4th Annual NIH Vivian W. Pinn Symposium

Progress on the Path to Better Maternal Outcomes

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Immediate Past President and Interim EVP/CEO
American College of Obstetricians and Gynecologists
May 15, 2019

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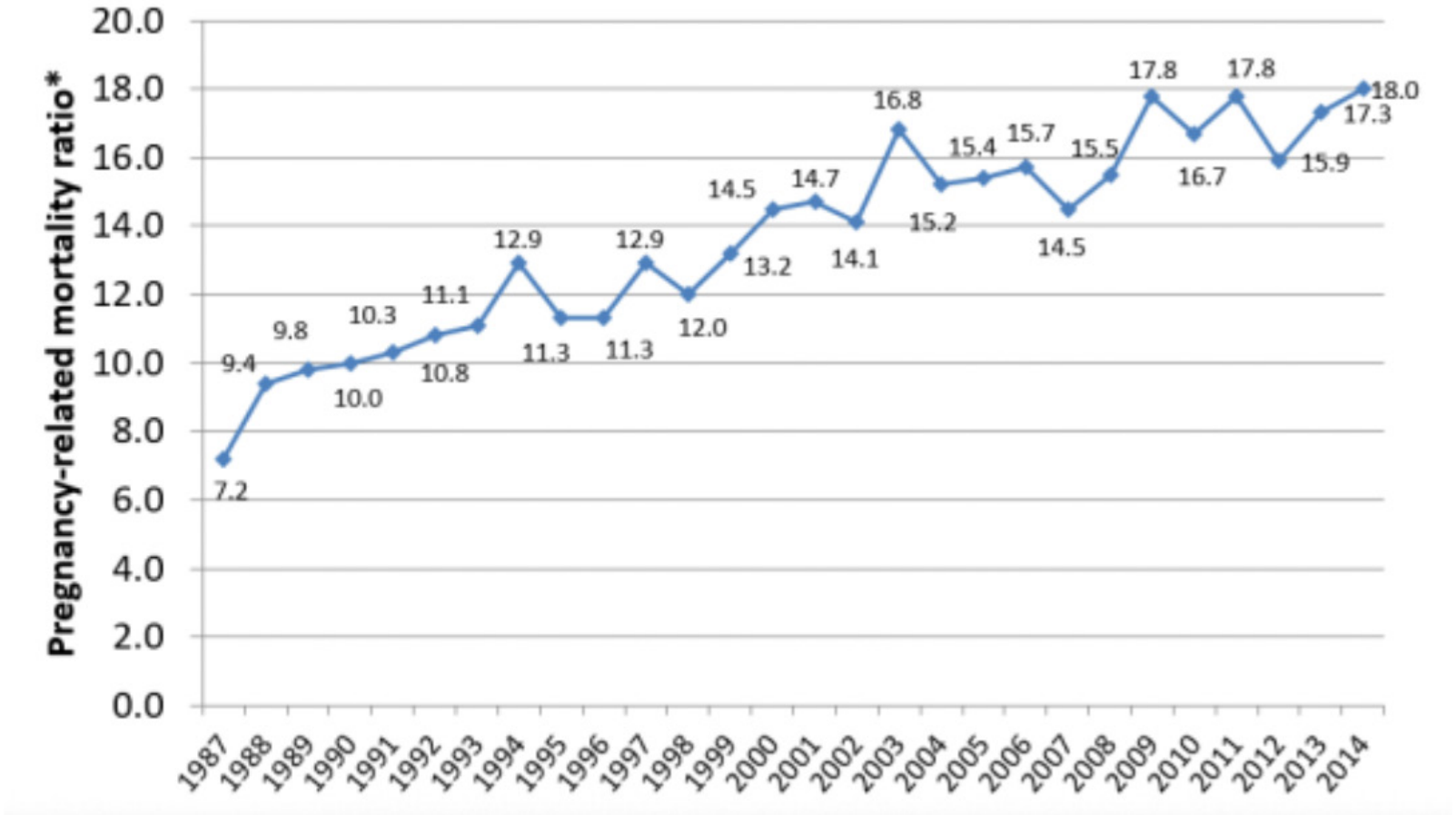
Pregnancy-Related Mortality
A Public Health Crisis



*Pregnancy-related deaths per 100,000 live births per year

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm

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Kassebaum NJ. The Lancet.2014

