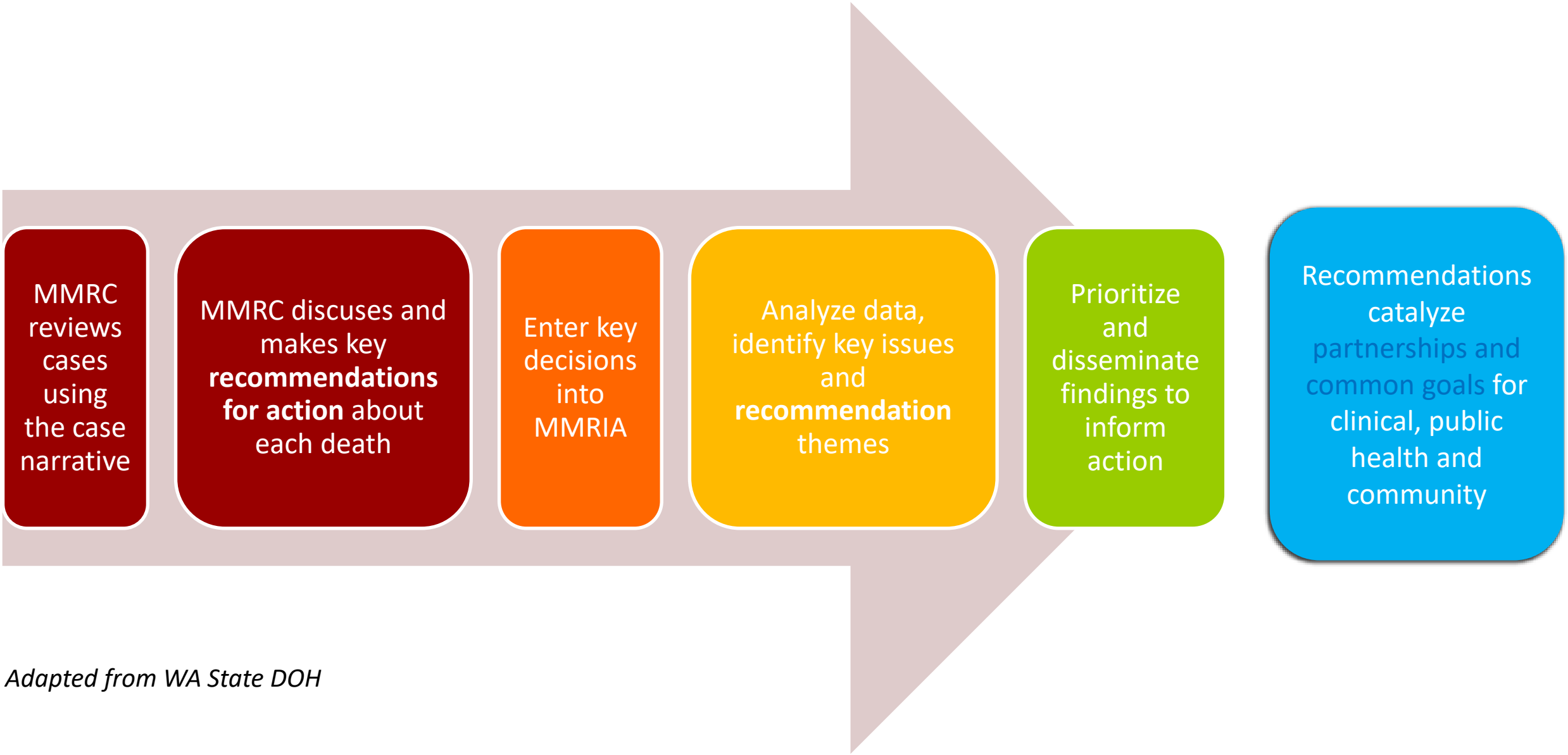
Lisa M. Hollier, MD, MPH, FACOG
Past Chair, Texas Maternal Mortality and Morbidity Review Committee

