OKLAHOMA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE

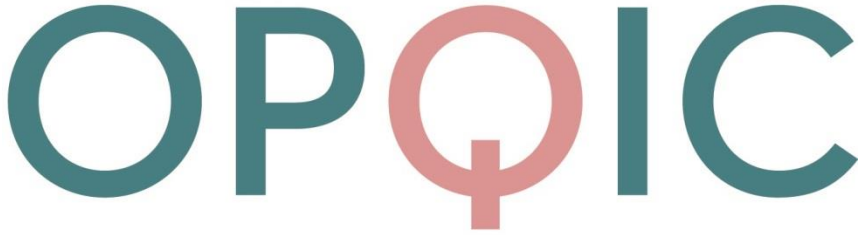
Relevant Disclosures

- Under the Oklahoma State Medical Association CME guidelines, disclosure must be made regarding relevant financial relationships with commercial interests within the last 12 months.

- Barbara O'Brien has no financial relationships or affiliations to disclose.

Objectives

- State three projects in Oklahoma focused on reducing infant mortality
- State 2 focus areas in Oklahoma to reduce severe maternal morbidity
- Cite at least 2 things you will do to reduce infant deaths in OK
- Cite at least 2 things you will do to reduce maternal deaths in OK



Creating a culture of excellence in perinatal care

OPQIC

WHAT'S THE LATEST? INITIATIVES COURSES CALENDAR RESOURCES ABOUT US

ABOUT US

Our mission is to provide leadership and engage interested stakeholders in a collaborative effort to improve the health outcomes for Oklahoma women and infants using evidence-based practice guidelines and quality improvement processes.

Check out our Featured Resource of the month

CONTACT US TODAY

INITIATIVES
See initiatives facilitated by the Oklahoma Perinatal Quality Improvement

COURSES
View a list of courses offered by the Office of Perinatal Quality Improvement.

RESOURCES
Find resources for perinatal health care providers.

Website Analytics

- 21,194 Sessions
- 41,170 page views
  - Average 1.94 pages per session
- Most popular pages:
  - New Neonatal Resuscitation Guidelines
  - Home Page
  - ACOG Workshop Summary: Evaluation and Management of Women and Newborns With a Diagnosis of Chorioamnionitis
  - AIM

The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 629 • April 2015 *(Replaces Committee Opinion 526, May 2012)*

Committee on Patient Safety and Quality Improvement

This document reflects emerging concepts on patient safety and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Clinical Guidelines and Standardization of Practice to Improve Outcomes

ABSTRACT: Protocols and checklists have been shown to reduce patient harm through improved standardization and communication. Implementation of protocols and guidelines often is delayed because of lack of health care provider awareness or difficult clinical algorithms in medical institutions. However, the use of checklists and protocols clearly has been demonstrated to improve outcomes and their use is strongly encouraged. Checklists and protocols should be incorporated into systems as a way to help practitioners provide the best evidence-based care to their patients.

STATE PROFILE

State Profile – Oklahoma

- Oklahoma Population – 3,923,561
  - 77.9% white
  - 8.9% AA/Black
  - 10.6% Am. Indian
  - 10.3% Hispanic
- Female population – 50.5%
  - 77.9% white
  - 8.8% AA/Black
  - 10.6% Am. Indian
  - 9.8% Hispanic
- Female median age 37 yrs

Source: U.S. Census Bureau

State Profile – Oklahoma

- Females age (15-44 years) – 38.8%
  - 74.9% white
  - 9.8% AA/Black
  - 11.8% Am. Indian
  - 11.6% Hispanic
- Females of childbearing age (18-44 years) – 34.9%
  - 75.2% white
  - 9.7% AA/Black
  - 11.5% Am. Indian
  - 11.3% Hispanic

Source: U.S. Census Bureau

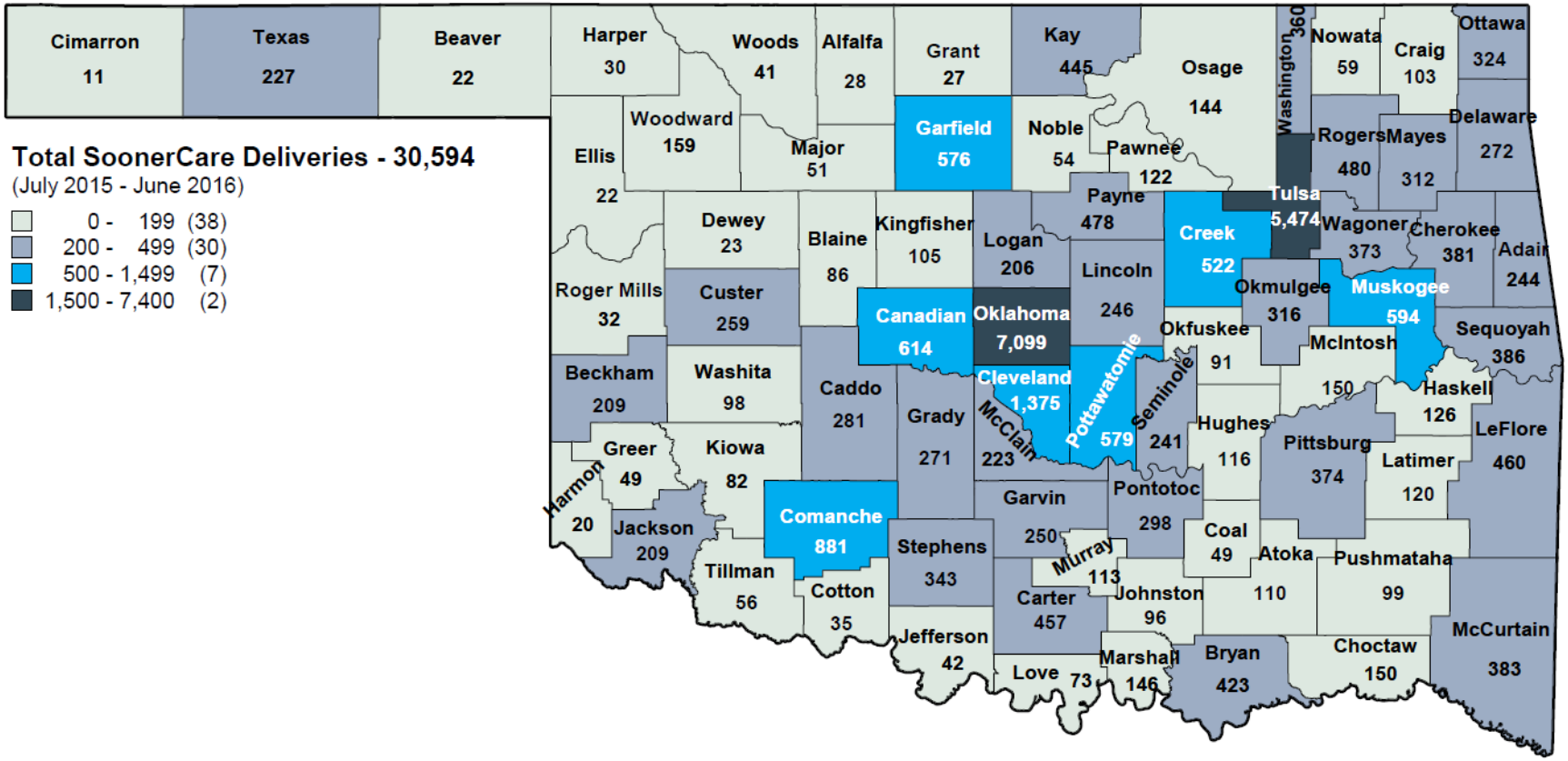
State Profile – Oklahoma

	Medicaid deliveries July 2015-June 2016	# Live births 2016	% of live births delivered via Medicaid
Overall	30,594	52,607	58.2%
White	19,319	39,039	49.5%
AA/Black	3,229	5,539	58.3%
Am Indian	3,394	6,201	54.7%
Hispanic	6,464	7,583	85.2%

