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Health Services**

Preventing Maternal Mortality in Texas A PUBLIC HEALTH COMMITMENT

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June 16, 2017

*Let us have a moment of silence for the families in Texas
forever impacted by the loss of a mother*

Overview

1) Roles & Responsibilities

2) Maternal Death Data Trends

3) Severe Maternal Morbidity Trends

4) Case Reviews

5) Key Findings to Date

6) Action Plan

- More Accurate Death Data & Maternal Mortality Rate
- New Legislative Charges
- Need for Maternal Safety Bundles
- Texas Maternal Mortality Forum



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Roles & Responsibilities

Roles

- Multidisciplinary Task Force was established in 2013 and began its work in late 2014 supported by DSHS
- **Task Force** studies and reviews cases and data trends, and makes recommendations for prevention
- **DSHS** provides administrative support:
 - 1 Epidemiologist — surveillance, research, and data analytic expertise, statewide data trends, case review record requests, data collection, analysis
 - 1 Public Health Nurse — case review medical expertise, oversight, quality monitoring, summarizes all cases
 - ½ Program Specialist — coordination of logistics of Task Force, subject matter expertise for implementing recommendations



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Roles & Responsibilities (cont'd)

Responsibilities

- **Maternal Death Data Trends**
- **Case Reviews —**
to gain a more in-depth picture of causes and risk factors related to maternal death to make recommendations for prevention



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Maternal Death Data Trends

Maternal Mortality Rate (MMR)

- Number of maternal deaths occurring within 42 days of the end of pregnancy per 100,000 live births
- Maternal death within 42 days is determined by coding done by CDC
- CDC coding based on pregnancy status information and cause of death description on death certificate certified by physicians, medical examiners, or justices of the peace



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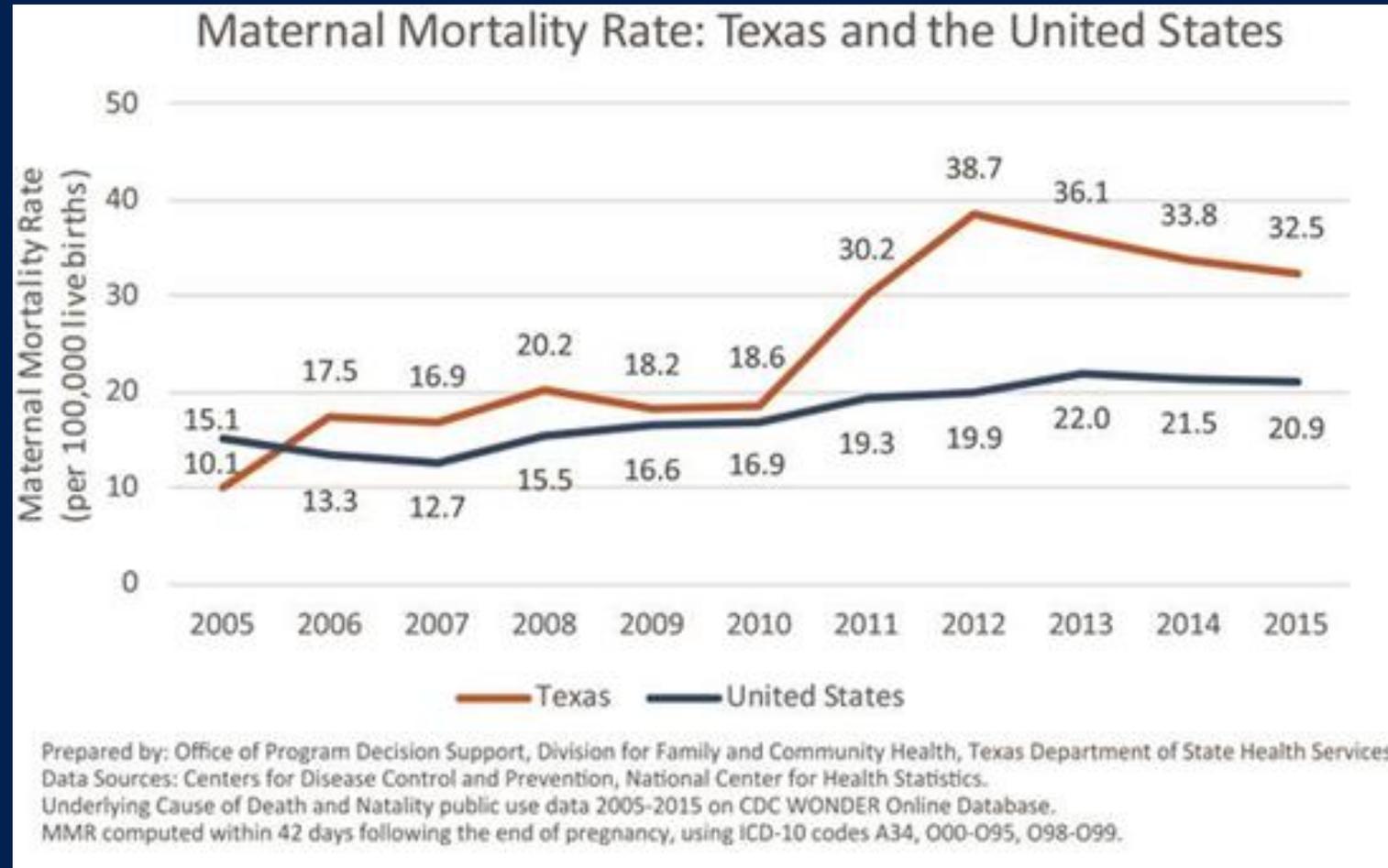
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Maternal Death Data Trends (cont'd)