Review to Action



Adapted from WA State DOH

Review to Action



Adapted from WA State DOH

The 4 Iterative Steps

Step 1. Use Data to Understand the Scope of the Problem

- Identify and review complementary information

Step 2. Understand the Context of the Solution

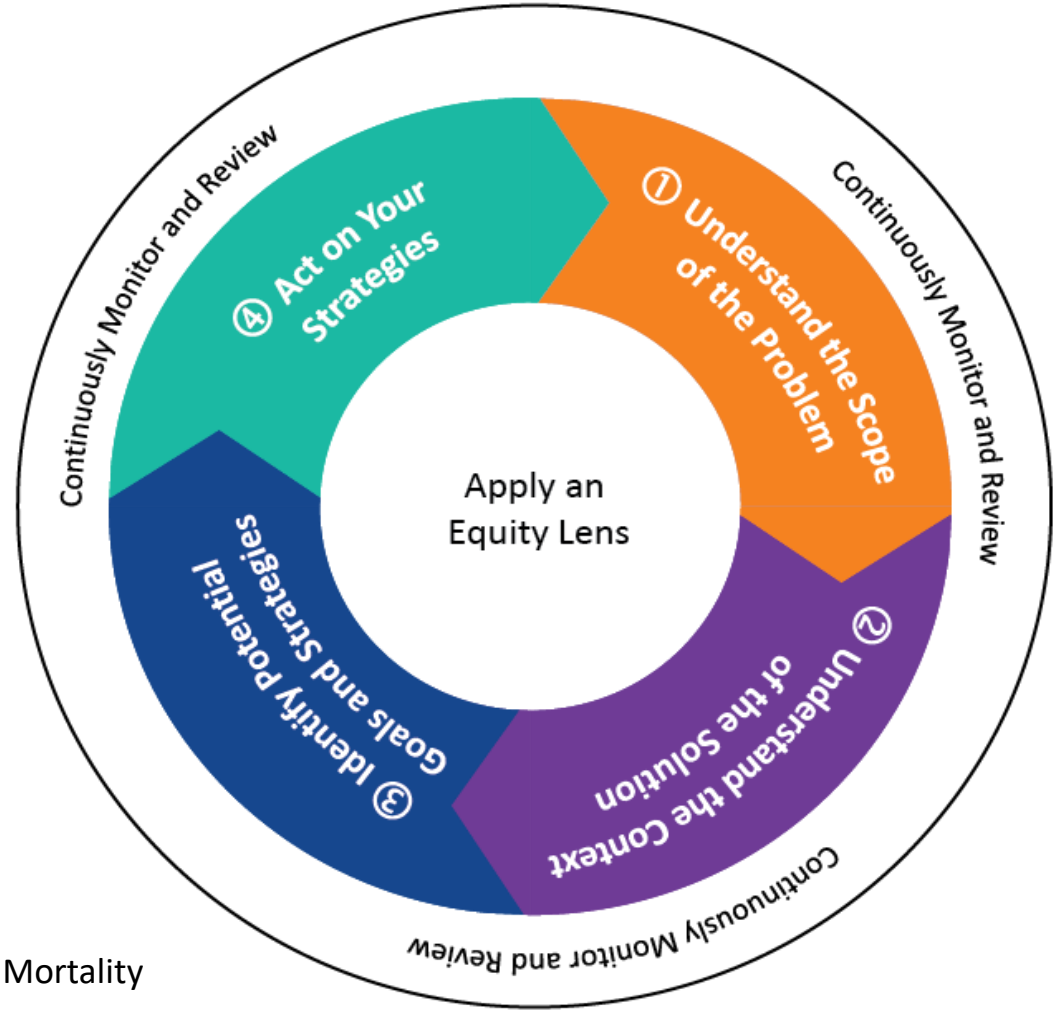
- Assess current activities, partnerships, and resources

Step 3. Identify Potential Goals and Strategies

- Look for common goals

Step 4. Act on Your Strategies

- Work together – whether it is legislatively or directly implementing initiatives