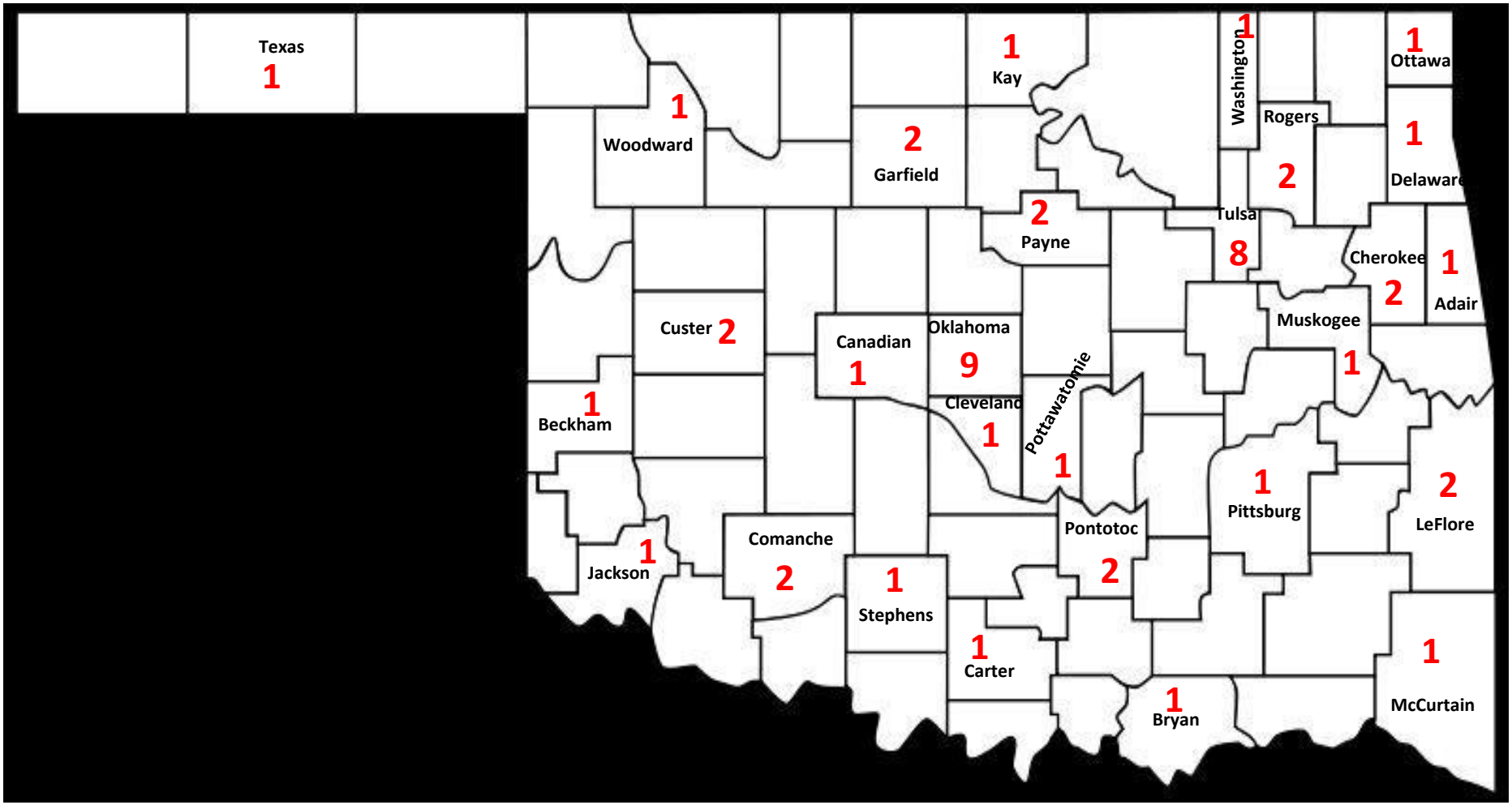
Source: the Oklahoma Health Care Authority -*SoonerCare Delivery Fast Facts SFY2016*
Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics

SoonerCare Delivery Fast Facts
SFY2016

Oklahoma HealthCare Authority



Source: the Oklahoma Health Care Authority -*SoonerCare Delivery Fast Facts SFY2016*