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Maternal Death Data Trends (cont'd)

More Accurate Texas MMR

- Enhanced method for identifying maternal deaths:
 - Linking death record to birth or fetal death within 42 days
 - Checking medical records for evidence of pregnancy near/at time of death
- Preliminary findings suggest that enhanced method will result in significantly lower 2012 Texas MMR than MMR previously published by other researchers
- Use enhanced method going forward for MMR trends and comparisons



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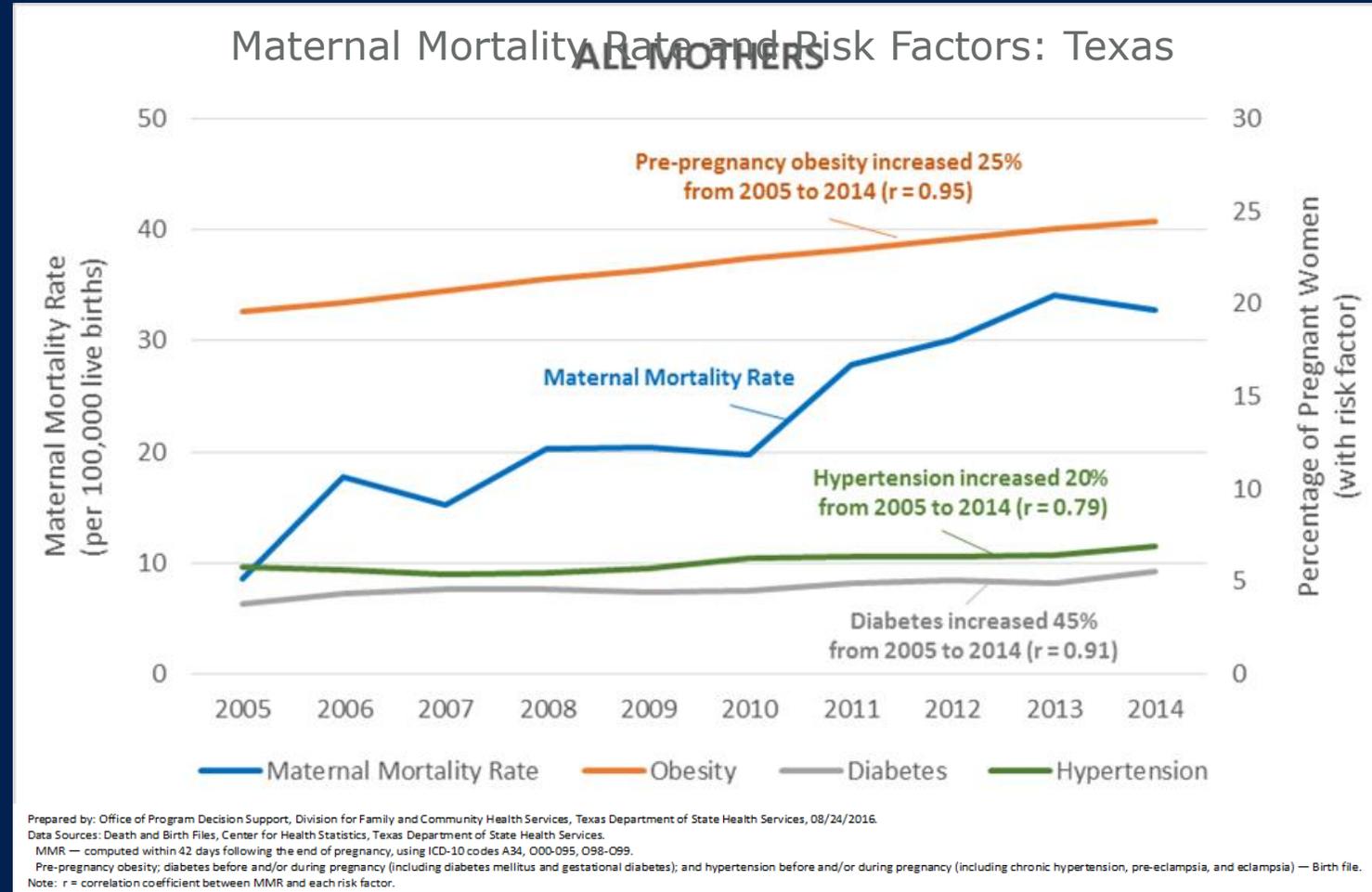
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Maternal Death Data Trends (cont'd)



