Texas Maternal Morbidity and Mortality: Past, Present & Future

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Lisa M. Hollier, MD, has no relevant financial relationships with commercial interests to disclose.
Acknowledgements

• Texas Department of State Health Services
  • Maternal and Child Health Epidemiology
  • Community Health Improvement

• Members of the Texas Maternal Mortality and Morbidity Task Force
Learning Objectives

At the completion of this session, the participants will be able to:

1. Discuss trends in maternal mortality and severe morbidity in Texas.
2. Compare strategies for reduction of mortality and morbidity.
3. Outline gaps and understand new programs to reduce disparities in perinatal outcomes.
Implementation is:

- Complicated
- Expensive
- Complex
- Hard
- Difficult
- Annoying
- Someone else’s problem
- Hard work
Texas Maternal Mortality

• Vital statistics data using pregnancy check box coding both under- and over-reported maternal death
  • Over reporting was significantly more common and accounted for approximately half the reported deaths

• Based on evidence, DSHS transitioned to enhanced case identification system
  • Death certificate information
  • Matching live birth and fetal death certificates to deaths among all women
Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm
Texas Maternal Mortality

- 2012 Maternal Deaths Reviewed by MMMTF
- 89 deaths were identified
  - 34 cases (38%) were categorized as pregnancy-related
  - 50 cases (56%) were categorized as pregnancy-associated, but not pregnancy-related
  - 5 cases (6%) pregnancy-relatedness could not be determined
Texas Pregnancy-related Mortality

• Leading underlying causes of pregnancy-related death in 2012 identified by the Task Force were:
  1. cardiovascular and coronary conditions
  2. obstetric hemorrhage
  3. infection/sepsis
  4. cardiomyopathy
  5. preeclampsia/eclampsia, mental health conditions, and amniotic fluid embolus

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm
Maternal Mortality by Race/Ethnicity

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

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm
Preventability of PRM

- Cardiovascular disease: 10 (Some, Good, or Strong Chance) 2 (No Chance or Unknown)
- Obstetric hemorrhage: 6 (Some, Good, or Strong Chance) 1 (No Chance or Unknown)
- Infection: 5 (Some, Good, or Strong Chance) 2 (No Chance or Unknown)
- Preeclampsia and eclampsia: 2 (Some, Good, or Strong Chance)
- Other: 4 (Some, Good, or Strong Chance) 2 (No Chance or Unknown)

PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, DSHS.
A Framework

Community
System
Facility
Provider
Individual/Family
Contributing Factors

Top *individual and family level factors* contributing to death:

- Underlying medical conditions
  - Cardiovascular conditions, including chronic hypertension
  - Obesity
  - Depression
- Delay in or failure to seek care or treatment
  - Lack of patient recognition of early warning signs of worsening condition

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

Top *Provider level* factors contributing to death:

• Failure to recognize high risk maternal health status
  • failure to refer high risk patients to appropriate care specialties
• Failure to recognize and respond to maternal early warning signs
  • delay in or lack of bedside clinician presence
• Delays in diagnosis
• Delays in initiation of treatment
• Inadequate or ineffective treatment
• Lack of effective communication

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

Top *facility level* factors included:
- Failure to recognize high risk status
- Delayed and inadequate response to clinical warning signs
- Lack of continuity of care
  - lack of appropriate hand-off of patients between hospital staff and outpatient providers
  - impacted by the inability to secure appropriate outpatient care and.

Top *systems and community level factors* included:
- Poor care coordination from the inpatient to outpatient setting
- Lack of access to interconception care services and transitional care services.

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm
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- Obesity: 29.2
- Diabetes: 39.9
- Hypertension: 56.3
- Smoking During Pregnancy: 86.0
- Late Entry into Prenatal Care: 26.8
- Cesarean Delivery: 33.3

Pre-pregnancy Obesity 2007-2016

*2016 Texas data are preliminary
Source: 2007-2016 Birth Files
Prepared by: Maternal & Child Health Epidemiology Unit
Oct 2017
Maternal Diabetes and Hypertension, 2007-2016

MATERNAL DIABETES

MATERNAL HYPERTENSION

*2016 Texas data are preliminary.
Source: 2007-2016 Birth Files
Prepared by: Maternal & Child Health Epidemiology Unit
Oct 2017

Texas Children’s Health Plan
MMMTF Recommendations

1. 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.