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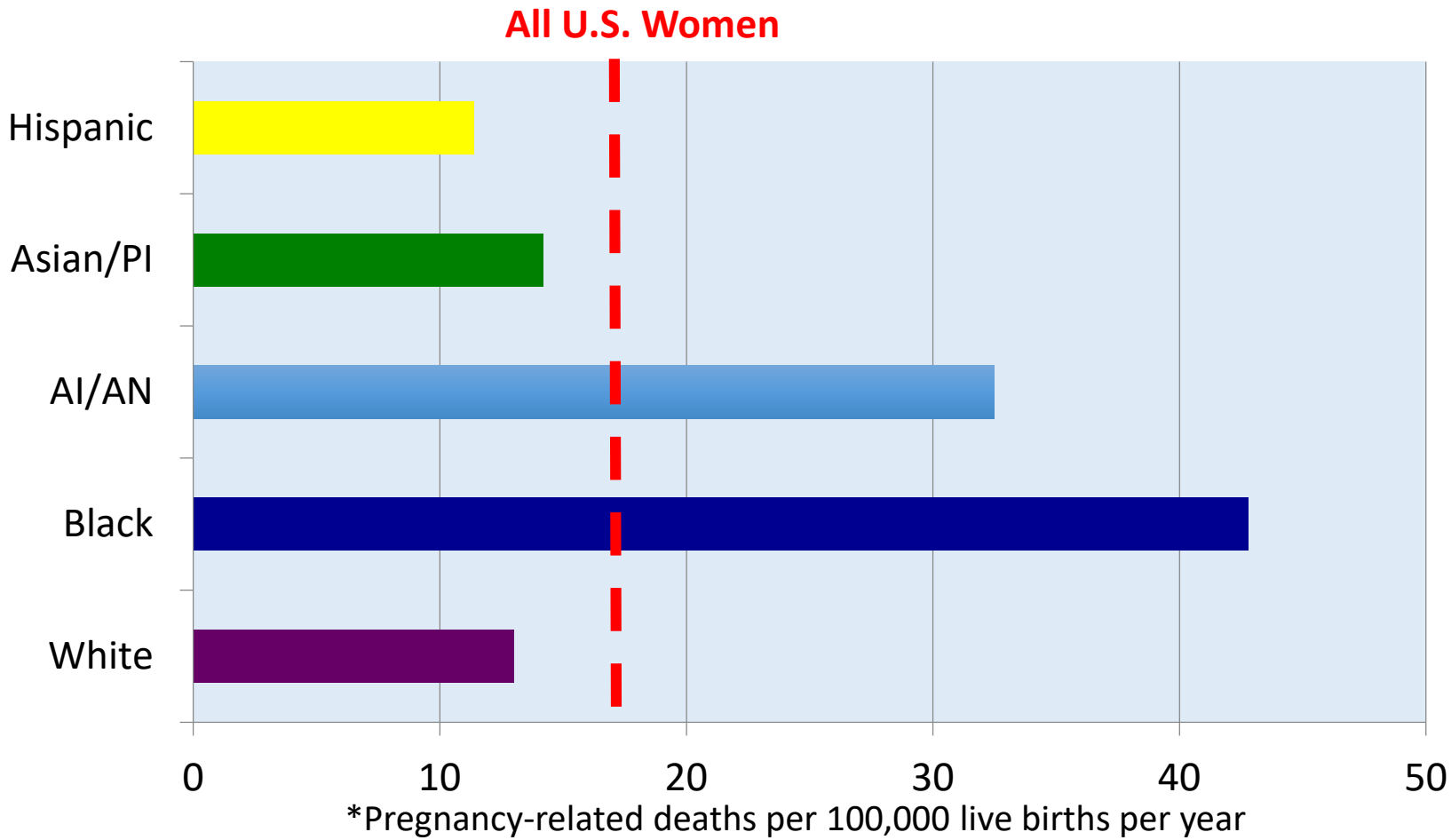
Pregnancy-Related Mortality Disparities

Significant reductions in maternal mortality and morbidity cannot be accomplished without addressing gaps in care for Black and Native American women



https://www.cdc.gov/vitalsigns/index.html

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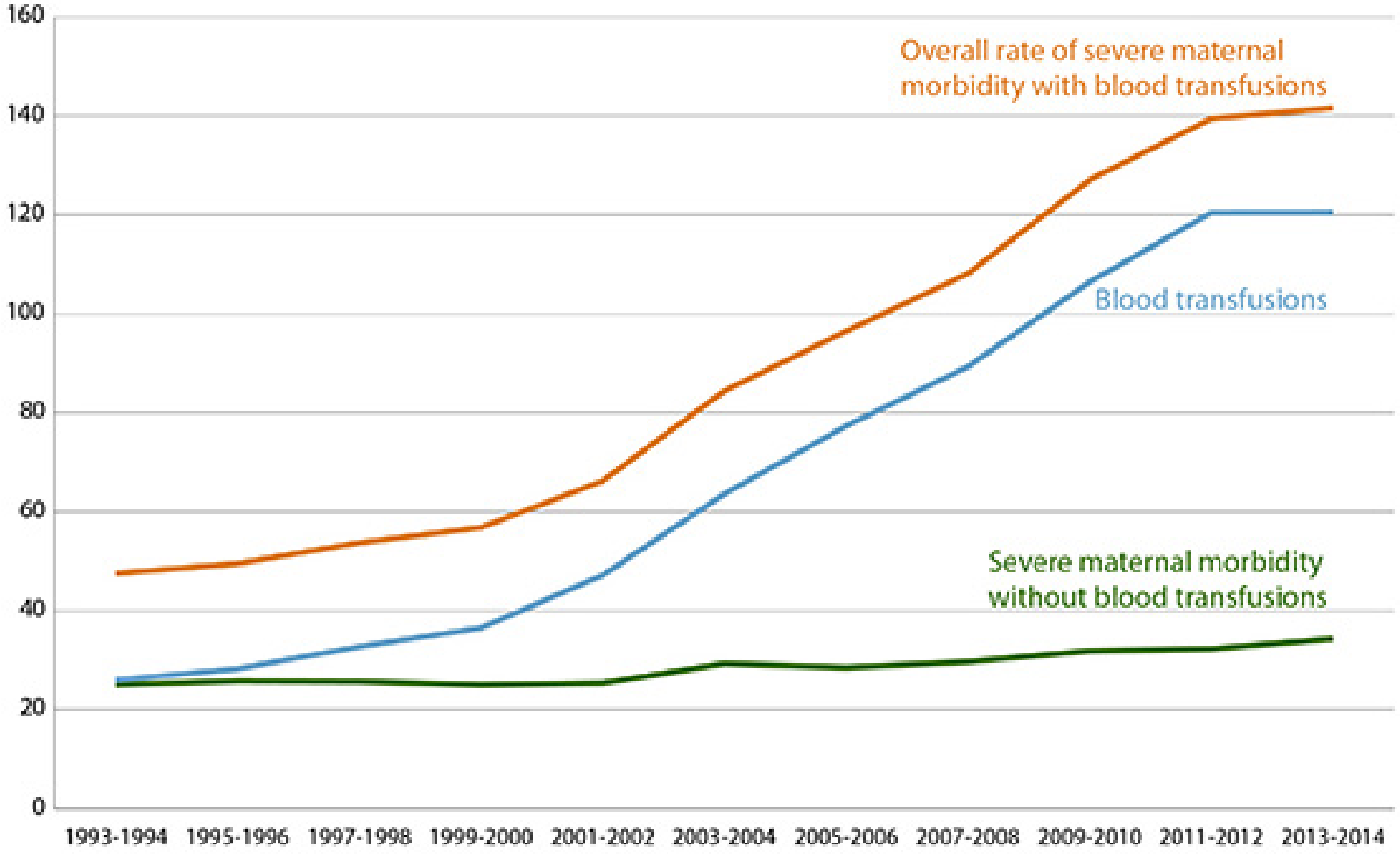
Severe Maternal Morbidity

