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Prevention Maternal Mortality:

A Progress Report on PHHPC Recommendations from February, 2016

Public Health Committee of the Public Health and Health Planning Council

March 22, 2017

Overview of presentation

Implementation focuses on:

- Enhancement of Existing Maternal Mortality Review Process
- Partnership for Maternal Health Campaign
- Perinatal Regionalization
- Delivery System Reform
  - Maternity Bundle

Maternal Mortality Review

Maternal Mortality in New York State

Maternal Mortality State Ranking: 30th

America's Health Rankings United Health Foundation. 2016 Health of Women and Children Report.

More timely reviews:

- Cohort of 2012-2013 pregnancy associated maternal deaths completed (1 outstanding)
  - Of note for 2012 - 2013
    - 29 death records had obstetric causes of death that when investigated were in error
    - Reported to CDC which inflates our maternal mortality rate
- Cohort of 2014 – 2015
  - Case work beginning

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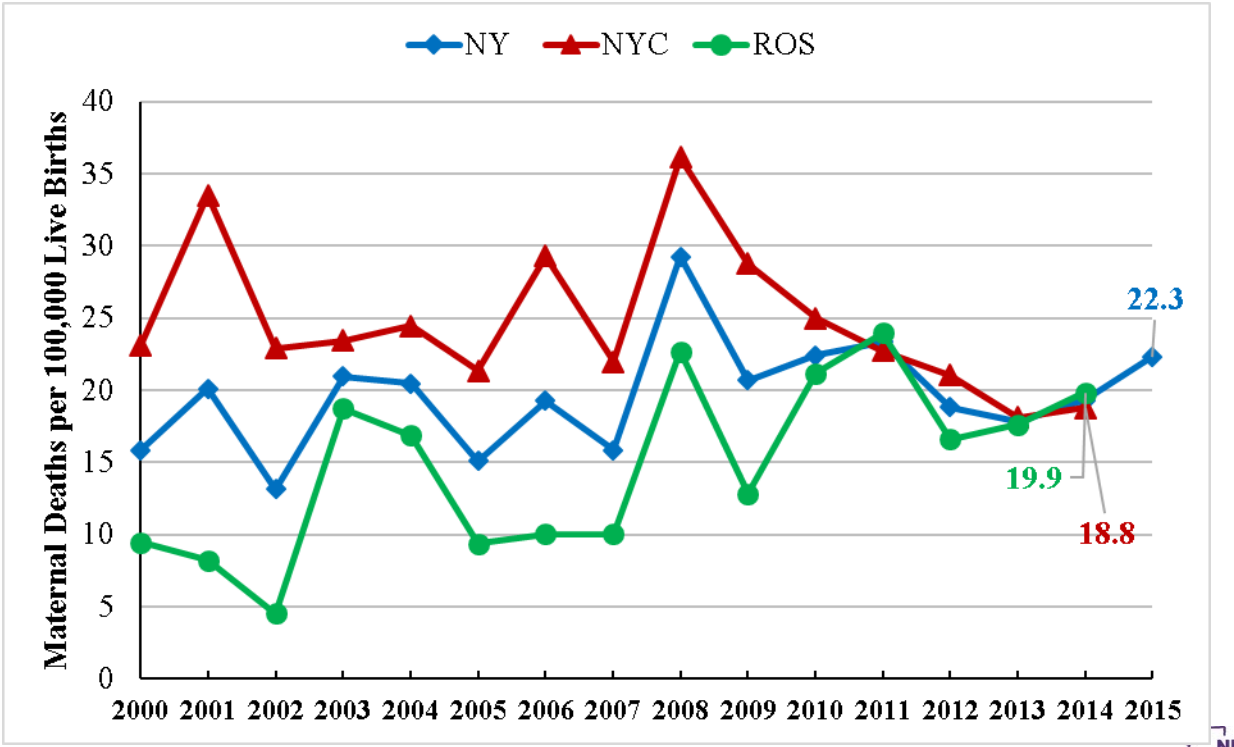
Trends in Maternal Mortality as Reported in Vital Records*



*Causes of death from death records A34, O00-O95,O98-O99.

