Surveillance and Prevention with Maternal Mortality Review Committees

Wednesday, June 29, 2022
Meet Our Speakers

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Baylor College of Medicine
Surveillance and Prevention with Maternal Mortality Review Committees

Julie Zaharatos, MPH, Maternal Mortality Prevention Team
CDC Division of Reproductive Health
The data we have

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<th>National (CDC) – National Vital Statistics System (NVSS)</th>
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<td>During pregnancy – 42 days</td>
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<td>ICD-10 codes</td>
<td>Medical epidemiologists</td>
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<td>Maternal Mortality Rate - # of Maternal Deaths per 100,000 live births</td>
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<td>Show national trends and provide a basis for international comparison</td>
<td>Analyze clinical factors associated with deaths, publish information that may lead to prevention strategies</td>
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<tr>
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<td>Death records</td>
<td>Death records, and death records linked birth or fetal death records, additional information as available</td>
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Each year in the U.S., about 700 women die as a result of pregnancy complications. 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
Pregnancy-Related Mortality, PMSS, 1999-2018: Not Improving

Deaths per 100,000 births

13.2

17.3
PMSS: State Variation


2.8 1.7 3.3 3.1 3.0 3.3

Black PRMR ÷ White PRMR
Native PRMR ÷ White PRMR

Pregnancy-related Mortality Ratio by Race-Ethnicity and Age, 2007-2016


*≥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)

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<th>Data Source</th>
<th>Death certificates and death certificates linked to birth or fetal death certificates, medical records, social service records, autopsy, informant interviews, etc.</th>
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<td>Terms</td>
<td>Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related</td>
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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

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.
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 is a CDC data system that provides a common data language for MMRCs, facilitating their functions and promoting a national approach.
Existing Maternal Mortality Review Committees (MMRCs)

www.cdc.gov/erasemm
Review to Action

Staff present each *selected case* to the MMRC using the case narrative

MMRC discusses and makes key decisions about each death

Enter key decisions into MMRIA

Analyze data, identify key issues and recommendation themes

Prioritize and disseminate findings

*Adapted from WA State DOH*
Review to Action

- **Staff present each selected case to the MMRC using the case narrative**
- **MMRC discusses and makes key decisions about each death**
- **Enter key decisions into MMRIA**
- **Analyze data, identify key issues and recommendation themes**
- **Prioritize and disseminate findings**

Adapted from WA State DOH
What have we learned from MMRCs?
Leading causes of pregnancy-related deaths

Cardiovascular Conditions
Hemorrhage
Infection
Embolism*
Cardiomyopathy
Mental Health Conditions
Preeclampsia and Eclampsia

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

Leading causes vary by race-ethnicity: 14 MMRCs

Non-Hispanic Black
- Cardiomyopathy
- Cardiovascular and coronary conditions
- Hypertensive disorders of pregnancy
- Hemorrhage
- Embolism*
- Infection or sepsis

Non-Hispanic White
- Mental health conditions
- Hemorrhage
- Cardiovascular and coronary conditions
- Infection or sepsis
- Cardiomyopathy
- Embolism*