51 Oklahoma Birthing Hospitals

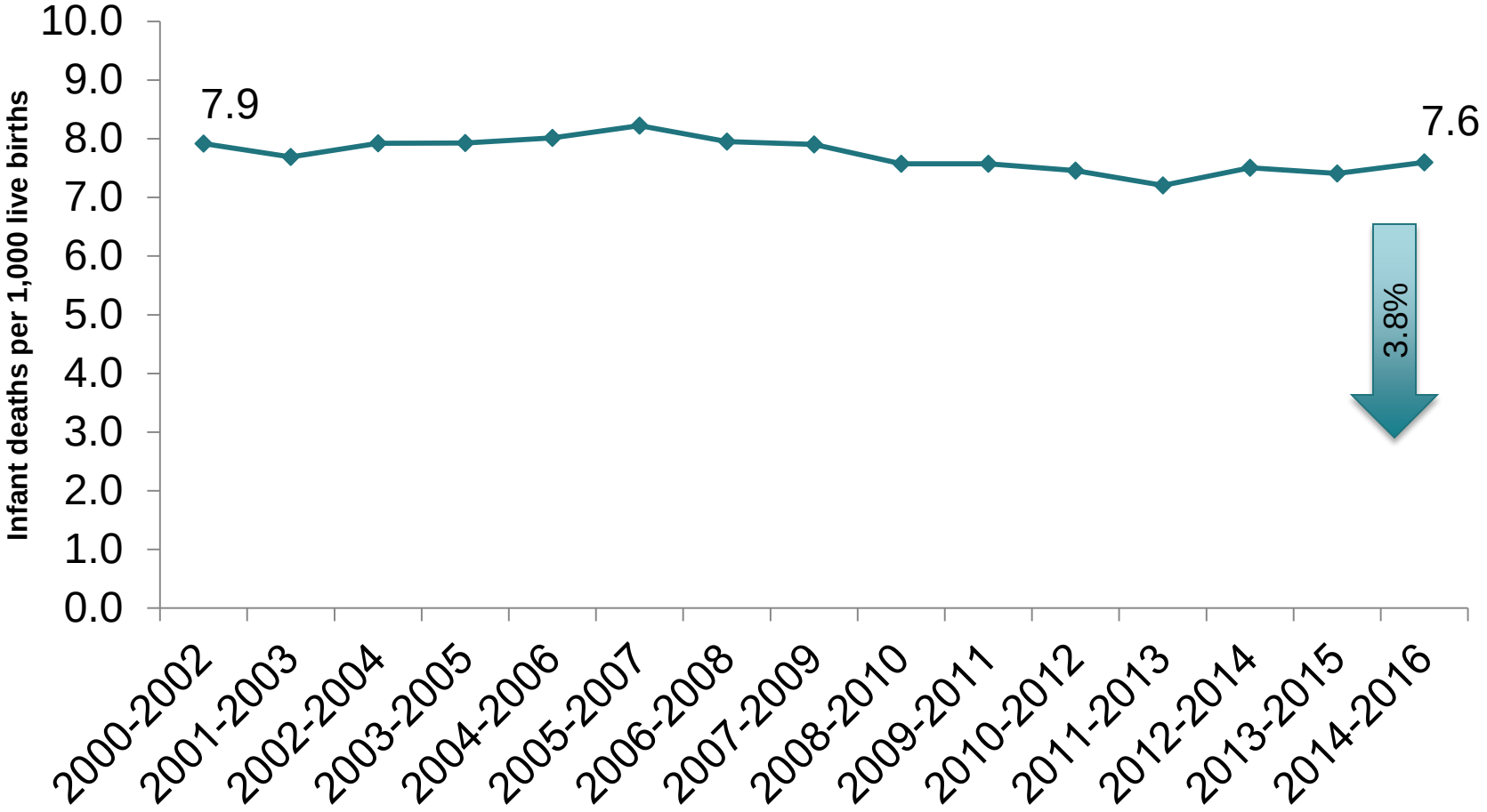
As of September 2017

INFANT MORTALITY

Definitions

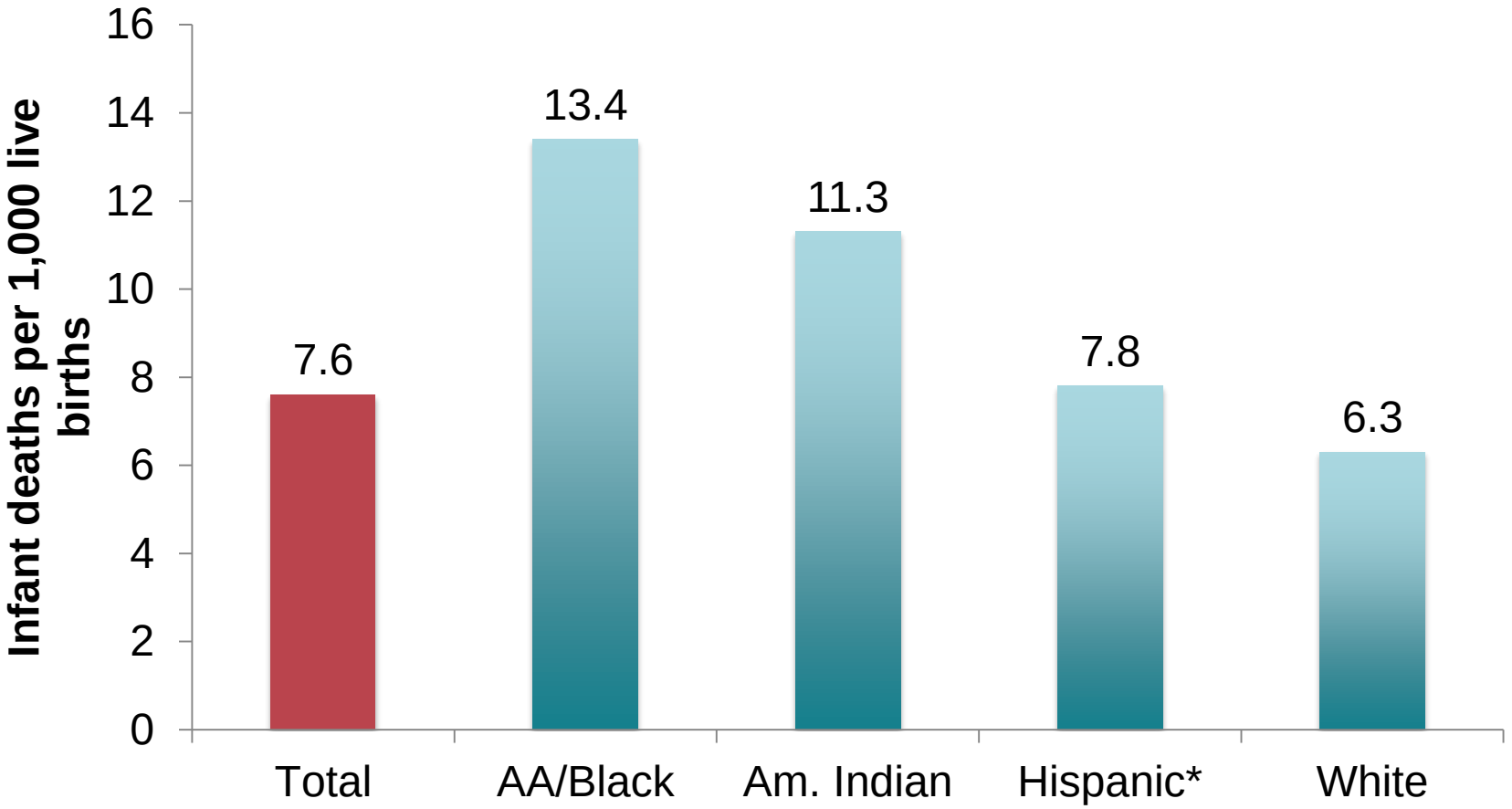
- Infant death = death prior to first birthday
- Neonatal death = death occurring < 28 days of life
- Post-neonatal death = death occurring during 28 to 364 days of life
- Infant mortality rate = number of infant deaths per 1,000 live births

Infant mortality rate: Oklahoma, 3-year moving



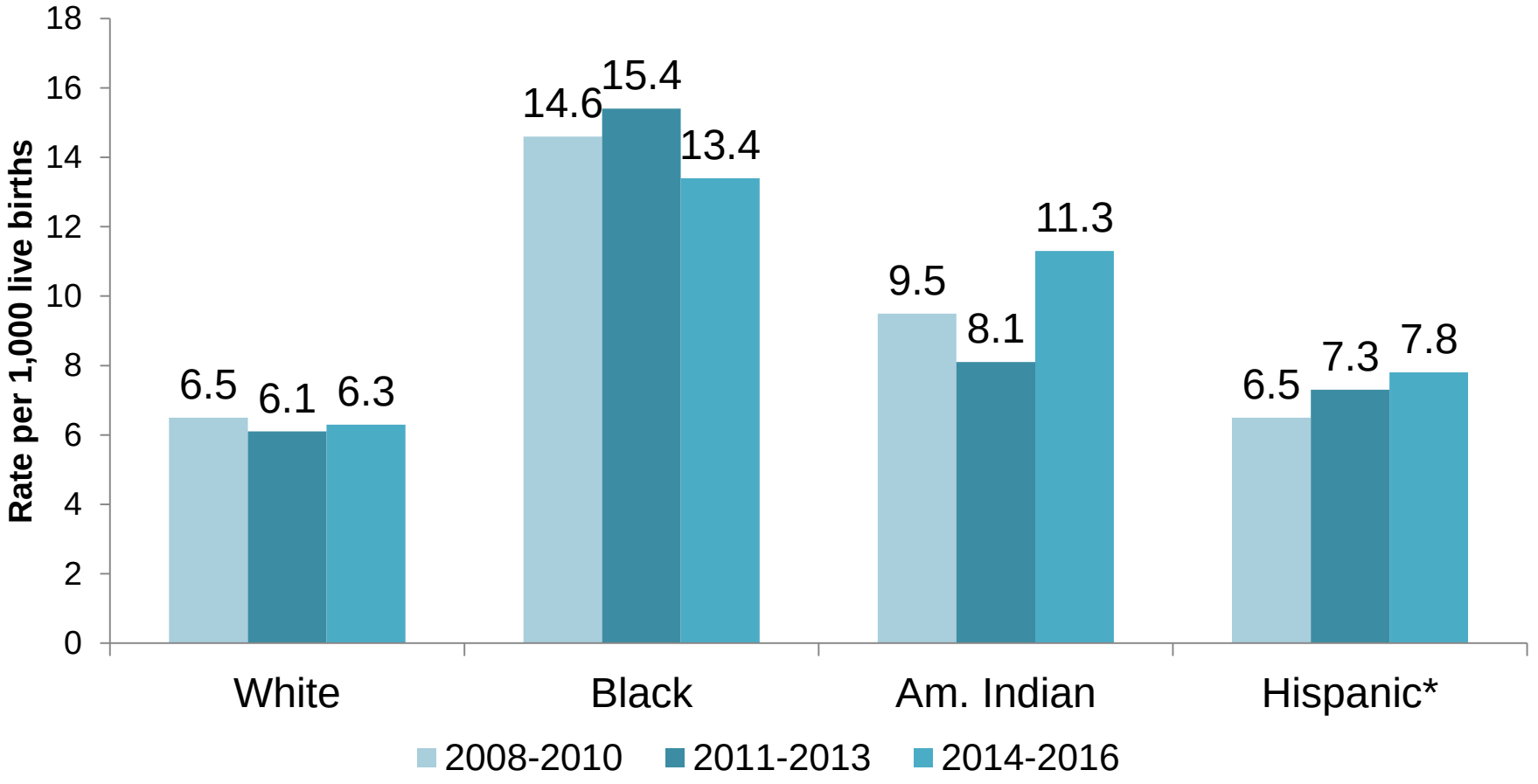
Source: OSDH, Center for Health Statistics, Health Care Information, OK2SHARE