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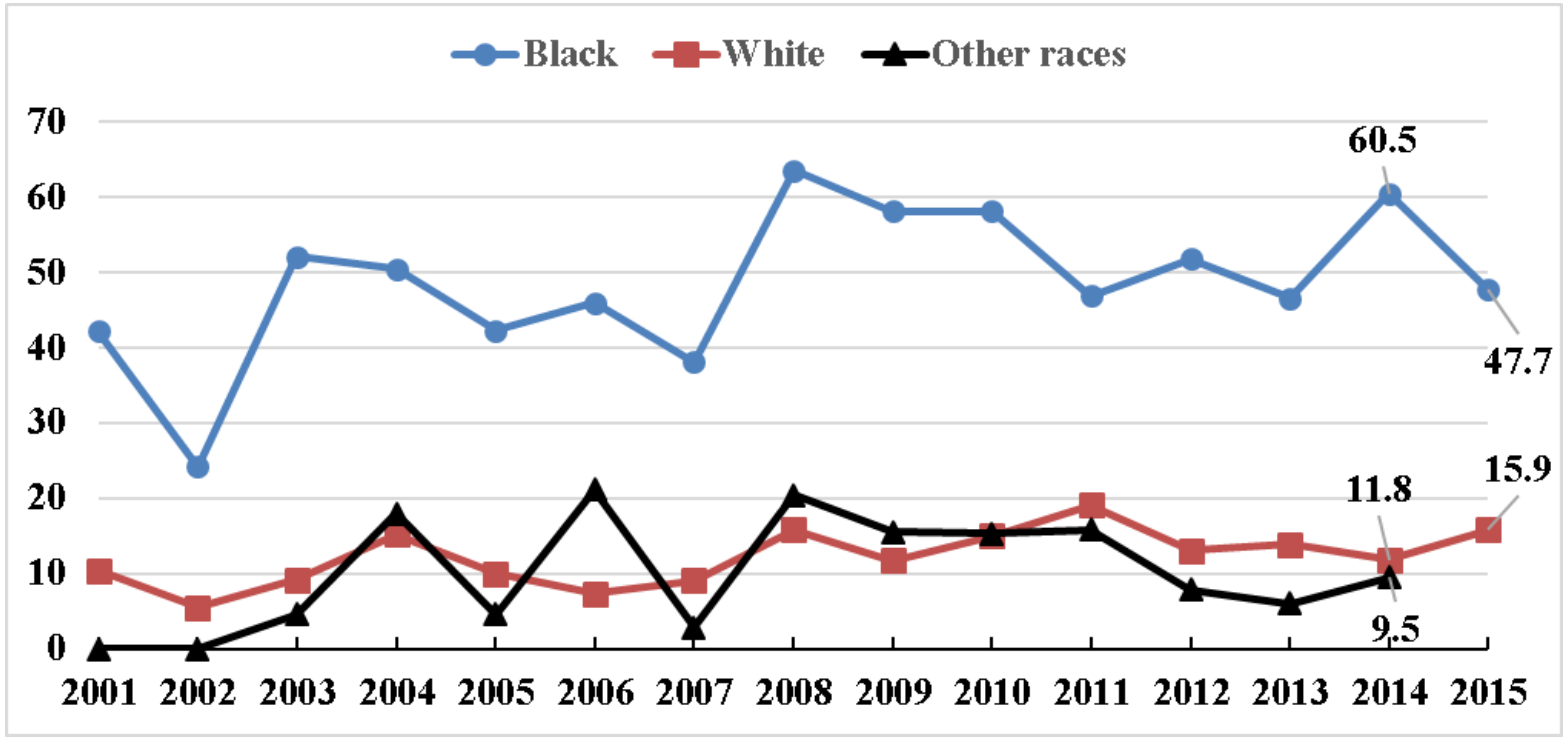

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Maternal Characteristics

Characteristic	2006-2008 (N=125)	2012-2013 (N=60)
Age		
Most women in cohort are less than 35	**70% (n=88)**	**62% (n=37)**
Women at highest risk are	30 and older *30% more likely to die than younger women*	35 and older *85% more likely to die than younger women*

Maternal Characteristics

Characteristic	2006-2008 (N=125)	2012-2013 (N=60)
Race		
Black	**46%**	**42%**
White	**18%**	**43%**
Asian	**10%**	**10%**
Other	8%	5%
Native Hawaiian	1%	0%
Unknown	18%	0%

Maternal Characteristics

Characteristic	2006-2008 (N=125)	2012-2013 (N=60)
Pre-pregnancy weight status		
Overweight (BMI between 25 and 30)	15% (n=19)	12% (n=7)
Obese (BMI of 30 or more)	**30% (n=38)**	**35% (n=21)**
Substance use prior to pregnancy		
Smoking	**12% (n=15)**	**12% (n=7)**
Alcohol	**2% (n=3)**	**12% (n=7)**
Drug use	**6% (n=7)**	**13% (n=8)**

Provider-identified risk factors

	2006-2008 (n=125)	2012-2013 (n=60)
At least one risk factor identified	64%	85%
Hematologic	19% (n=29)	**25% (n=15)**
Hypertension	17% (n=26)	17% (n=10)
Cardiac	13% (n=20)	**18% (n=11)**
Pulmonary	9% (n=13)	**18% (n=11)**
Endocrine	8% (n=12)	**17% (n=10)**
Psychiatric disorders	5% (n=8)	**12% (n=7)**