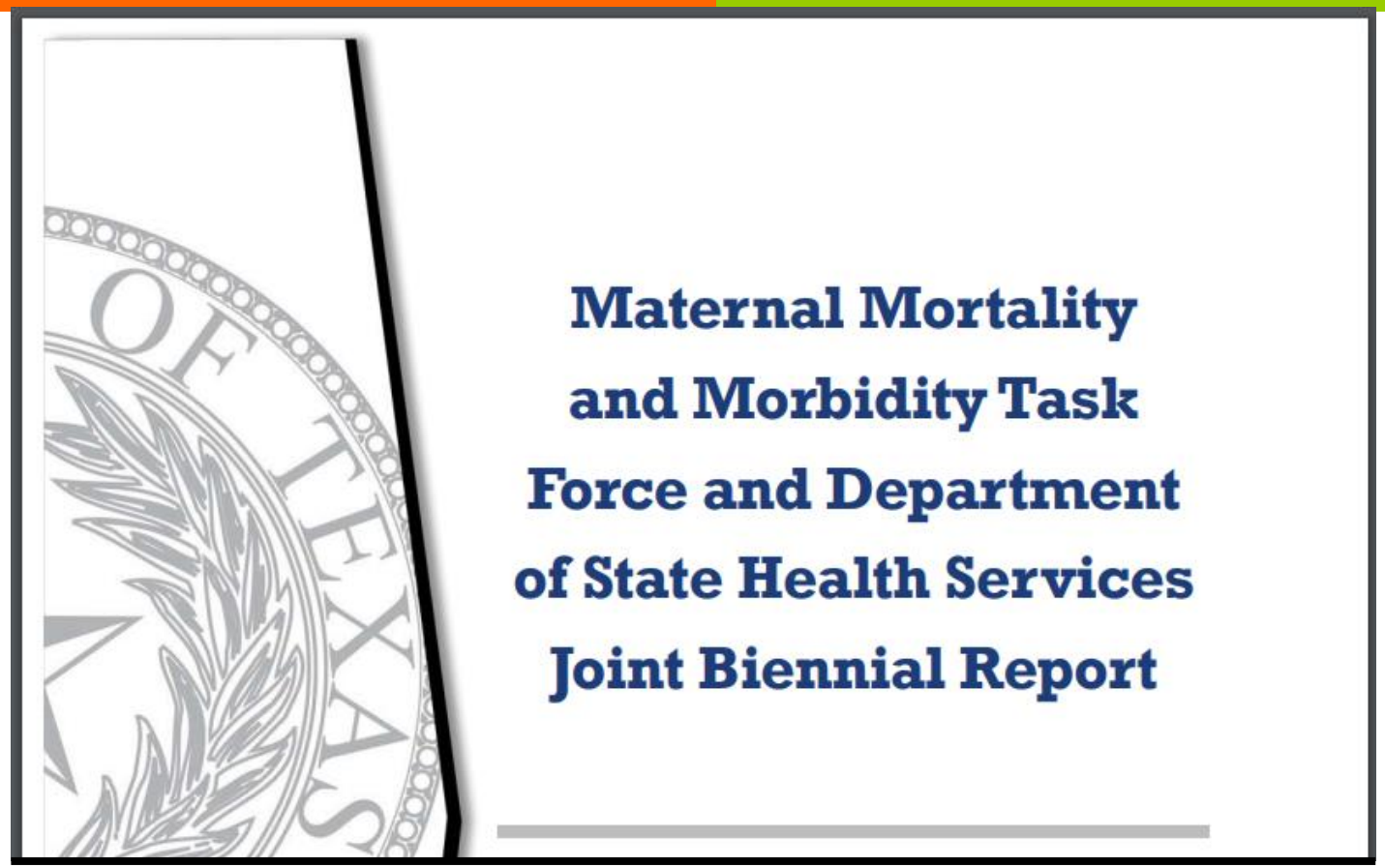


State Strategies for Preventing Pregnancy-Related Deaths: A Guide for Moving Maternal Mortality Review Committee Data to Action. CDC/NCCDPHP/DRH