- For every woman who dies, about 100 more suffer a severe maternal complication – severe maternal morbidity
  - Link between maternal mortality, particularly preventable maternal deaths, and severe maternal morbidity
- Prevalence of delivery hospitalizations in which a woman suffered severe morbidity increased by nearly 40%, to affect approximately 34,000 women in the United States each year
- Racial and ethnic disparities exist

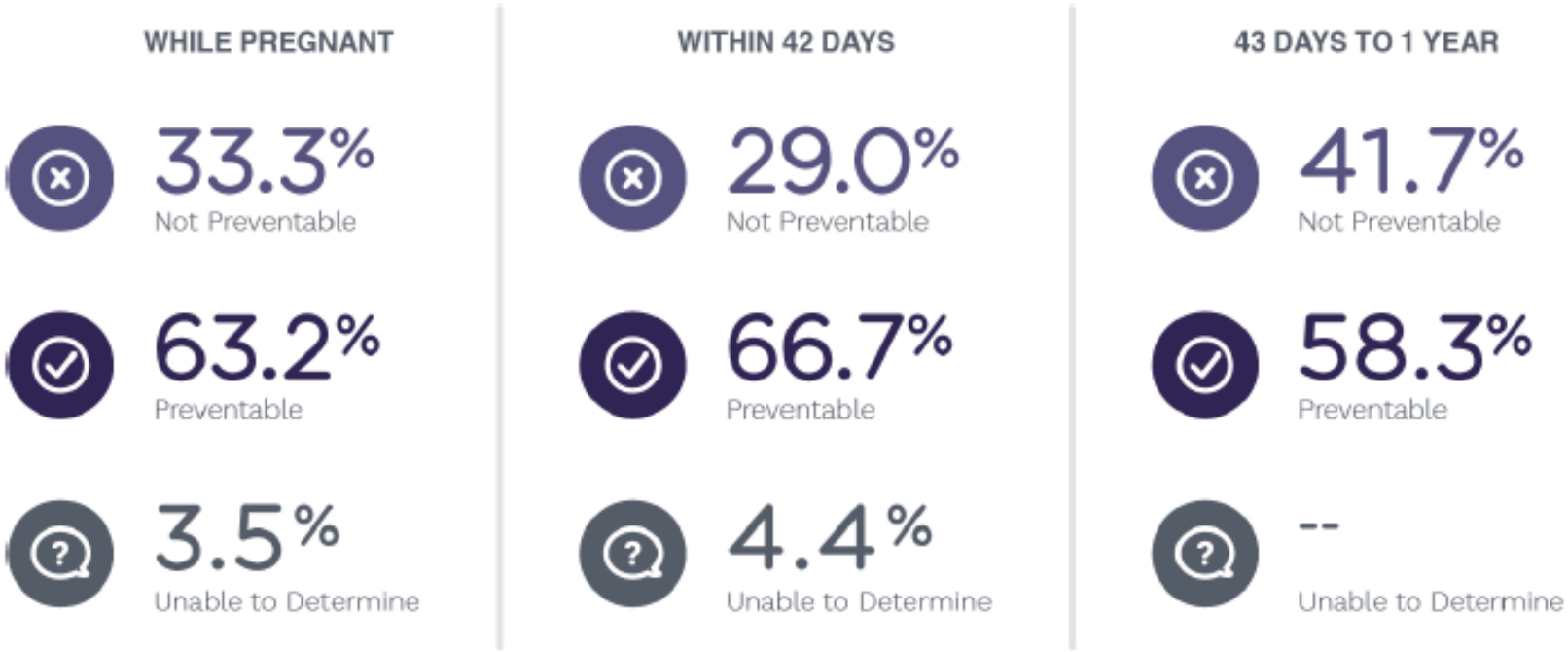
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

Severe Maternal Morbidity – U.S.