Causes of death over time

Cause of death	2006-2008	2012-2013
Hemorrhage	**23% (n=29)**	**18% (n=11)**
Hypertensive disorders	**23% (n=29)**	10% (n=6)
Embolism	**17% (n=21)**	**30% (n=18)**
Cardiovascular problems	10% (n=12)	5% (n=3)
Infection	3% (n=4)	**15% (n=9)**
Cardiomyopathy	2% (n=2)	10% (n=6)

Enhancing the Maternal Mortality Review Process

Maternal Mortality Review in New York State

- NYSDOH and ACOG District II are working collaboratively to add Committee review of cases to current process

- A more complete assessment of
  - Causes of death
  - Factors leading to death
  - Preventability
  - Opportunities for intervention

- Translate trends and issues to action
  - Collaborate to develop Issue Briefs, Grand Rounds
  - Quality improvement projects
    - Working collaboratively with partners (NYSDOH, ACOG, GNYHA, HANYS,RPCs)
  - Issue maternal mortality report

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Maternal Mortality: Understanding Racial Disparities

- Potential explanations:
  - Higher rates of chronic conditions
  - Greater socioeconomic risk factors
  - Quality of care
  - Higher rate of unintended pregnancy
  - Impact of racial discrimination

Bottom Line: We need to address <u>both</u>

Overall health & well being of women across the reproductive life course

Quality of care provided to women (systems improvements)

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Partnership for Maternal Health (PMH)

- Multi-stakeholders came together to address the increasing rates of maternal mortality
- The **New York Partnership for Maternal Health:**
  - New York State Department of Health
  - American Congress of Obstetricians and Gynecologists District II,
  - New York City Department of Health and Mental Hygiene
  - Healthcare Association of NYS
  - Greater NY Hospital Association
  - New York Academy of Medicine
- **Goal:** promote equity in maternal health outcomes within at-risk populations, to reduce ethnic and economic disparities, and preventable maternal mortality and morbidity in NYS.

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Multi-prong Approach to Reduce Maternal Mortality

- Multi-prong approach needed to address maternal mortality:
  - Preconception Care
  - Unintended Pregnancy
  - Disparities (inequities)

An Important Question:

Would you like to become pregnant this year?

- Certain medical conditions, personal behaviors, psychosocial risks, and environmental exposures associated with negative pregnancy outcomes can be identified and modified before conception through clinical interventions.
- Chronic conditions contribute significantly to increased maternal mortality rates in NYS
  - Emphasize the need for preconception care of women with chronic conditions with all health care providers
- Every Woman, Every Time.
  - Discuss reproductive plans
  - Prescribe contraception, if appropriate
  - Address risk factors and chronic conditions that could compromise maternal health

Elements of Preconception Care

Increase focus on elements which must be done before or shortly after conception to be effective

- Risk assessment
- Health promotion
- Medical and psychosocial interventions

Opportunities for Preconception Care

When should preconception care be offered

- As part of routine health maintenance care
- At a defined preconception visit
- For women with chronic illness
- At one visit v. several visits
- Any time a woman interacts with a health care provider.

Commissioner Zucker's Letter on Preconception Health

September 9, 2016 Dr. Zucker sent a Dear Colleague letter recognizing preconception health as key to improving maternal health:

- Recognized the formation of the New York State Partnership for Maternal Health
- Asked all clinicians to initiate conversations with all female patients of reproductive age the one essential question: *"Would you like to become pregnant within the next year?"*
- Identified resources to support their practice- "Before and Beyond" CME-accredited educational modules developed by the National Preconception Health and Health Care Initiative

Examples of Positive Improvements in Preconception Care

Through NYS's work on the **national CoIIN to reduce infant mortality**, the NYSDOH is facilitating three initiatives, which have:

- Engaged six MICHCs and three FQHCs across the state to work collaboratively on goals such as:
  - Improving birth spacing/intention by increasing adherence to the post-partum visit, and increasing selection and use of an effective contraceptive method; and
  - Improving the integration of evidence-based preconception messages into routine preventive care services.
    - ***Would you like to become pregnant in the next year?***

Examples of Positive Improvements in Preconception Care

Successes to date as a result of the NYS IM-CoIIN:

- Among MICHCs participating in the initiatives there has been:
  - An increase from 76.2% to 77.3% in providing information to clients about the importance of the postpartum visit;
  - An increase from 76.2% to 81.8% in providing information to clients about effective contraception methods; and
  - The percent of clients selecting an effective contraception method in the prenatal period increased from 38.9% to 52.9%.
- Among FQHCs participating in the initiatives:
  - 100% of clients have been asked about pregnancy intention in 2016; up from 75.2% in 2015 (a 33% improvement); and
  - In 2016, 8.0% clients received or were referred for a highly effective/LARC method; up from 3.2% of clients in 2015.