Infant mortality rate: Oklahoma, 2014-2016



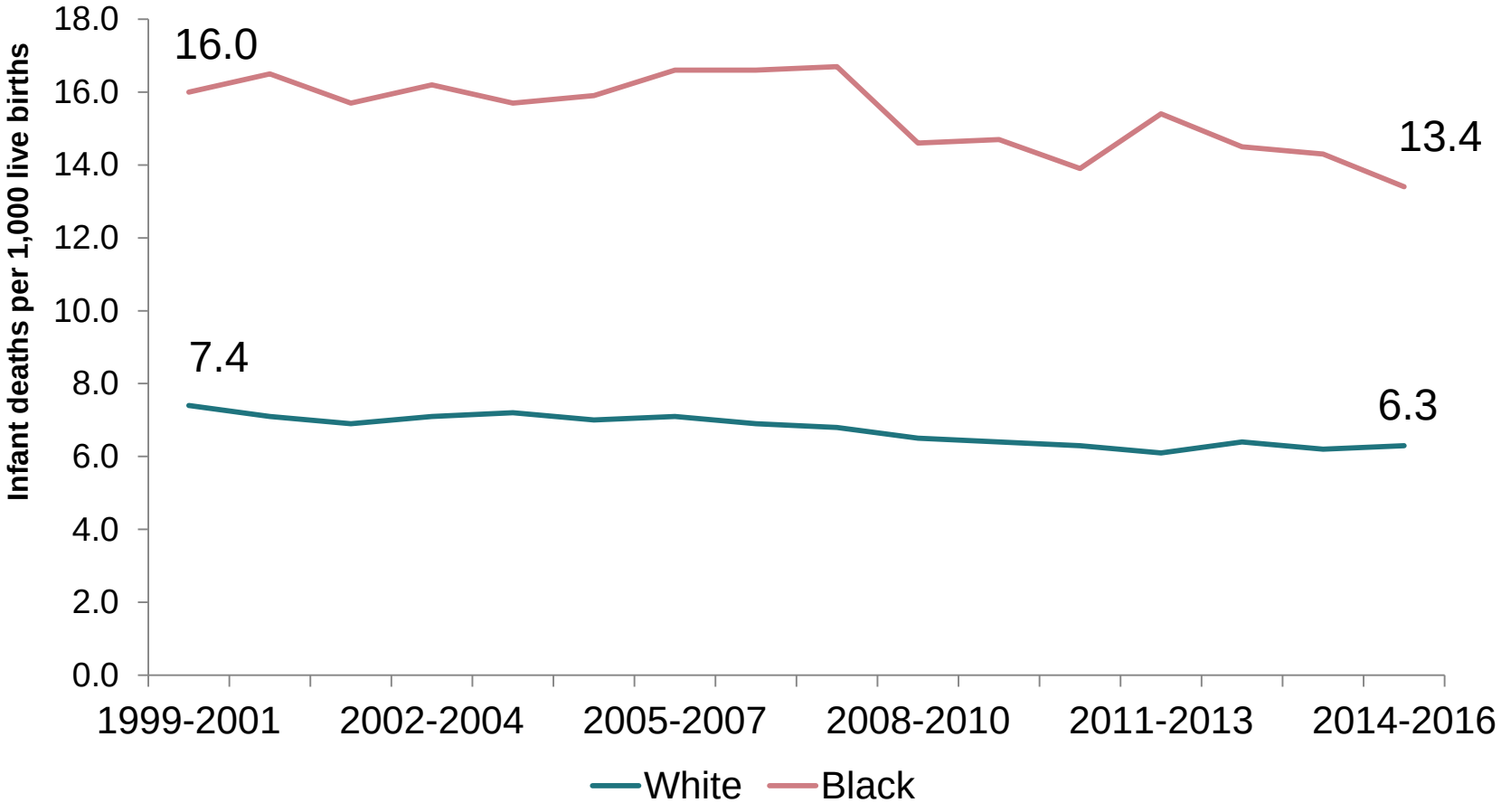
Source: OSDH, Center for Health Statistics, Health Care Information, OK2SHARE
*Hispanics may be of any race

Infant mortality rates by race and Hispanic origin: Oklahoma, 2008-2010, 2011-2013, 2014-2016



Source: OSDH, Center for Health Statistics, Health Care Information, OK2SHARE
*Hispanics may be of any race

Infant mortality rates for Black and White infants: Oklahoma, 3-year rates, 1999 to 2016



Source: OSDH, Center for Health Statistics, Health Care Information, OK2SHARE

Top 3 rankable* causes of infant death

- White
  1. Congenital anomalies (Q00-Q99)
  2. Disorders related to short gestation and low birth weight (P07)
  3. Sudden Infant Death Syndrome (SIDS) (R95)

- African American/Black
  1. Disorders related to short gestation and low birth weight (P07)
  2. Congenital anomalies (Q00-Q99)
  3. Sudden Infant Death Syndrome (SIDS) (R95)

- American Indian
  1. Disorders related to short gestation and low birth weight (P07)
  2. Congenital anomalies (Q00-Q99)
  3. Sudden Infant Death Syndrome (SIDS) (R95)

- Hispanic
  1. Congenital anomalies (Q00-Q99)
  2. Disorders related to short gestation and low birth weight (P07)
  3. Sudden Infant Death Syndrome (SIDS) (R95)

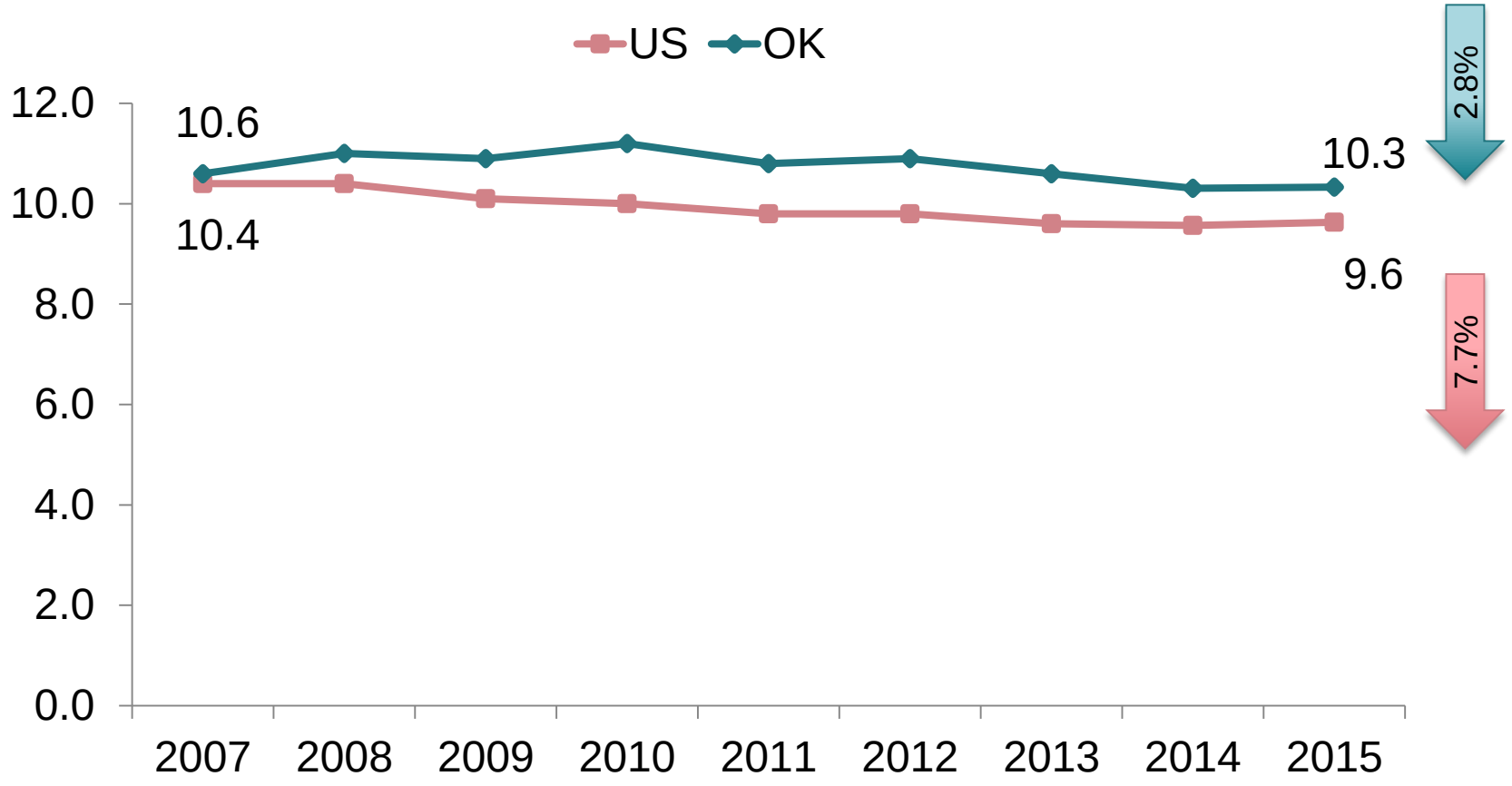
*Based on International Classification of Diseases, 10th Revision
†Rates are per 10,000 live births.
Source: OSDH, Center for Health Statistics, Health Care Information, OK2SHARE