Texas MMMRC History

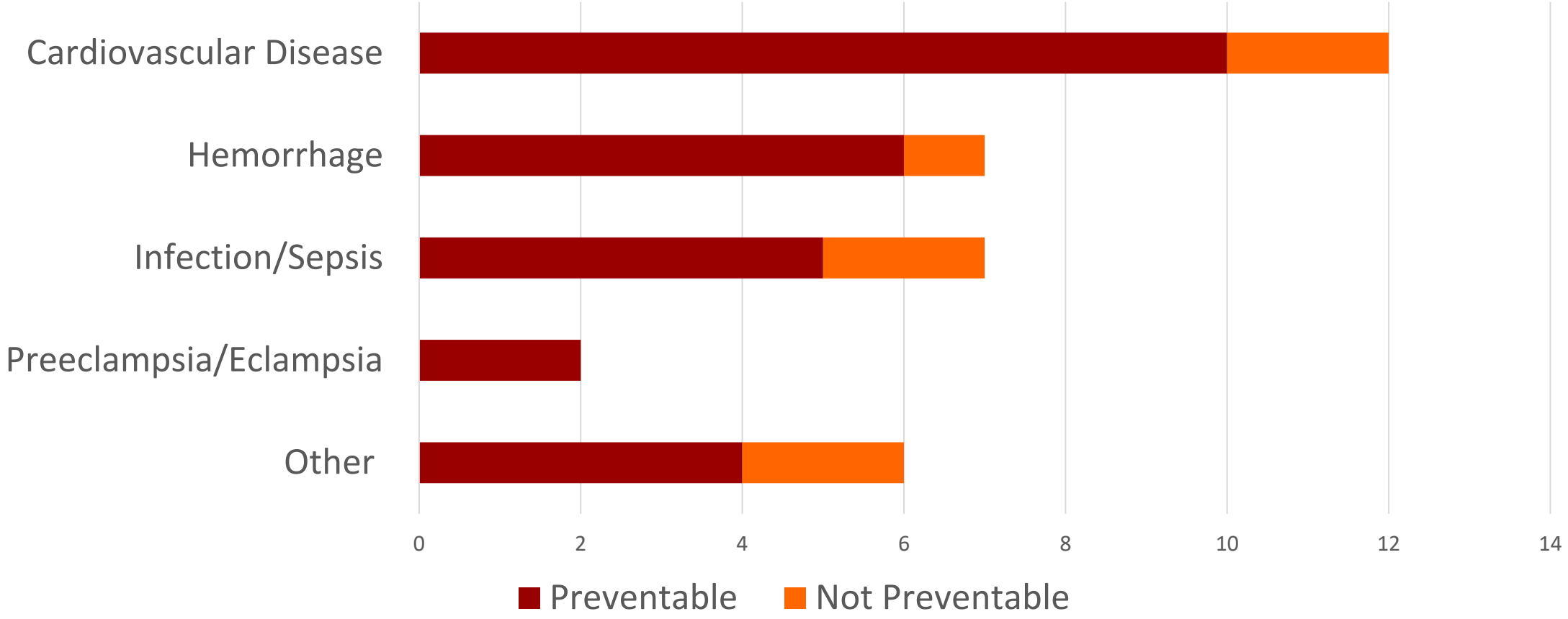
- Established by legislation under the Texas Department of State Health Services as a “Task Force” in 2013 and updated to “Review Committee” in 2019
- Duties by Statute amended in 2017
  - Study and Review
    - Trends, rates, or disparities in pregnancy-related deaths
    - Health conditions and factors that disproportionately affect the most at risk populations
    - Best practices and programs operating in other states that have reduced rates of pregnancy-related deaths
  - Compare rates of pregnancy-related deaths based on SES of the mother
  - Determine the feasibility of the review committee reviewing cases of SMM
  - Consult with PAC when making recommendations to reduce MM and SMM

MMMTF Biennial Report 2018



HTTPS://WWW.DSHS.TEXAS.GOV/MCH/MATERNAL_MORTALITY_AND_MORBIDITY.SHTM

Pregnancy-Related Deaths, 2012



Maternal & Child Health Epidemiology, Division for Community Health Improvement, DSHS.

Pregnancy-Associated Deaths, 2012-2015

Cause of Death	While Pregnant	0-7 Days Postpartum	8-42 Days Postpartum	43-365 Days Postpartum	Total
Drug Overdose	0	3	7	54	64
Cardiac Event	2	12	9	32	55
Homicide	2	1	5	34	42
Suicide	0	1	2	30	33
Infection/Sepsis	1	3	14	14	32
Cerebrovascular Event	0	8	9	10	27
Hemorrhage	3	12	2	3	20
Hypertension/Eclampsia	0	7	4	7	18
Pulmonary Embolism	2	3	4	4	13
Amniotic Fluid Embolism	1	9	0	0	10
Other	5	5	8	50	68
Total	16	64	64	215	382

Maternal & Child Health Epidemiology, Division for Community Health Improvement, DSHS.

