4th Annual NIH Vivian W. Pinn Symposium

Progress on the Path to Better Maternal Outcomes

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Pregnancy-Related Mortality
A Public Health Crisis


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

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

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

<table>
<thead>
<tr>
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<th>WHILE PREGNANT</th>
<th>WITHIN 42 DAYS</th>
<th>43 DAYS TO 1 YEAR</th>
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<tbody>
<tr>
<td>Preventable</td>
<td>63.2%</td>
<td>66.7%</td>
<td>58.3%</td>
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<tr>
<td>Not Preventable</td>
<td>33.3%</td>
<td>29.0%</td>
<td>41.7%</td>
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<tr>
<td>Unable to Determine</td>
<td>3.5%</td>
<td>4.4%</td>
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We are making progress
Partnership and Coordination

Bringing Together Key Efforts to Save Lives

- MMRCs
- AIM
- PQCs

- Maternal Mortality Review Committees conduct detailed reviews to get complete and comprehensive data on maternal deaths to prioritize prevention efforts.
- Perinatal Quality Collaboratives mobilize state or multi-state networks to implement quality improvement efforts and improve care for mothers and babies.
- Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in maternity care.

Source: CDC
MMRCs can provide answers

Source: CDC

Map showing the distribution of Existing Review, Planning a review, and Unknown / No review across the United States.
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.

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

**Reduction of Peripartum Racial/Ethnic Disparities**

**READINESS**
- Establish systems to accurately document self-identified race, ethnicity, and primary language.
- Provide system-wide staff education and training on how to ask demographic intake questions.
- Ensure that patients understand why race, ethnicity, and language data are being collected.
- Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
- Evaluate non-English language proficiency (e.g., Spanish proficiency) for providers who communicate with patients in languages other than English.
- Educate all staff (e.g., inpatient, outpatient, community-based) on interpreter services available within the healthcare system.
- Provide staff-wide education on:
  - Peripartum racial and ethnic disparities and their root causes.
  - Best practices for shared decision making.
  - Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

**RECOGNITION**
- Every patient, family, and staff member:
  - Provide staff-wide education on implicit bias.
  - Provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the maternal patient, in a clear and simple format that summarizes information most pertinent to perinatal care and wellness.
  - Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscalculation or disrespect.
AIM and Disparities

CMQCC
California Maternal Quality Care Collaborative
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
ACOG Guidance: Informing Policy

ACOG COMMITTEE OPINION
Number 736 • May 2018
(Replaces Committee Opinion Number 665, June 2015)

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 Stueh, MD, MSc; Tanika Angote, MD; and Martha Galaci, MD, MS.

Optimizing Postpartum Care

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, Lastacia Coleman, ARNP, CNM, Uri Elhayyan, MD, Anthony Gregg, MD, MBA, Alison Haddock, MD, Stacy M. Higgins, MD, FACP, Sue Kendig, JD, Robyn Liao, MD, MPH, FAAA, 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, Calonder Tibbs, MPH, Eleni Z. Tsigas, Rachel Villanueva, MD, Janet Wei, MD, and Carolyn Zelop, MD.

Pregnancy and Heart Disease
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

Death can happen up to a year after delivery.

- 33% 1 week to 1 year after delivery
- 31% During pregnancy
- 36% During delivery and up to 1 week afterward

Source: CDC Vital Signs
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

I’m listening.

Every mom.
Every time.

ACOG