Priority areas for addressing infant mortality

- Preterm Birth Prevention
- Breastfeeding
- Infant Injury Prevention
- Infant Safe Sleep
- Postpartum Depression
- Preconception/Interconception Health
- Tobacco Cessation

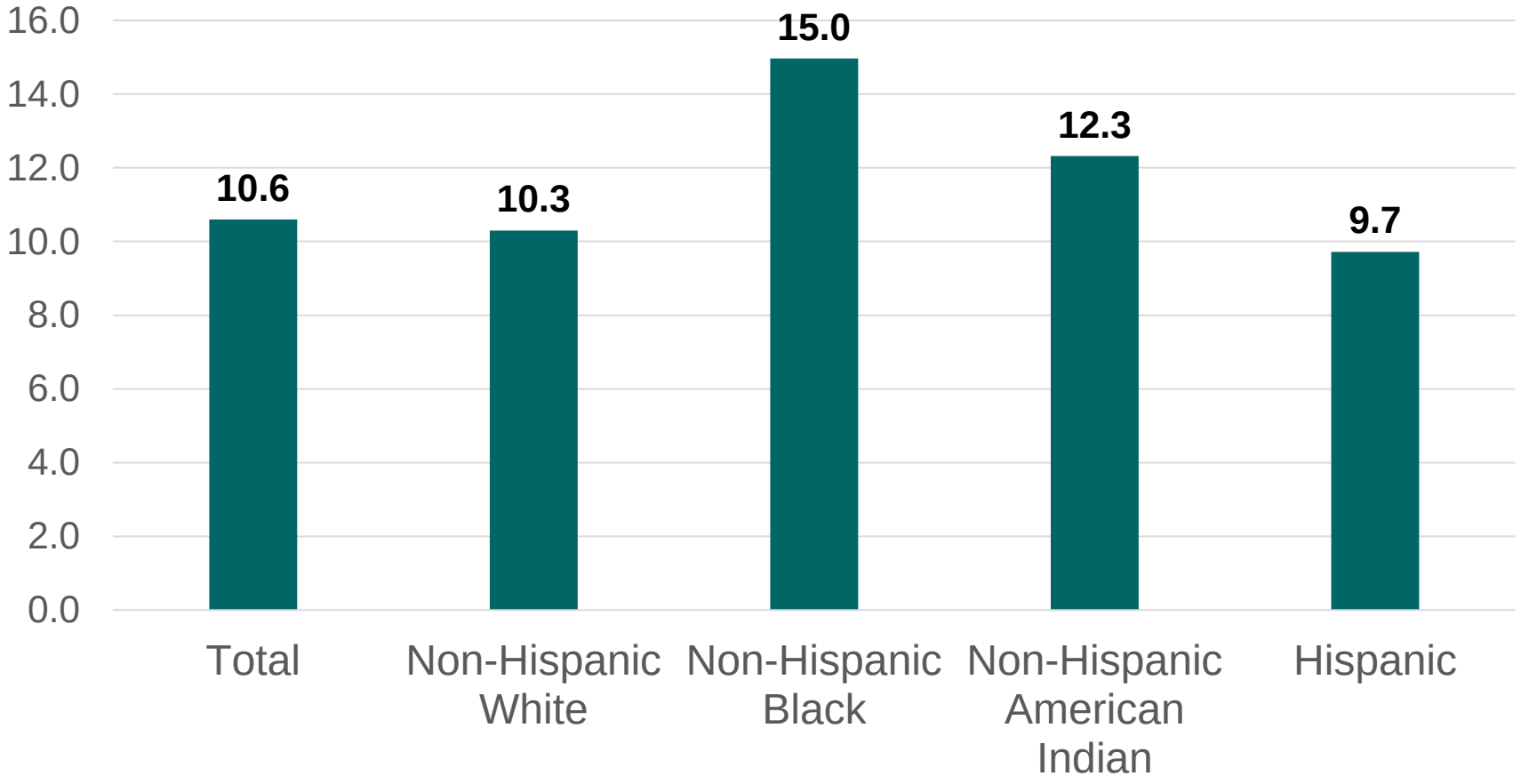
PRETERM BIRTH PREVENTION

Percent of births delivered preterm: U.S. and Oklahoma, 2007-2015



Preterm birth = delivery prior to 37 completed weeks gestation, based on obstetric estimate
Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS)

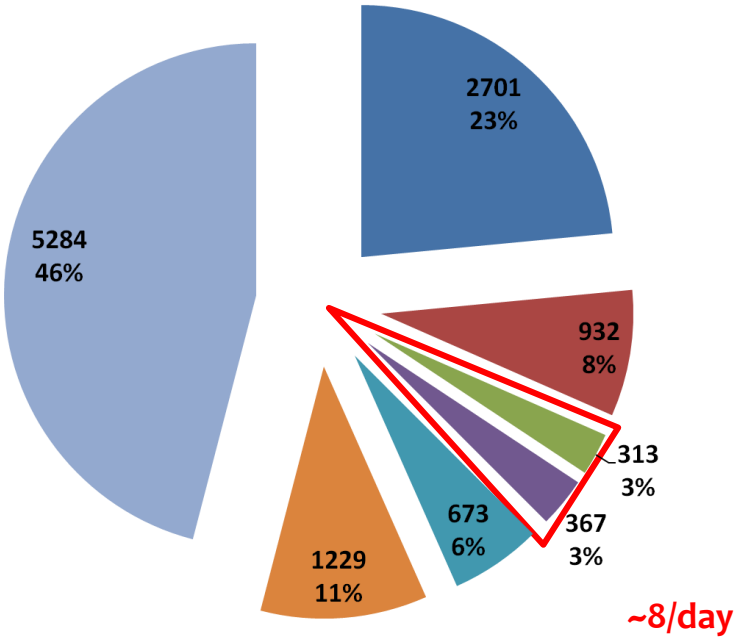
Percentage of births delivered prior to 37 weeks gestation by race and ethnicity, Oklahoma, 2016



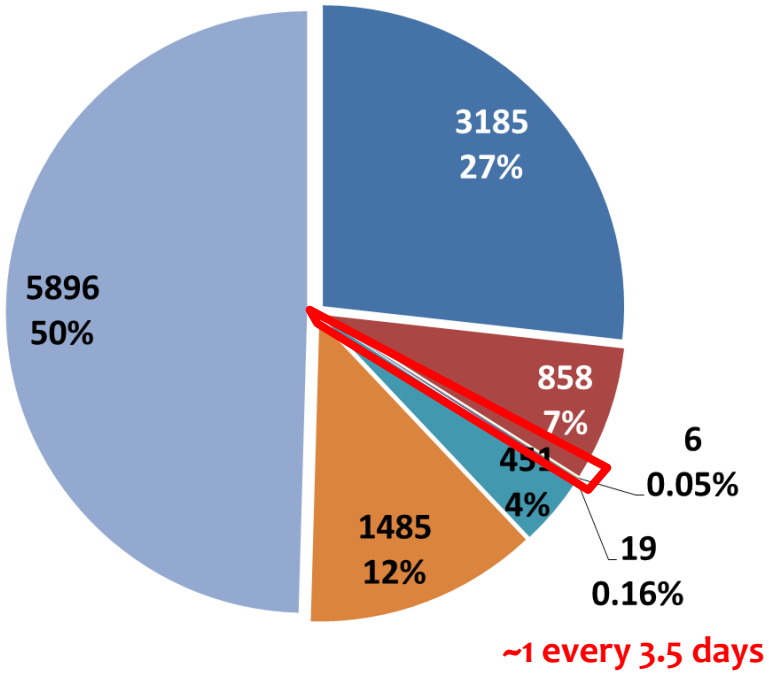
Source: MCH Standardized Birth File, 2016