https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

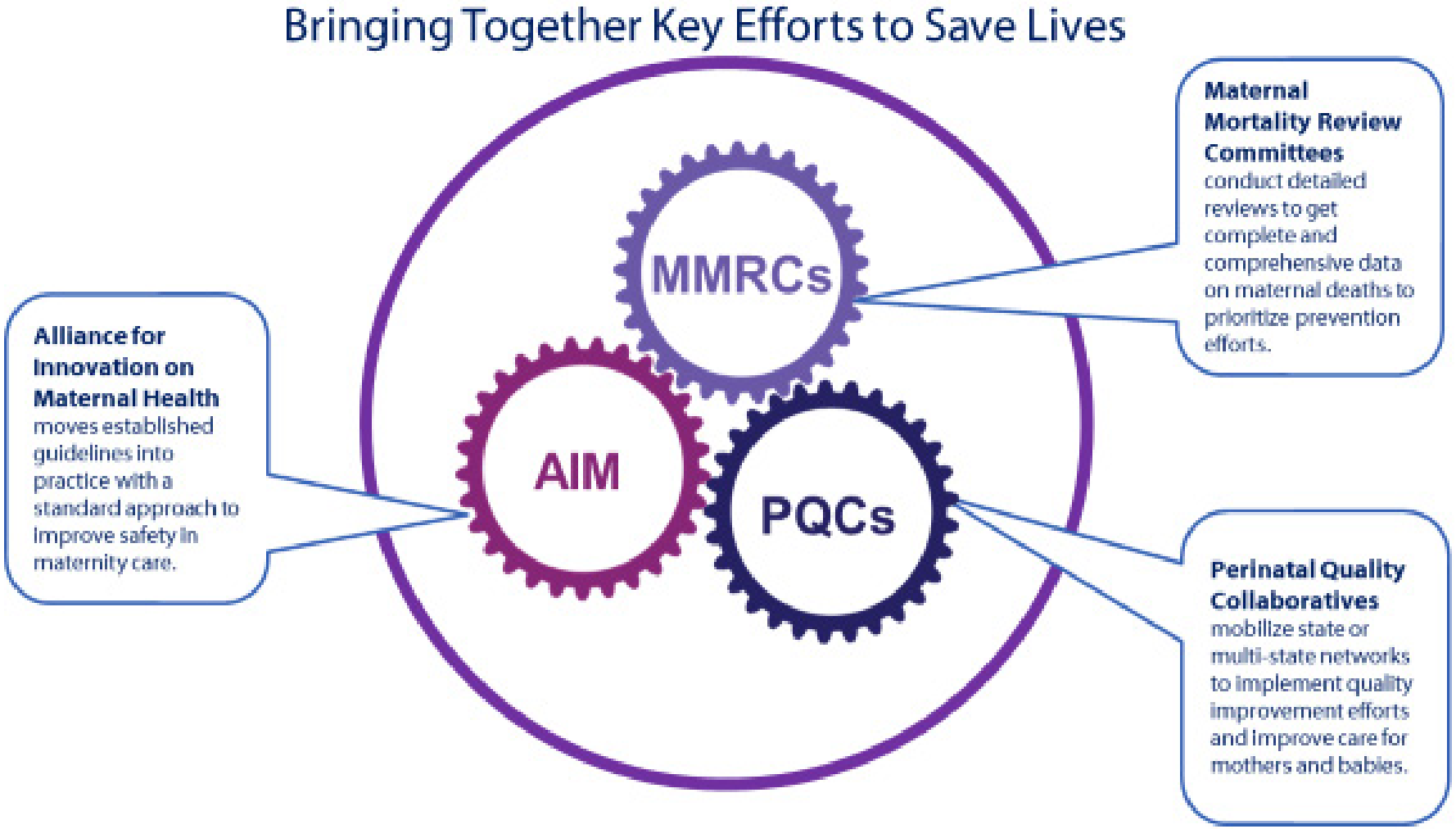
Prevention Is Possible!



Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

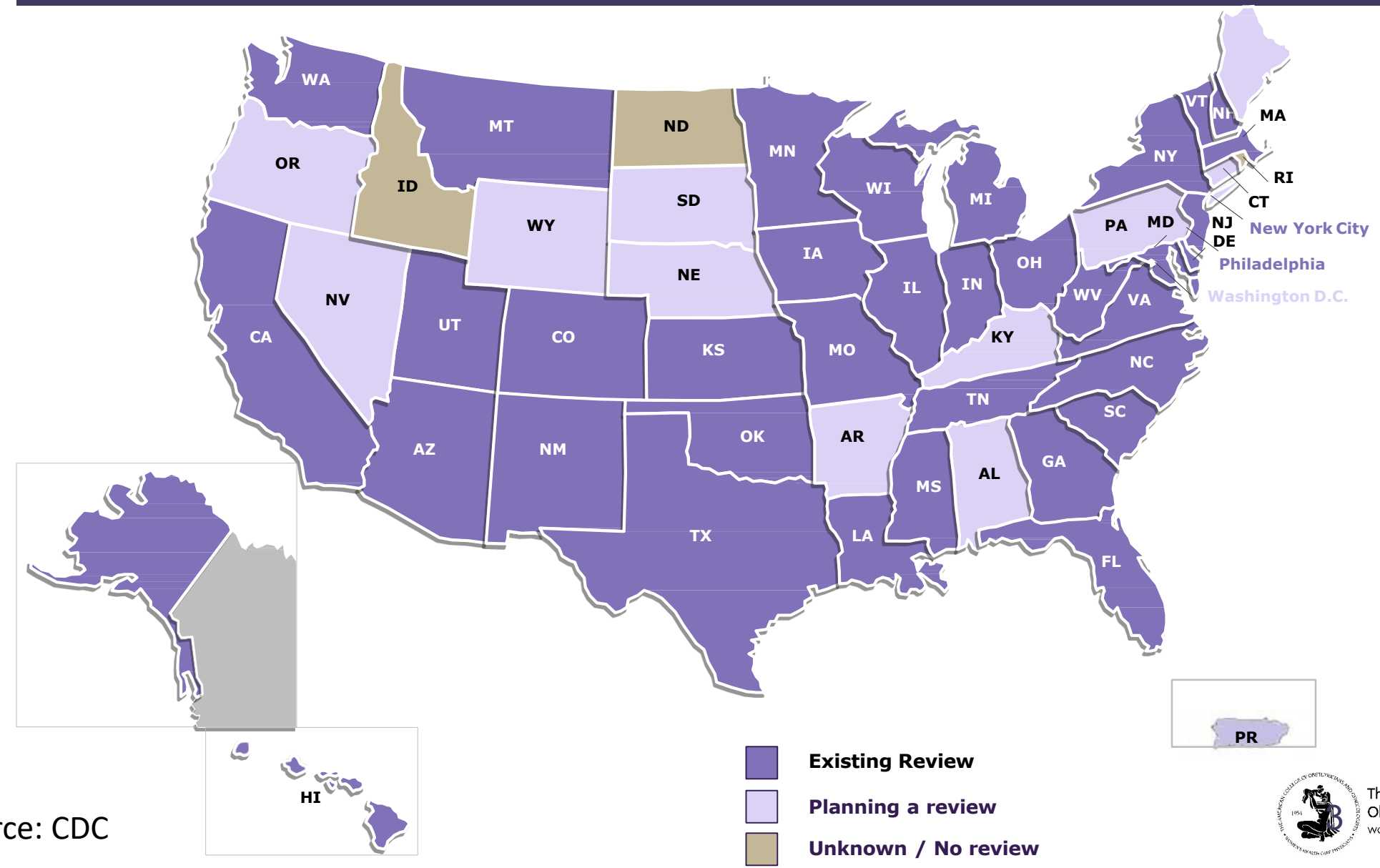
We are making progress

Partnership and Coordination



Source: CDC

MMRCs can provide answers



Source: CDC

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Progress for MMRCs

- Approximately 38 states have active maternal mortality review committees
  - Provide more detailed data from medical records, family interviews, social context
    - more robust analysis to identify systemic problems
    - provide a baseline that can be used in monitoring interventions that are implemented
  - Some committees now reviewing severe maternal morbidity