2. Enhance screening and appropriate referral for maternal risk conditions.

3. Prioritize care coordination and management for pregnant and postpartum women.

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

4. Promote a culture of safety and high reliability through implementation of best practices in birthing facilities.

5. Identify or develop and implement programs to reduce maternal mortality from cardiovascular and coronary conditions, cardiomyopathy and infection.

6. Improve postpartum care management and discharge education for patients and families.

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

7. Increase maternal health programming to target high-risk populations, especially Black women.

8. Initiate public awareness campaigns to promote health enhancing behaviors.

9. Champion integrated care models combining physical and behavioral health services for women and families.

10. Support strategies to improve the maternal death review process.

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm
## Healthy Texas Mothers and Babies

### DSHS Maternal and Child Health Knowledge, Leadership, and Partners

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<thead>
<tr>
<th>Healthy Women</th>
<th>Healthy Mothers</th>
<th>Healthy Babies</th>
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<tbody>
<tr>
<td><strong>Individual and Public Awareness and Knowledge</strong></td>
<td><strong>Professional Education</strong></td>
<td><strong>Community Improvement</strong></td>
</tr>
<tr>
<td>Increase Knowledge to Change Attitudes and Behaviors for Improved Maternal and Infant Health Outcomes</td>
<td>Strengthen Competencies and Prepare Professionals to Optimize Clinical Outcomes</td>
<td>Foster Development of Environments that Reduce Barriers, Promote Healthy Lifestyle Choices, and Optimize Maternal and Infant Health Outcomes</td>
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<tr>
<td>Someday Starts Now</td>
<td>Online Provider Education</td>
<td>Drive System Changes to Support Adoption and Diffusion of Quality Improvements for Maternal and Infant Health and Safety</td>
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<tr>
<td>Preconception Peer Education Program</td>
<td>HTMB Life Course Conferences</td>
<td>Maternal Mortality &amp; Morbidity Task Force</td>
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<td>Peer Dads Program</td>
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<td>One Key Question</td>
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<td>Texas Ten Step Star Achiever Initiative</td>
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### DSHS Maternal and Child Health Epidemiology, Surveillance, Research, and Analytics

- Texas Mother-Friendly Worksite Program
- Child Care
- Health Care
- Public Spaces
Perinatal Quality Improvement Network

• To drive adoption and diffusion of quality improvements for maternal and infant health and safety

• Key initiatives:
  ➢ Maternal Morbidity and Mortality Task Force
  ➢ Texas Collaborative for Healthy Mothers and Babies
  ➢ Risk appropriate maternal care
  ➢ Maternal safety bundles
MMMTF Subcommittee
Maternal Health Disparities

Identify key drivers and root causes of racial disparities in maternal mortality and morbidity in Texas with the goal of reducing or eliminating disparities in maternal health outcomes.

• determine if there are cause-specific diseases driving maternal mortality and morbidity based on race
• determine if racial differences exist in preventability
• determine if there are racial differences in adequacy and application of care
MMMTF Subcommittee
Maternal Health Disparities

_Understanding Why to Make a Change_

• Evaluate areas with less disparate maternal health outcomes, assess their strategies and determine what makes them different

• Optimizing patient/provider communication, including assessment of current resources for cultural competence, discrimination/implicit bias training

• Understand and address inequities in prenatal care access
Implement AIM Maternal Safety Bundles

• **Goal:**
  - Reduce severe maternal morbidity using evidence-based systems to enhance maternal care

• **Implementing AIM bundles for:**
  - Obstetric hemorrhage
  - Severe hypertension in pregnancy
  - Obstetric care for women with opioid use disorder
TexasAIM Current Hospitals as of January 23, 2019
By TexasAIM Cohort Region

Legend
- \( \text{H} \) Enrolled hospitals (207)
- \( \text{TexasAIM Cohort Region} \)