EVERY WEEK COUNTS
2011-2014

Total Deliveries by Gestational Age and Documented Indication



Qtr 1 2011: January 1 – March 31, 2011

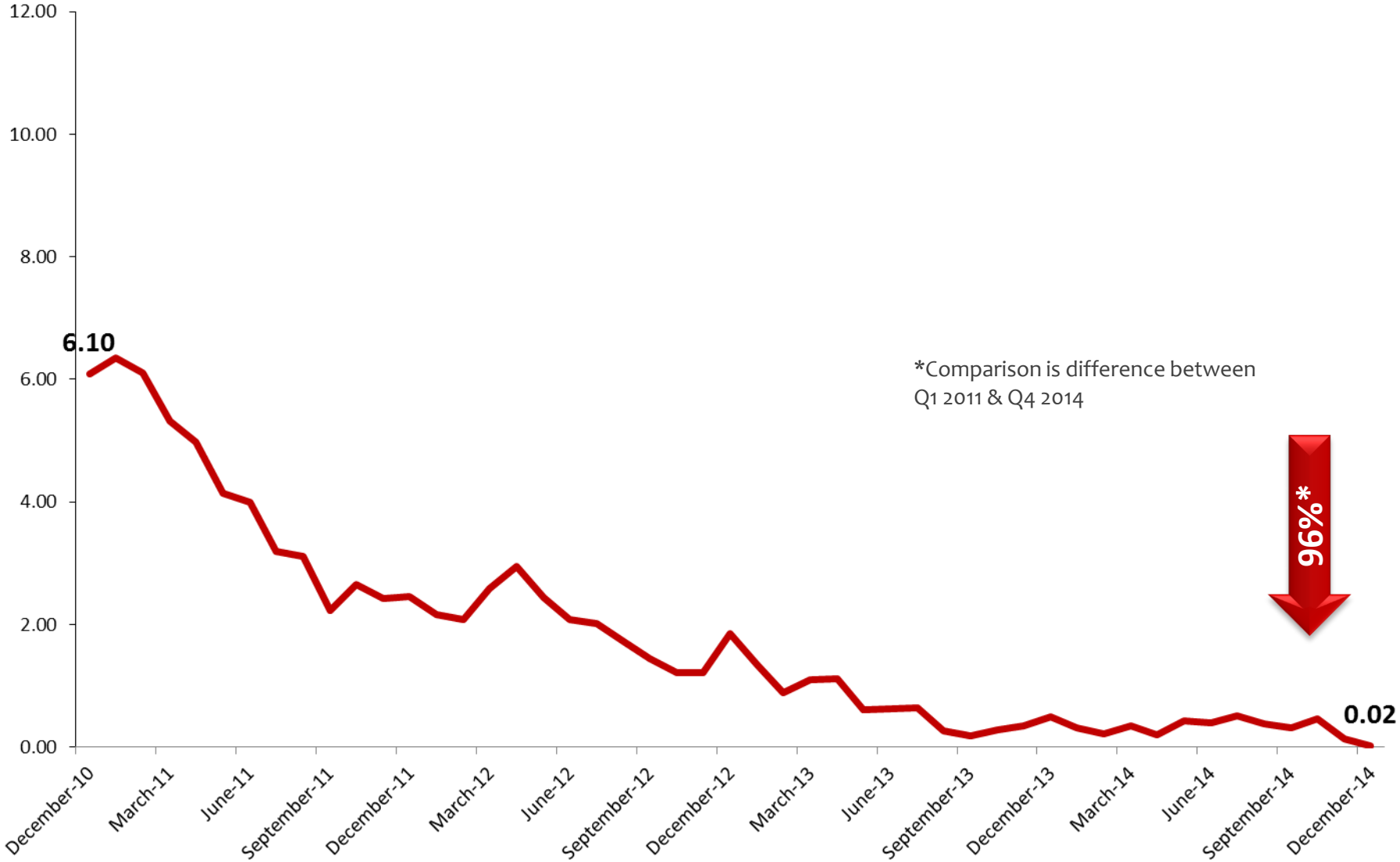


Qtr 4 2014: October 1 – December 31, 2014

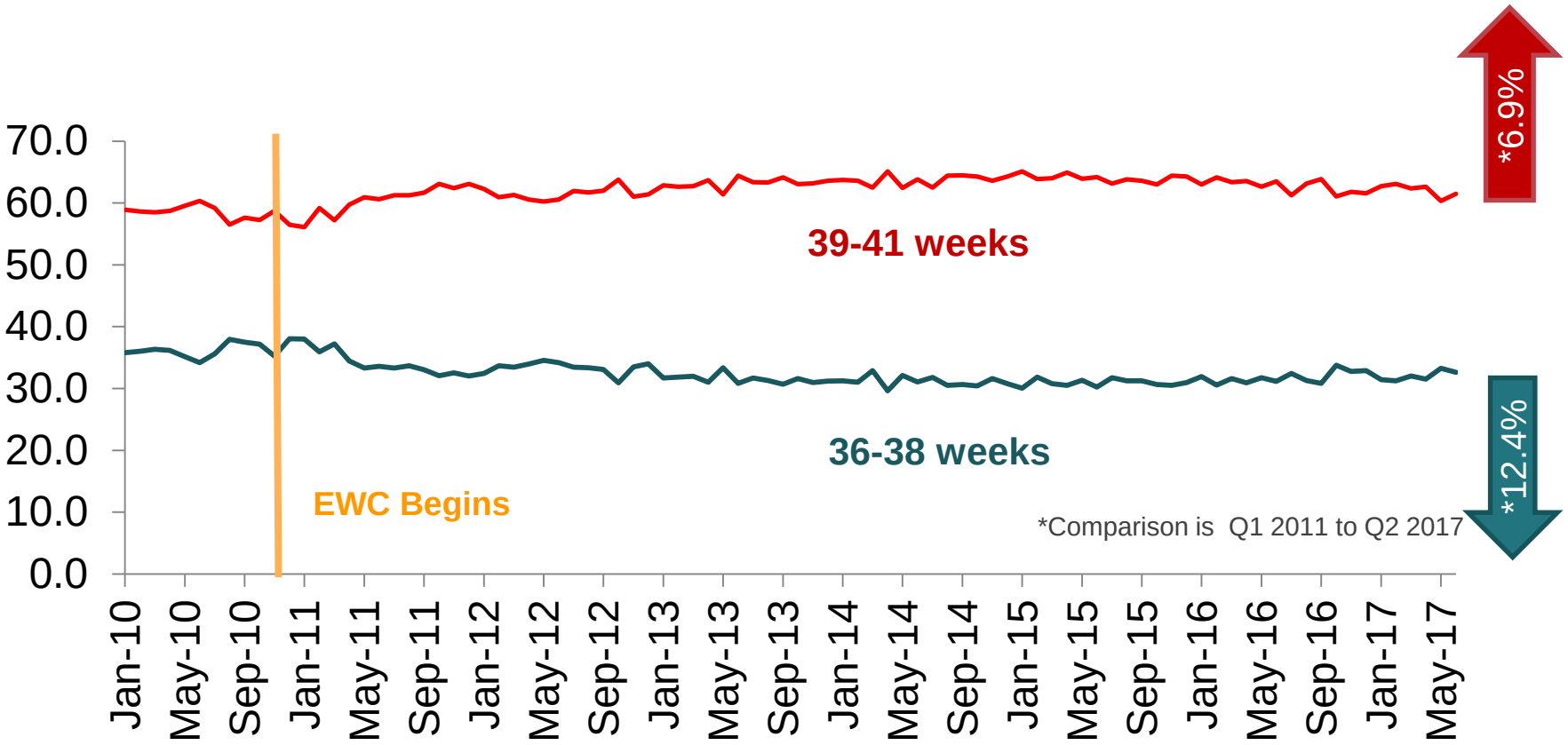
- Inductions > 39 weeks
- Inductions <39 weeks WITH a documented indication
- Inductions <39 weeks WITHOUT a documented indication
- Scheduled C-Sections <39 weeks WITHOUT a documented indication
- Scheduled C-Sections <39 weeks WITH a documented indication
- Scheduled C-Sections >39 weeks
- Others