Data to Action:
Alliance for Innovation on Maternal Health (AIM)

AIM's Goal: Eliminate Preventable Maternal Mortality and Severe Maternal Morbidity in Every U.S. Birthing Facility

By:

- Promoting safe maternal care for every U.S. birth.
- Engaging **multidisciplinary partners** at the national, state and hospital levels.
- Developing and implementing **evidence-based maternal safety bundles**.
- Utilizing **data-driven quality improvement** strategies.
- Aligning existing safety efforts and developing/collecting resources.

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH AIM

Funded through HRSA Maternal and Child Health Bureau with a cooperative agreement.

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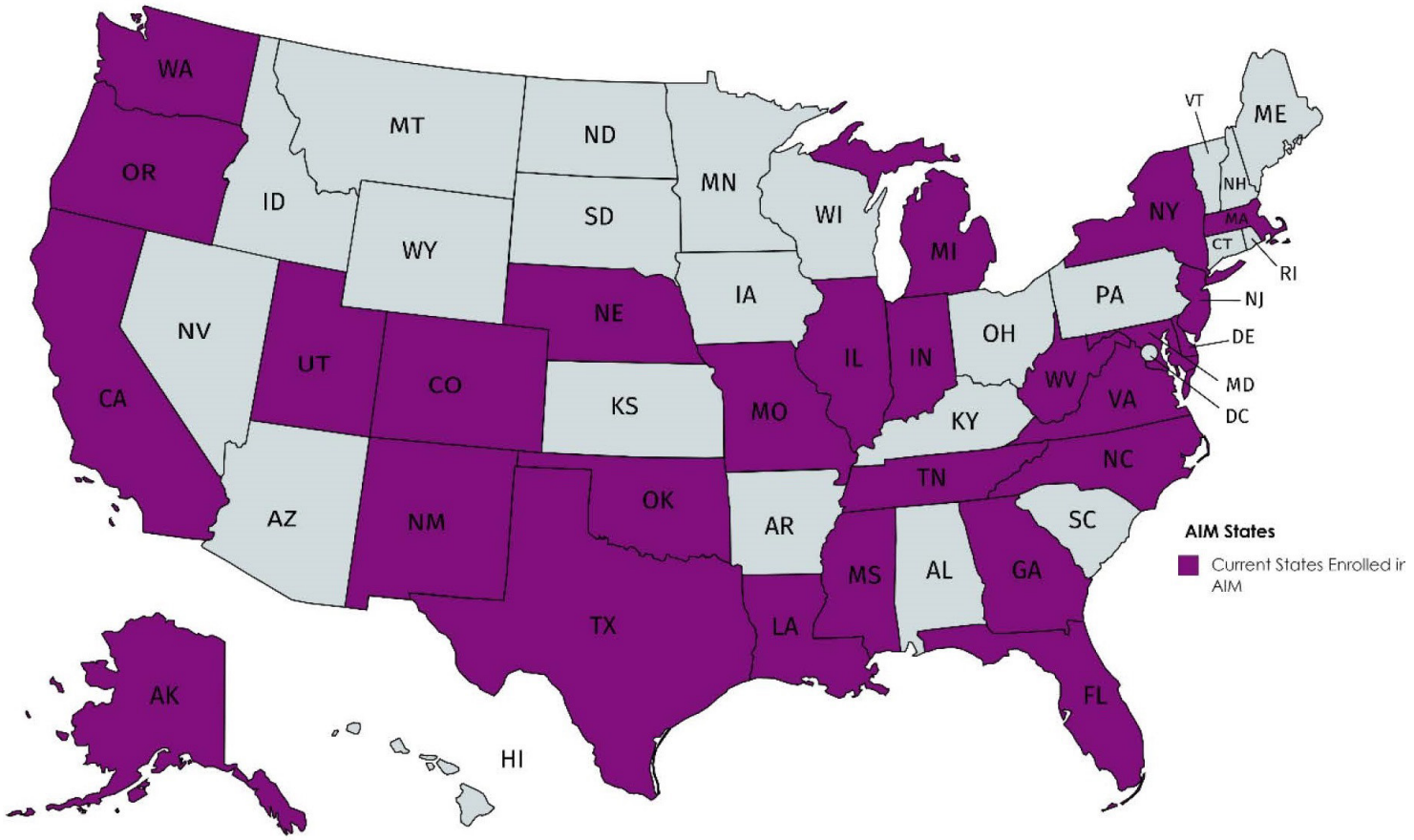
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH AIM



COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

May 2015

For more information visit the Council's website at www.safehealthcareforeverywoman.org

AIM and Disparities

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AIM and Disparities

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AIM Program Results

- **One AIM state had: 21.3% reduction in patients who suffered from severe complications from hemorrhage**

- **In Illinois, timely treatment of severe hypertension rose from 41% to 85% of women**
  - Timely treatment remained through sustainability period
  - No significant differences in hospital results based on hospital characteristics including race, ethnicity, and Medicaid patient mix

Right care, Right place, Right time

- By establishing “Levels of Maternal Care,” ACOG and SMFM envision the following outcomes:
  - Standardized definitions and nomenclature for facilities that provide each level of maternal care
  - Consistent guidelines according to each level of maternal care for use in quality improvement and health promotion
  - Equitable geographic distribution of full-service maternal care facilities and systems that promote proactive integration of risk-appropriate antepartum, intrapartum, and postpartum services