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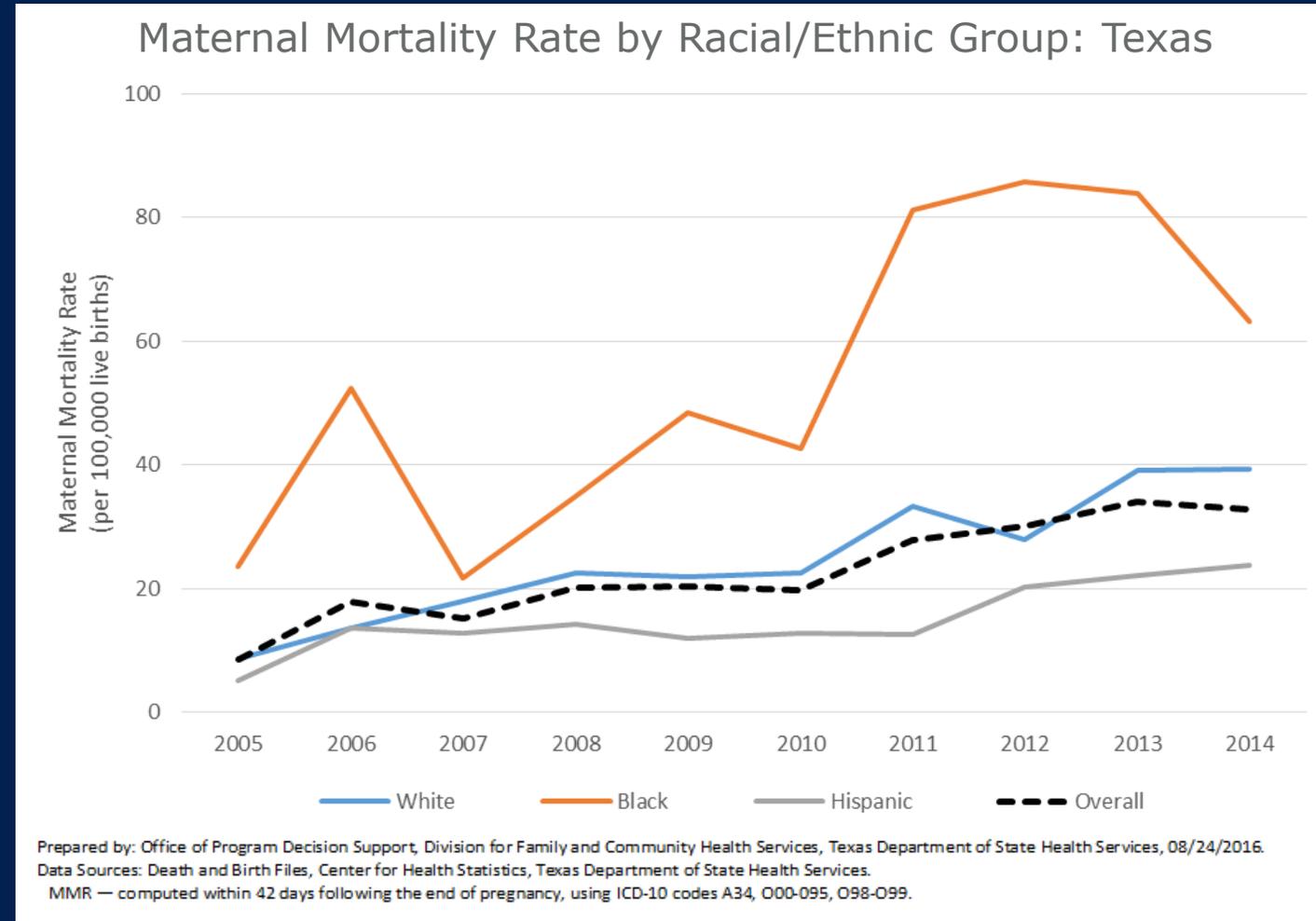