Role of Overdoses in Pregnancy-Associated Deaths, 2012-2015

- Drug overdose leading cause of maternal death, mostly occurring after 60 days postpartum
  - Combination of drugs involved in 66%
  - Opioids detected in 58%

- Demographic groups at higher risk:
  - White women
  - Ages 40+
  - Medicaid at delivery
  - Urban counties

Contributing Factors

Patient/Family Level

- Chronic Disease
- Delay

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm

Contributing Factor: Chronic Disease

- **Example Committee Description of Chronic Disease contribution to death**
  - *Complex medical issues during pregnancy with no single point of contact. Need for case management.*

- **Recommendation to address**
  - Prioritize care coordination and management for pregnant and postpartum women, specifically expanding care management services for pregnant and postpartum women to provide education, service coordination, and advocacy for women's needs.

Chronic Disease AND Delay

Care Coordination

- Texas Legislature appropriated funds for DSHS to develop and establish a high-risk maternal care coordination services pilot for women of childbearing age

Patient/Family/Provider Education

- Funds appropriated for DSHS to develop public awareness campaigns

Contributing Factors

Provider Level

- Assessment
- Referral
- Clinical Skill
- Delay

Facility Level

- Assessment
- Clinical Skill
- Continuity of Care

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm

Contributing Factors: Assessment & Delay

- **Example Committee Description of Assessment contribution to death**
  - *Patient had risk factors for hemorrhage but she was not identified as high risk, early warning signs of hemorrhage were missed and there was delay in appropriate treatment.*

- **Recommendations to address**
  - Promote a culture of safety and high reliability through implementation of best practices in birthing facilities. Specifically, continue support and promotion of state maternal safety initiatives that foster a culture of safety and high reliability of care.

Rapid Assessment and Appropriate Treatment

Texas Legislature

- Added “Maternal Health and Safety Initiative” into the Texas Health and Safety Code
- Added “Opioid Use Disorder Initiative” to Texas Health and Safety Code
- Subsequently appropriated funds for program staff and implementation of safety bundles

Texas DSHS

- Created the TexasAIM program and >99% of Texas birthing hospitals voluntarily enrolled
- Included standardized MEWS processes (led by TCHMB) in hospitals that provide maternity services

TEXAS Health and Human Services | Texas Department of State Health Services

TexasAIM

Obstetric Hemorrhage	Severe Hypertension	Opioid Use Disorder
• First bundle statewide implementation 2019	• Second bundle statewide implementation 2020	• Pilot project with 10 experienced facilities

- During COVID, the TexasAIM OB Learning Collaborative pivoted to providing support to hospitals who were treating COVID patients.

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Pregnancy-Associated Deaths with OUD

- AIM national released a new Substance Use Disorder Bundle to be relaunched in Texas fall of 2022
- Community organizations partnering with others in on-going work:
  - SBIRT Training for providers
  - Expanded access to MAT
  - Training on Trauma-Informed Care and strategies to reduce stigma/bias
  - Development of Plans of Safe Care
  - Care Coordination Program will include screening for SUD

Contributing Factors

Systems/Community Level

- Access
- Outreach

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm

Contributing Factor: Access

- **Example Committee Description of Access contribution to death**
  - *Patient had medical complications but was unable to access necessary care between pregnancies*

- **Recommendations to address**
  - Increase access to health services during the year after pregnancy and throughout the interconception period to improve the health of women, facilitate continuity of care, enable effective care transitions, and promote safe birth spacing. Specifically, the TF recommended extending access to healthcare coverage for 12 months following delivery.

Access and Coverage

Advocacy Efforts

- Medical organizations including Texas Medical Association (along with specialty organizations) worked together
- Hospitals and Hospital-systems
- Community-based organizations

Texas Legislature

- Expanded the Healthy Texas Women program to include a “plus” version with additional services/supports in 2019
- Extended postpartum Medicaid coverage for an additional 4 months (total of 6 months of coverage) in 2021

Thank you for your time today

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Questions

This event was supported by cooperative agreement number CDC-RFA-OT18-1802, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the presenters and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the U.S. Department of Health and Human Services Office for the Assistant Secretary for Planning and Evaluation