Society for Maternal-Fetal Medicine

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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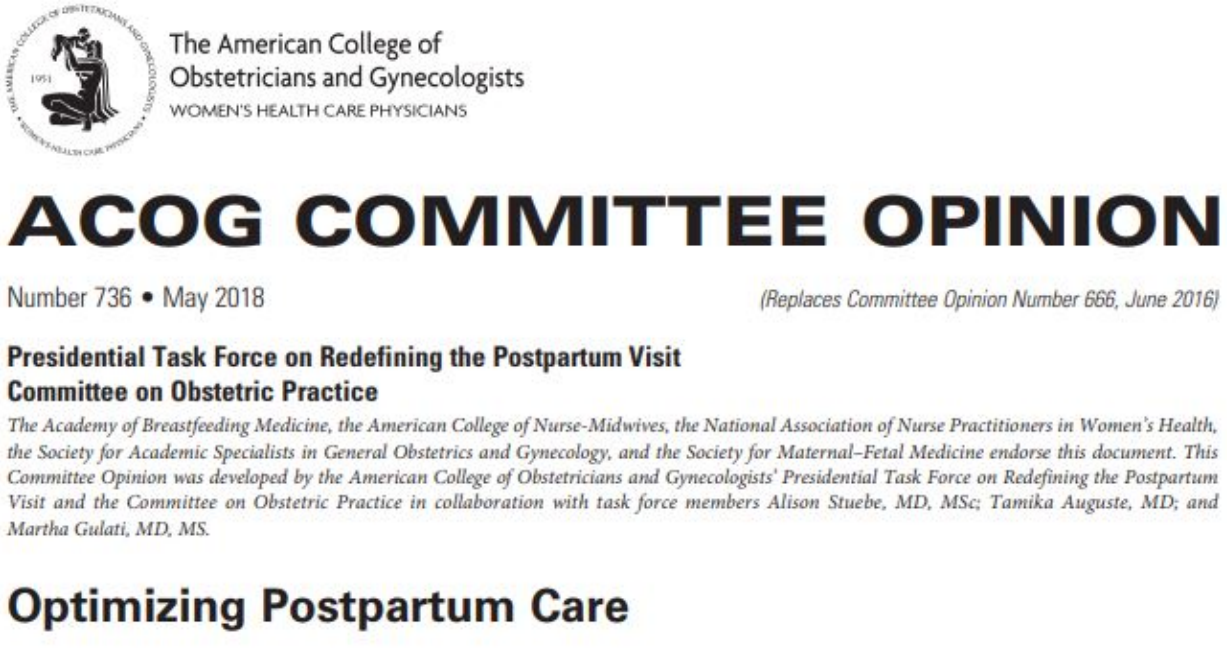
ACOG Guidance: Informing Policy



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ACOG COMMITTEE OPINION

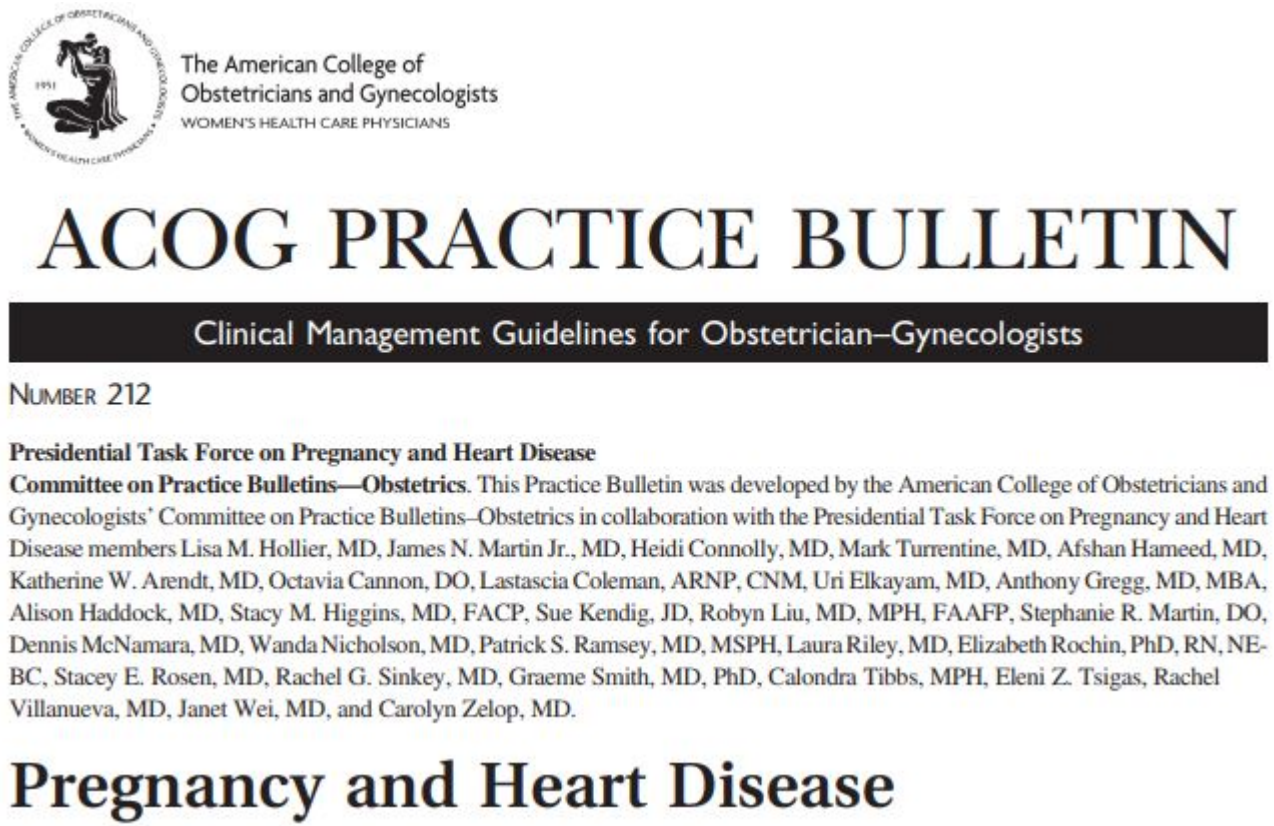
Number 736 • May 2018

(Replaces Committee Opinion Number 666, June 2016)

Presidential Task Force on Redefining the Postpartum Visit
Committee on Obstetric Practice

The Academy of Breastfeeding Medicine, the American College of Nurse-Midwives, the National Association of Nurse Practitioners in Women's Health, the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal–Fetal Medicine endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice in collaboration with task force members Alison Stuebe, MD, MSc; Tamika Auguste, MD; and Martha Gulati, MD, MS.