Scheduled C-Sections AND Inductions <39 Weeks WITHOUT a Documented Indication

- as percentage of Total Deliveries



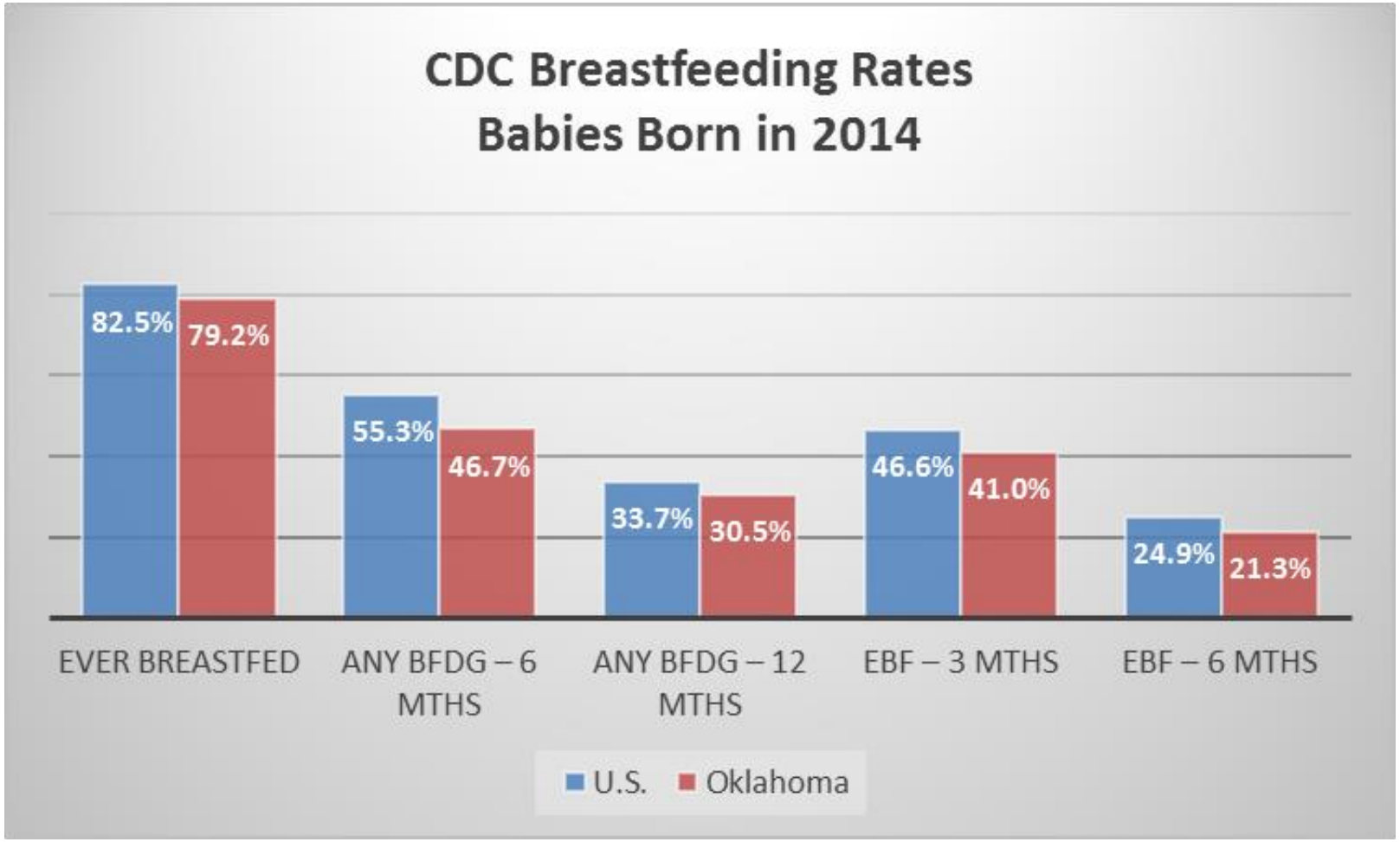
Percent of singleton births by length of gestation: Oklahoma, Jan 2010 to Jun 2017