NYS Initiatives to Increase Access to LARC

CDC 6|18 Long Acting Reversible Contraceptive (LARC) Initiative

- Opportunity for DFH and OHIP to partner with CDC to accelerate evidence into action to improve health, control costs, and facilitate:
  - The 2016-17 NYS Executive Budget included an initiative for the comprehensive coverage and promotion of LARC
  - Effective 9/1/16, Medicaid Managed Care plans are required to pay hospitals for immediate PP LARC separately from the inpatient stay. FFS payment was separated 4/1/14.
  - The Department obtained approval from the CMS to allow the cost of LARC to be paid to FQHCs separately from the Prospective Payment System (PPS) rate. Reimbursement for actual acquisition cost of LARC is available retroactively to 4/1/16

NYS Initiatives to Increase Access to LARC

ACOG LARC Task Force

- Developed, disseminated and analyzed a provider knowledge, attitudes, and practice patterns survey to help inform bundle education
- Develop a provider “bundle” complete with patient counseling scripts and algorithms, including guidance on how to alleviate patient concerns and dispel myths on LARC.
- Diverse group of clinicians, NYCDOHMH and NYSDOH have provided feedback and will help disseminate the contraceptive counseling algorithm, fact sheets and administrative/infrastructure support
- Provide a foundation for consistent messaging on LARC

NYS Initiatives to Increase Access to LARC

ASTHO LARC Learning Community

- State Team of ACOG, CHCANYS, NYCDOHMH and NYSDOH (DFH, OHIP and OQPS):
  - Expands focus on implementing LARC broadly through state level policy changes and operationalizing the logistics associated with access to LARC.
  - Multi-level approach to address healthcare delivery system barriers related to provider education, hospital systems and community health centers
  - Utilization of promising practices between NYS partners and other states to address access to highly effective contraception

PMH – Next steps

Expand partners

- Primary Care Providers
- Emergency Room Providers
- Specialists
- Licensed Midwives
- Nurses

Include other DOH initiatives

- Health Homes
- DSRIP
- APC

Multi-prong education campaign

- Develop education pieces with PMH for email lists/newsletters
- Design material for offices on pregnancy intendedness and contraception
- Create webinar for continuing education credits on preconception targeting primary care providers

Perinatal Regionalization

Perinatal Regionalization is a comprehensive, coordinated geographically structured system of care organized around a series of Regional Perinatal Centers (RPCs), each supporting and providing clinical expertise, education and quality improvement to a group of affiliate hospitals.

Benefits of Perinatal Regionalization

- To ensure that women and their babies will have ready access to the services they need through:
  - Ensuring access to an expert health care team
  - Ensuring high quality, comprehensive care for women and babies.
  - Maximizing resources of the various facilities across the state – centralizes technology
  - Allows for ongoing quality improvement to better ensure quality services across all levels of perinatal care

Levels of Care in Perinatal System

- Regional Perinatal Center – critical role
- Level III provides care to high risk women and newborns
- Level II provides care for moderately complicated women and newborns.
- Level I provides basic care to women and newborns and does not provide NICU services
- Birthing centers provide care to low-risk women and newborns who require a stay of less than 24 hours after birth.

Role of RPC

- Care for a concentration of high-risk patients
- Reduce duplication of services within their region
- Maintain the expertise required to consistently provide the best quality care to the highest risk patients
- Ensure the quality of care provided throughout the affiliative region:
  - 24 hour consultation
  - Transport coordination
  - Outreach and education
  - Onsite quality if care visits

Redesignation Process

- Review and Update perinatal hospital standards, with increased emphasis on maternal health
- Convene expert workgroup to assist with review and to finalize standards
- Produce recommendations for revisions of 10 NYCRR Section 405.21 Perinatal Services and Part 721 Perinatal Regionalization

Redesignation Process

- Webinar for hospitals on revised criteria and process
- Electronic survey of all birthing hospitals related to new standards
- Clinical review of surveys for compliance
- Multidisciplinary teams will conduct onsite reviews of:
  - All RPCs and Level III perinatal hospitals
  - All hospitals requesting higher level designation
  - 20% of Level II and I perinatal hospitals
  - Birthing Centers- Hospital and Mid-wife administered
- Final Report to DOH with recommendations and approval

Questions & Discussion