Optimizing Postpartum Care



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ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 212

Presidential Task Force on Pregnancy and Heart Disease
Committee on Practice Bulletins—Obstetrics. This Practice Bulletin was developed by the American College of Obstetricians and Gynecologists' Committee on Practice Bulletins–Obstetrics in collaboration with the Presidential Task Force on Pregnancy and Heart Disease members Lisa M. Hollier, MD, James N. Martin Jr., MD, Heidi Connolly, MD, Mark Turrentine, MD, Afshan Hameed, MD, Katherine W. Arendt, MD, Octavia Cannon, DO, Lastascia Coleman, ARNP, CNM, Uri Elkayam, MD, Anthony Gregg, MD, MBA, Alison Haddock, MD, Stacy M. Higgins, MD, FACP, Sue Kendig, JD, Robyn Liu, MD, MPH, FAAFP, Stephanie R. Martin, DO, Dennis McNamara, MD, Wanda Nicholson, MD, Patrick S. Ramsey, MD, MSPH, Laura Riley, MD, Elizabeth Rochin, PhD, RN, NE-BC, Stacey E. Rosen, MD, Rachel G. Sinkey, MD, Graeme Smith, MD, PhD, Calondra Tibbs, MPH, Eleni Z. Tsigas, Rachel Villanueva, MD, Janet Wei, MD, and Carolyn Zelop, MD.

Pregnancy and Heart Disease

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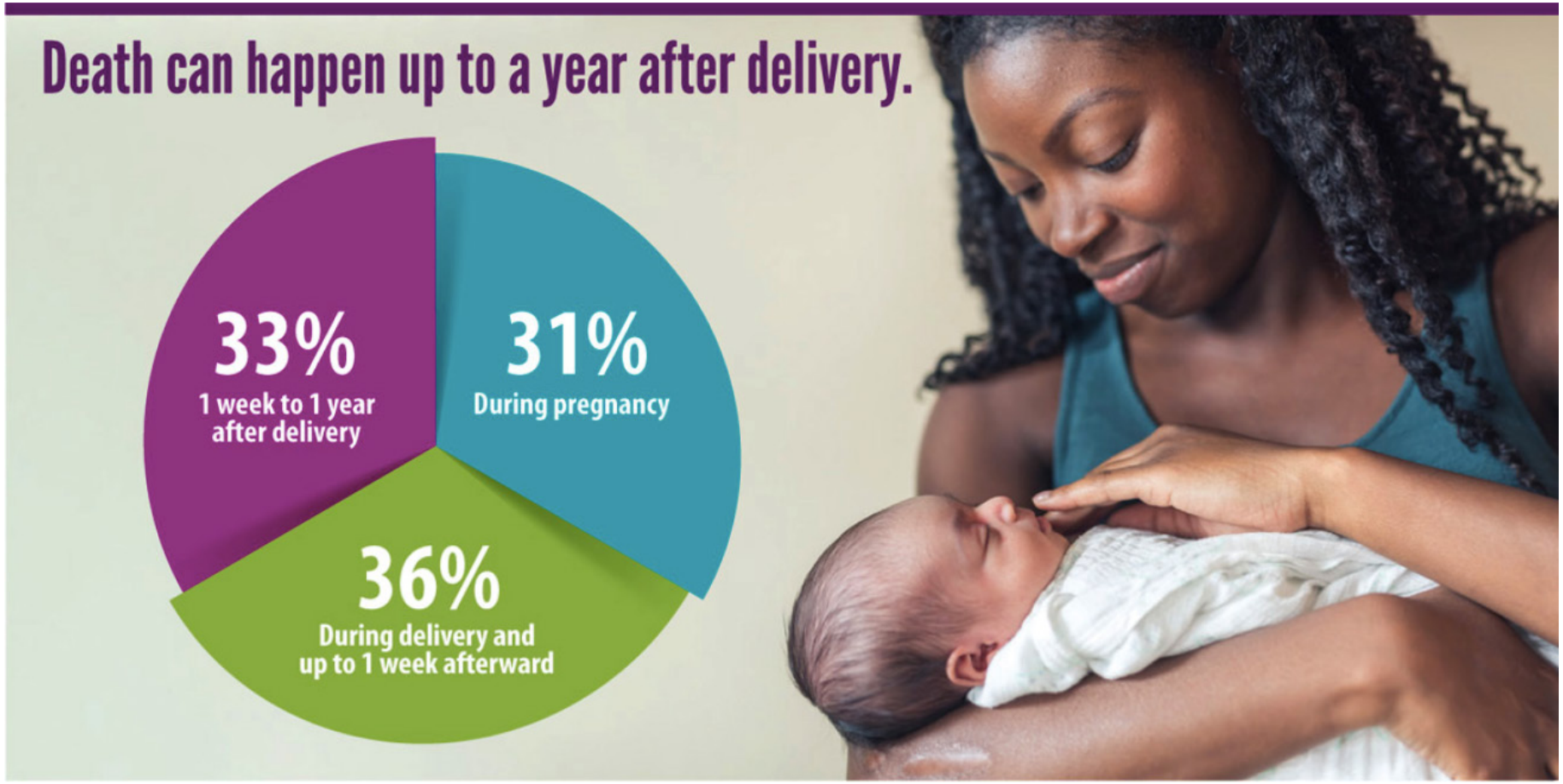
Progress toward better outcomes