Source: TexasAIM Enrollment Data
Exceptional Item Request

• Department of State Health Services requested an exceptional item to address maternal mortality
  • Implement maternal safety initiatives statewide
  • Implement care coordination pilot
  • Develop and train providers on use of risk assessment tools
  • Increase public awareness and prevention activities
TexasAIM – Next Steps

• Opioid maternal safety bundle now being piloted. Exceptional item funding could enable full roll out in 2020
• Implementation of AIM hypertension bundle
• Additional safety bundle implementation based on data
• With implementation of safety bundles, staff efforts will shift to identification of new interventions
Moving Beyond AIM

- MMMTF found that an average of 5.2 factors contributed to deaths of Texas mothers.
- Factors that increase risk for mothers include:
  - Individual and family: underlying medical conditions, obesity, and chronic disease.
  - Provider: delays in diagnosis, treatment and appropriate referral.
  - Facility: continuity of care from inpatient to outpatient settings.
  - System and community: lack of coordinated care.
New Interventions

• Care coordination pilot and new public awareness efforts
  • Increased attention to the health needs of high-risk populations, especially black women
  • Enhanced screening and referral for maternal risk conditions
  • Prioritization of care coordination for pregnant and postpartum women, for both physical and behavioral health
  • Public awareness campaigns to promote health-enhancing behaviors
  • Education for patients and families around postpartum care management
H.R. 1318 Preventing Maternal Deaths Act of 2017
S. 1112 Maternal Health Accountability Act of 2017

• **Strengthen state efforts to prevent maternal deaths**
• **Support states in establishing or expanding maternal mortality review committees**
• **Promote national information sharing**
Developing Clinical Guidance

- Pregnancy and Heart Disease Task Force
- Detection, evaluation, diagnosis and management of heart disease during pregnancy and postpartum period
- Management of women with obstetric complications associated with longterm CV disease
Developing Clinical Guidance

• Maternal Mental Health Expert Work Group
  • Goal: Understand the resources needed by obstetric practices to conduct screening, assessment, intervention, referral, and follow-up for women with perinatal depression.

• Maternal Mental Health Summit in mid December
SAVE YOUR LIFE: Get Care for These POST-BIRTH Warning Signs

Most women who give birth recover without problems. But any woman can have complications after the birth of a baby. Learning to recognize these POST-BIRTH warning signs and knowing what to do can save your life.

Call 911 if you have:

- Pain in chest
- Obstructed breathing or shortness of breath
- Seizures
- Thoughts of hurting yourself or your baby

Call your healthcare provider if you have:

(If you can’t reach your healthcare provider, call 911 or go to an emergency room)

- Bleeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger
- Incision that is not healing
- Red or swollen leg, that is painful or warm to touch
- Temperature of 100.4°F or higher
- Headache that does not get better, even after taking medicine, or bad headache with vision changes

Trust your instincts. Even if you are not sure, it’s better to be safe and get help.

Tell 911 or your healthcare provider:

“I had a baby on __________ and I am having __________”

These post-birth warning signs can become life-threatening if you don’t receive medical care right away because:

- Pain in chest, obstructed breathing or shortness of breath (may be catching your breath may mean you have a blood clot in your lung or a heart problem)
- Seizures may mean you have a condition called eclampsia
- Thoughts or feelings of wanting to hurt yourself or your baby may mean you have postpartum depression
- Bleeding (heavy), soaking more than one pad in an hour or passing an egg-sized clot or bigger may mean you have an obstetric hemorrhage
- Incision that is not healing, increased redness or any pus from episiotomy or C-section site may mean you have an infection
- Redness, swelling, warmth, or pain in the call area of your leg may mean you have a blood clot
- Temperature of 100.4°F or higher, bad smelling vaginal blood or discharge may mean you have an infection
- Headache (very painful), vision changes, or pain in the upper right area of your belly may mean you have high blood pressure or postbirth preeclampsia

GET HELP

My Healthcare Provider/Clinic: ___________________________ Phone Number: ___________________________

Hospital Closest To Me: ___________________________

https://www.awhonn.org/page/POSTBIRTH