Maternal Death Data Trends (cont'd)



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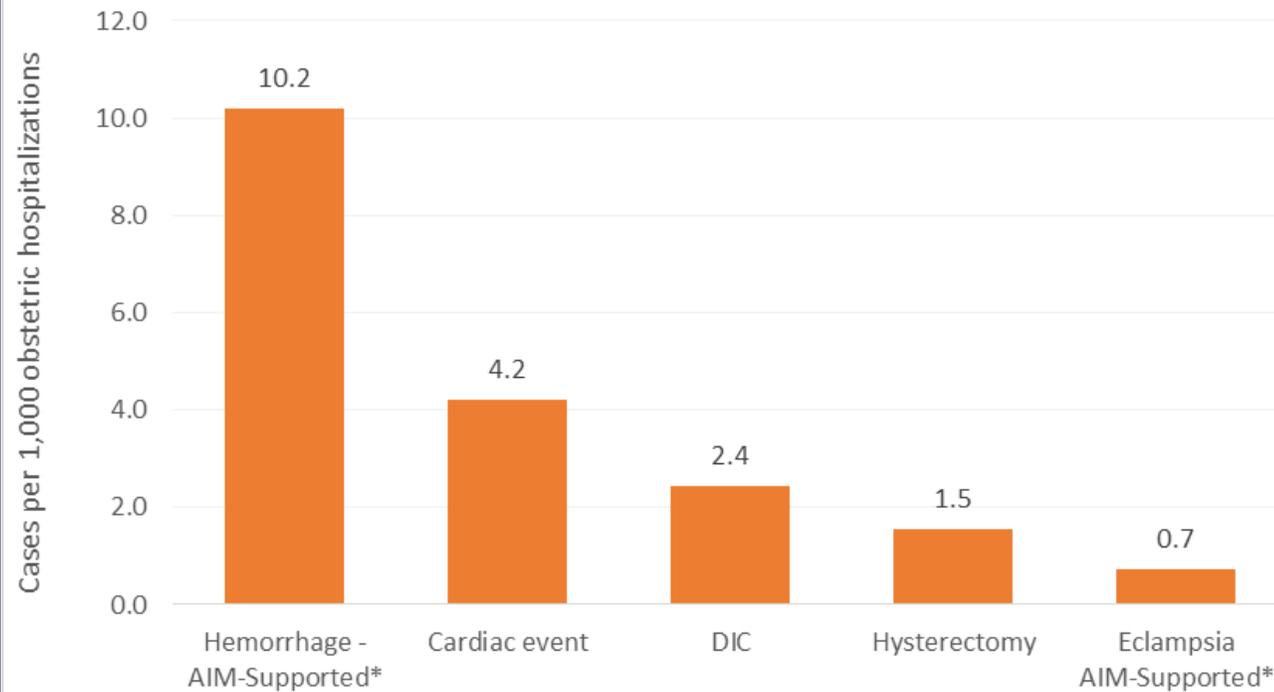
Severe Maternal Morbidity Data Trends



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Severe Maternal Morbidity in Texas, Top Causes, 2014