- Public awareness and attention
- Significant expansion of maternal mortality and morbidity review processes
- National collaboration to develop and implement patient safety solutions that change culture
- Enhanced education/training of OB providers in multidisciplinary teams

Progress toward better outcomes



Source: CDC Vital Signs

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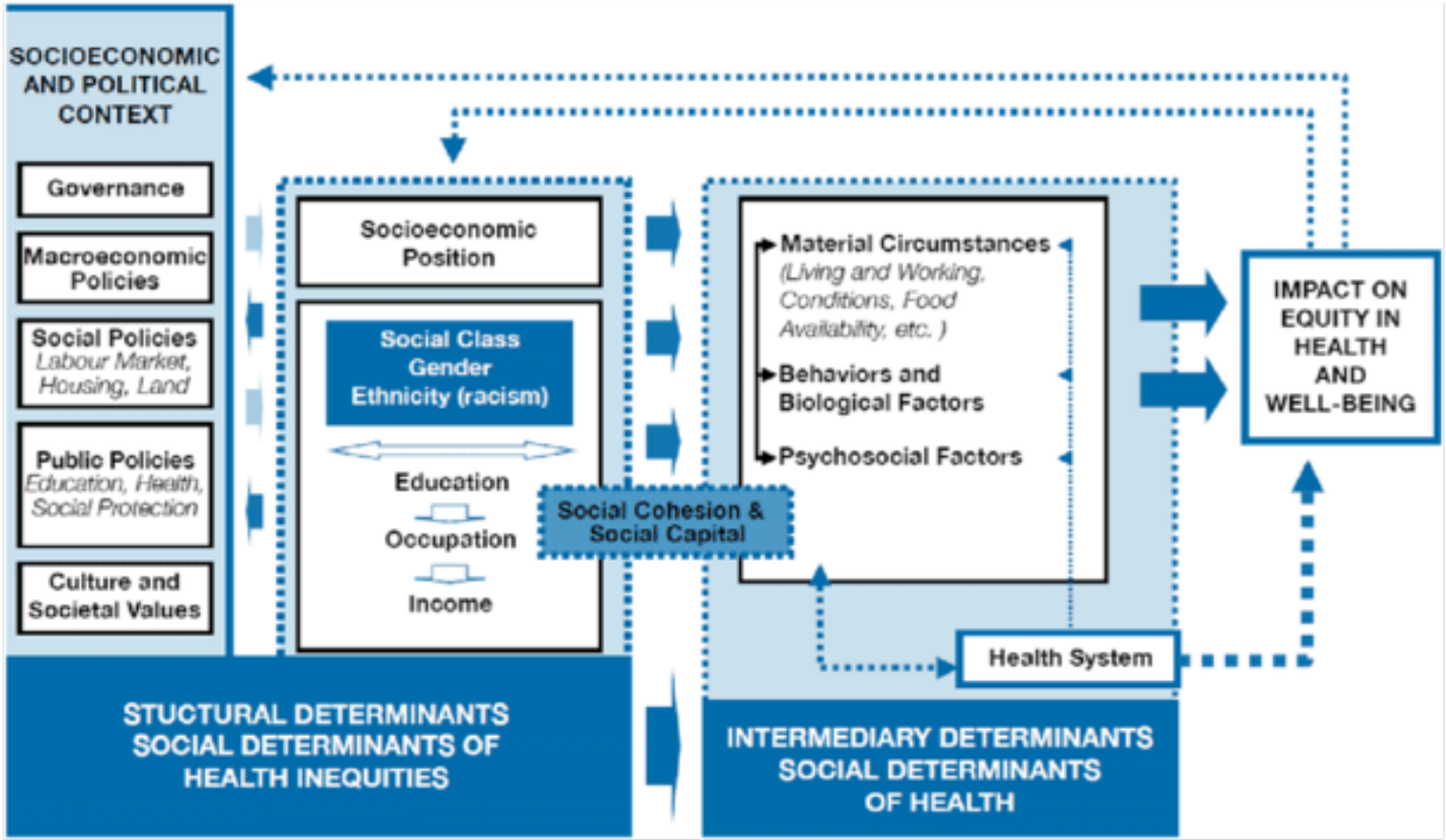
Maternal Mortality as an Indicator of Health

If we are to continue to reduce maternal deaths and reach our goals, we must think more broadly about maternal mortality and include the social context in which women live their lives.

Frameworks to Address Social Determinants



Source: WHO 2010

Identifying Gaps to Inform Research

- System Level
  - Use of standardized definitions of severe maternal morbidity (SMM)
  - Risk prediction models for SMM and maternal mortality
  - Improved maternal warning systems to avert adverse outcomes, including data for effectiveness
  - Measuring and improving hospital quality
  - Effectiveness of “levels of maternal care” to reduce adverse outcomes

Identifying Gaps to Inform Research

- Community Level
  - Improved assessments of “community factors” contributing to maternal morbidity and mortality
  - Development and utilization of woman-centered outcomes
  - Contributions of social determinants of health to maternal mortality and morbidity
  - Effective interventions to reduce disparities

Identifying Gaps to Inform Research

- Across Levels
  - Best strategies for rapid, consistent implementation of solutions
  - Best strategies to enhance communication between patients and providers and between providers themselves
  - Effective resources and supports to improve maternal outcomes in rural areas
  - Role of implicit bias training/education in improving maternal outcomes
  - Policy changes that improve maternal outcomes and women's health

Role of Clinical Research

- Increased public awareness means even greater demand for answers to questions that must be addressed via high-quality clinical research
- **Maternal-Fetal Medicine Units (MFMU) Network** can play an important role in this work

Thank You