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

Notes: * Embolism – thrombotic pulmonary and other embolisms
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<thead>
<tr>
<th>Contributing Factor</th>
<th>Recommendations to Address Contributing Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to clinical care</td>
<td>Expand office hours; Increase number of providers who accept Medicaid; Increase availability of group prenatal care</td>
</tr>
<tr>
<td>Unstable housing</td>
<td>Prioritize pregnant women for temporary housing programs</td>
</tr>
<tr>
<td>Lack of/inadequate transportation options</td>
<td>Strengthen/build systems that link persons to affordable transportation; Provide vouchers for non-emergency transportation</td>
</tr>
<tr>
<td>Obesity and associated chronic condition</td>
<td>Improve access to healthy food options; Improve education and promotion of health eating habits and weight management strategies</td>
</tr>
<tr>
<td>Limited experience with OB emergencies</td>
<td>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</td>
</tr>
<tr>
<td>Lack of appropriate personnel or services</td>
<td>Increase access to telemedicine by facilities with no OB onsite; Ensure Medicaid managed care organizations’ contracts include sufficient access to high risk care specialists</td>
</tr>
<tr>
<td>Lack of guiding protocols</td>
<td>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</td>
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<tr>
<td>-------------------------------------------------</td>
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<tr>
<td>Lack knowledge of warning signs or need to seek care</td>
<td>Improve counseling and increase use of patient education materials on warning signs and when to seek care, such as the AWHONN <em>Save Your Life</em> discharge instructions</td>
</tr>
<tr>
<td>Non-adherence to medical regimens or advice</td>
<td>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</td>
</tr>
<tr>
<td>Missed/delayed diagnosis</td>
<td>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</td>
</tr>
<tr>
<td>Inappropriate/delayed treatment</td>
<td>Establish polices and protocols that support only performing cesarean deliveries when medically indicated; Implement a maternal early warning system</td>
</tr>
<tr>
<td>Lack of continuity of care</td>
<td>Improve care transition protocols and communication between OB providers and primary care providers and specialty care providers</td>
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<td>---------------------</td>
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<tr>
<td>Inadequate receipt of care</td>
<td>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</td>
</tr>
<tr>
<td>Case coordination/management</td>
<td>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</td>
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<tr>
<td>Guiding policies, procedures, or standards not in place</td>
<td>Develop and implement protocols and policies that increase timely referrals and consultation; Increase (and monitor for) consistency of protocols and policies within healthcare systems</td>
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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

- 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
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.
STATE STRATEGIES FOR PREVENTING PREGNANCY-RELATED DEATHS:
A Guide for Moving Maternal Mortality Review Committee Data to Action

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

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

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

Data informing action

Maternal health care standards, tools and resources

Prioritization of right place-right time interventions informed by MMRIA analyses

Understanding of leading causes of pregnancy-related deaths as determined by MMRCs

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

Arizona        Louisiana  CDC Maternal Mortality Prevention Team
Colorado      Mississippi  CDC Foundation
Delaware       North Carolina Emory Rollins School of Public Health
Florida        Ohio        Association of Maternal and Child Health Programs
Georgia        South Carolina
Hawaii         Tennessee
Illinois       Utah

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Thank you!

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

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Surveillance and Prevention with Maternal Mortality Review Committees

Lisa M. Hollier, MD, MPH, FACOG
Past Chair, Texas Maternal Mortality and Morbidity Review Committee
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Adapted from WA State DOH
Review to Action

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MMRC discusses and makes key **recommendations for action** about each death

Enter key decisions into MMRIA

Analyze data, identify key issues and **recommendation themes**

Prioritize and disseminate findings to inform action

Recommendations catalyze partnerships and common goals for clinical, public health and community

*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

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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

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
Pregnancy-Related Deaths, 2012

- Cardiovascular Disease
- Hemorrhage
- Infection/Sepsis
- Preeclampsia/Eclampsia
- Other

Preventable vs. Not Preventable

Maternal & Child Health Epidemiology, Division for Community Health Improvement, DSHS.
<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>While Pregnant</th>
<th>0-7 Days Postpartum</th>
<th>8-42 Days Postpartum</th>
<th>43-365 Days Postpartum</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Overdose</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>54</td>
<td>64</td>
</tr>
<tr>
<td>Cardiac Event</td>
<td>2</td>
<td>12</td>
<td>9</td>
<td>32</td>
<td>55</td>
</tr>
<tr>
<td>Homicide</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>34</td>
<td>42</td>
</tr>
<tr>
<td>Suicide</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>Infection/Sepsis</td>
<td>1</td>
<td>3</td>
<td>14</td>
<td>14</td>
<td>32</td>
</tr>
<tr>
<td>Cerebrovascular Event</td>
<td>0</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>3</td>
<td>12</td>
<td>2</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Hypertension/Eclampsia</td>
<td>0</td>
<td>7</td>
<td>4</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Pulmonary Embolism</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Amniotic Fluid Embolism</td>
<td>1</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>50</td>
<td>68</td>
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<tr>
<td>Total</td>
<td>16</td>
<td>64</td>
<td>64</td>
<td>215</td>
<td>382</td>
</tr>
</tbody>
</table>

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

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
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
TexasAIM

- Obstetric Hemorrhage
  - First bundle statewide implementation 2019

- Severe Hypertension
  - Second bundle statewide implementation 2020

- Opioid Use Disorder
  - 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 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
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

lisahollier1@gmail.com
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.