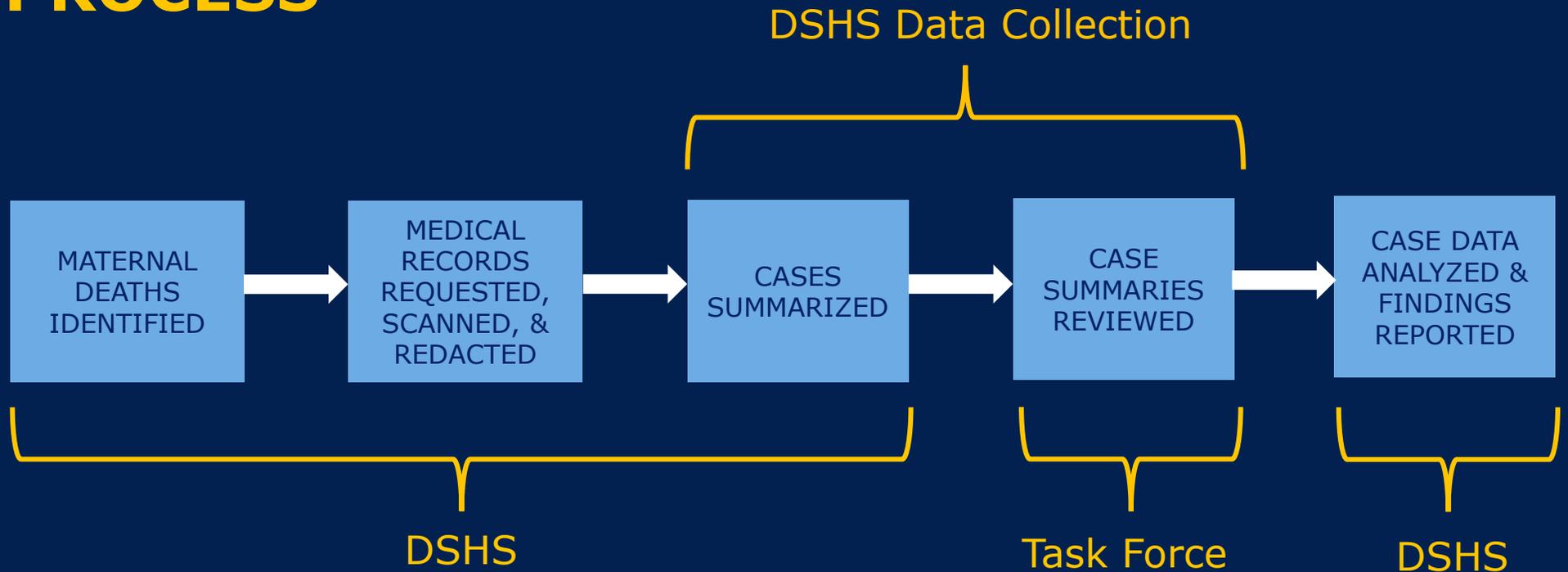
*Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundle is available for this condition

Data Source: Hospital Inpatient Discharge Public Use Data File, 2014

Prepared by: Office of Program Decision Support

CASE REVIEWS

PROCESS



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CASE REVIEWS (cont'd)

PROGRESS

- Late 2014, case reviews began for 2012 (year with highest Texas MMR)
- Approximately 45 of 90 cases for 2012 reviewed

PLAN FOR EXPEDITING

- Automating case record requests
- Adopting and adapting case review data collection system
- Sampling 50 percent of all maternal death cases for Task Force review annually
- Contracting for medical case record redaction and abstraction



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Key Findings to Date

- Need for more accurate death data and MMR
- Risk for maternal death highest among Black women
- Behavioral health issues, especially opioid use and postpartum depression often indirectly associated with maternal death
- Obstetric hemorrhage and hypertension/eclampsia among leading direct causes of severe maternal morbidity with greatest preventability of maternal death



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Action Plan

More Accurate Death Data & MMR

- Increase accuracy of death certificate data in new vital event registration system to reduce user error for death reporting
- User training of new system encouraged by professional organizations important for preventing user error
- Use enhanced method for identifying maternal deaths for more accurate MMR



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Action Plan (cont'd)

New Legislative Charges

- Examine role of postpartum depression and evaluate programs
- Develop best-practice guidelines and protocols for reporting and investigating pregnancy-related deaths



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Action Plan (cont'd)

Need for Maternal Safety Bundles

- To address obstetric hemorrhage and severe hypertension/preeclampsia — top causes of maternal death with greatest chances of being prevented
- Best-practice instructions, checklists, and supplies for hospital staff to prepare for, respond to, and prevent obstetric hemorrhage and severe hypertension during pregnancy
- Bundles designed to be implemented by state's perinatal quality collaborative, who has established relationships with hospitals
- Texas Collaborative for Healthy Mothers and Babies (TCHMB) supported by DSHS-funded contract with University of Texas



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Action Plan (cont'd)

Texas Maternal Mortality Forum

- To inform partners on issue of maternal mortality, develop technical planning workgroups and action plans for implementation of evidence-based initiatives
- Three main workgroups:
 - Data Collection and Reporting
 - Systems of Care
 - Public Health Systems



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Questions?