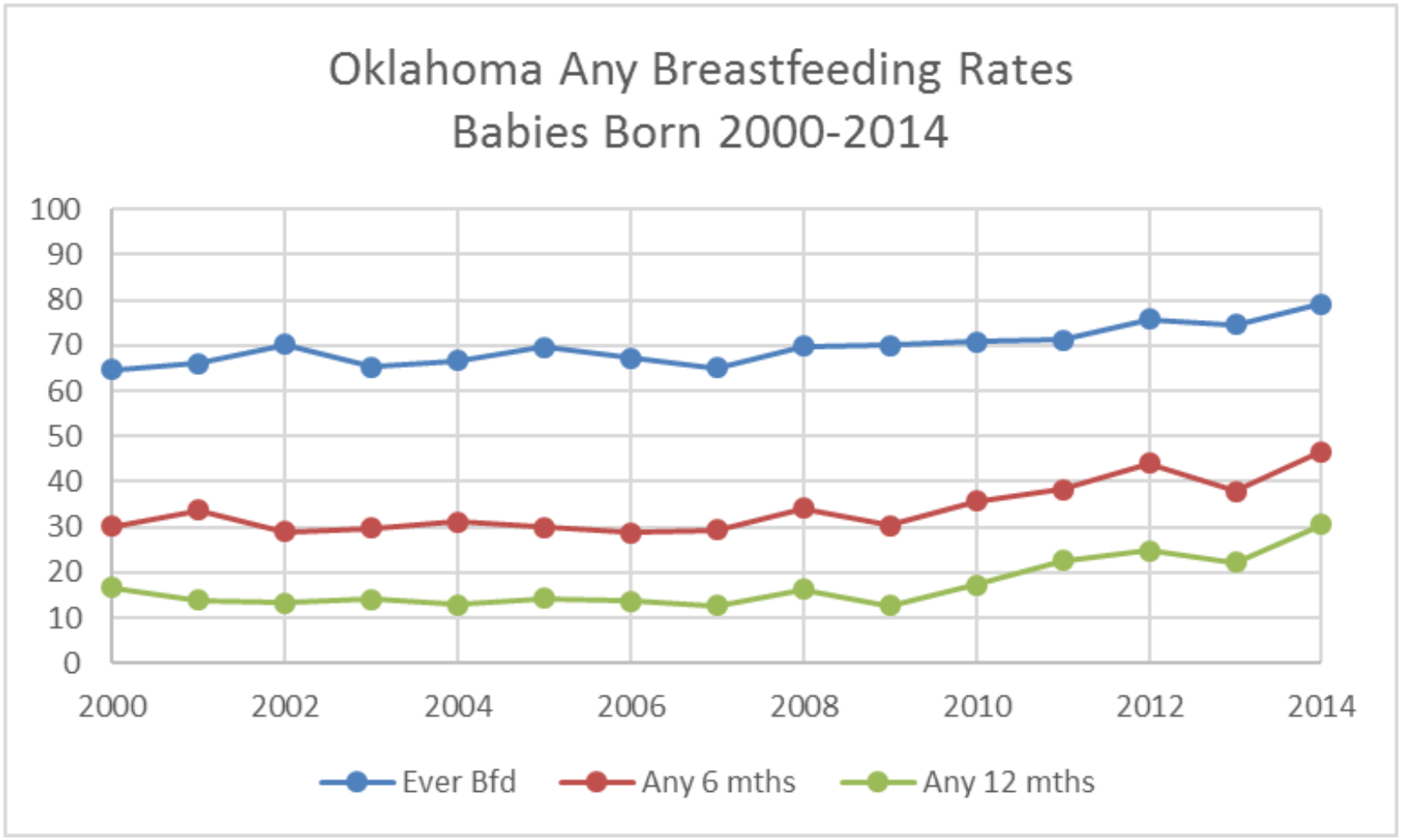


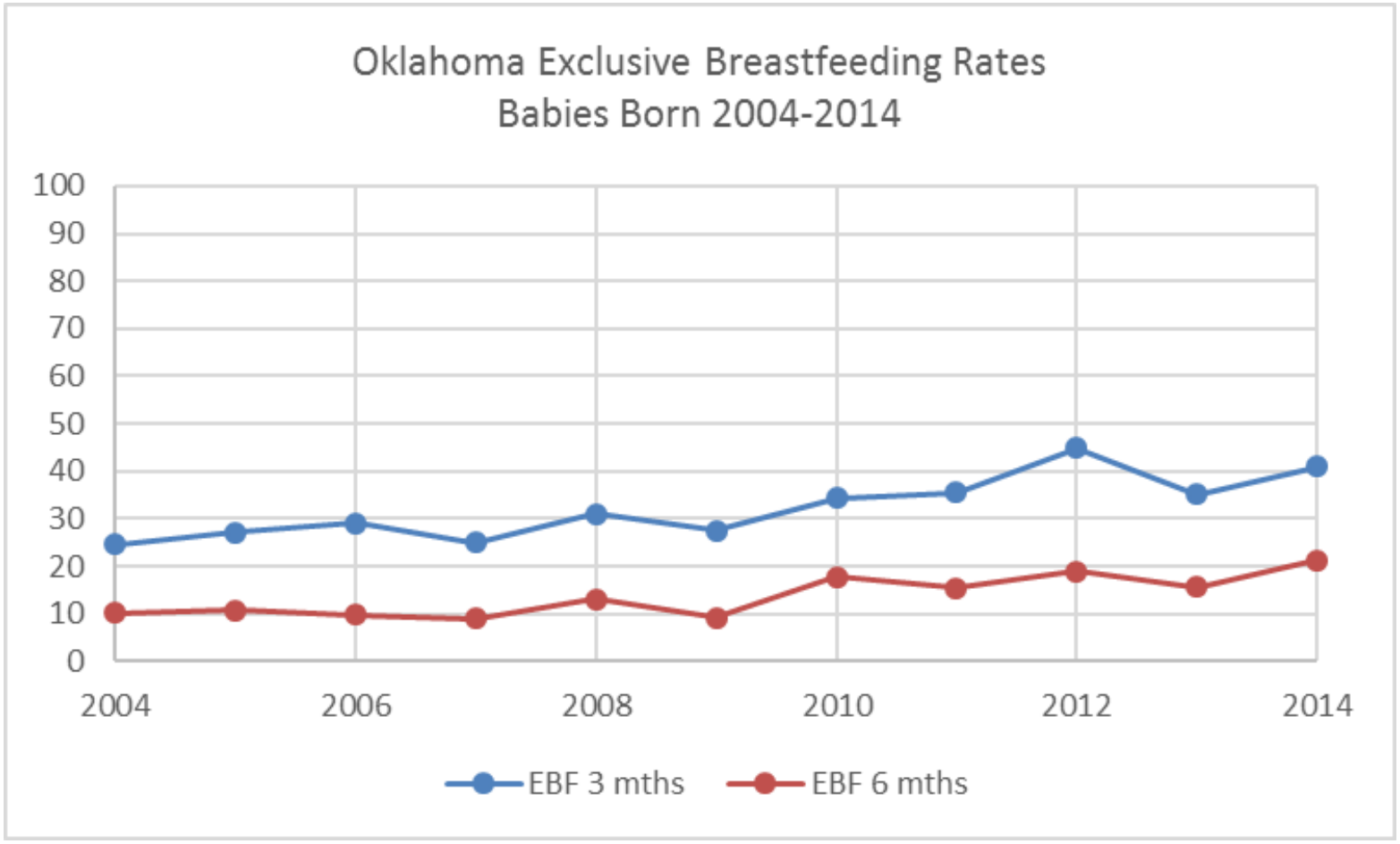
BREASTFEEDING

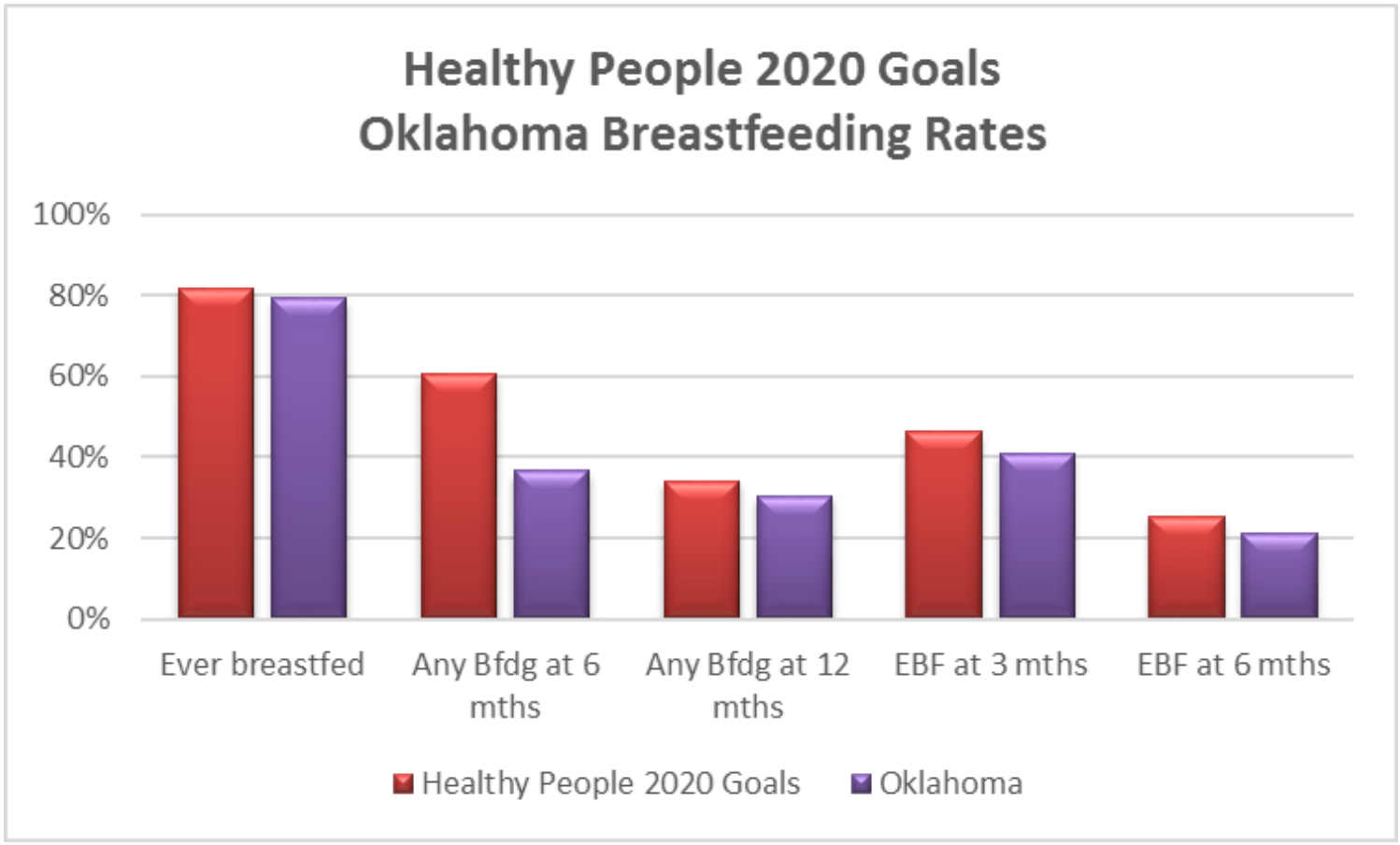
Oklahoma Breastfeeding Rates

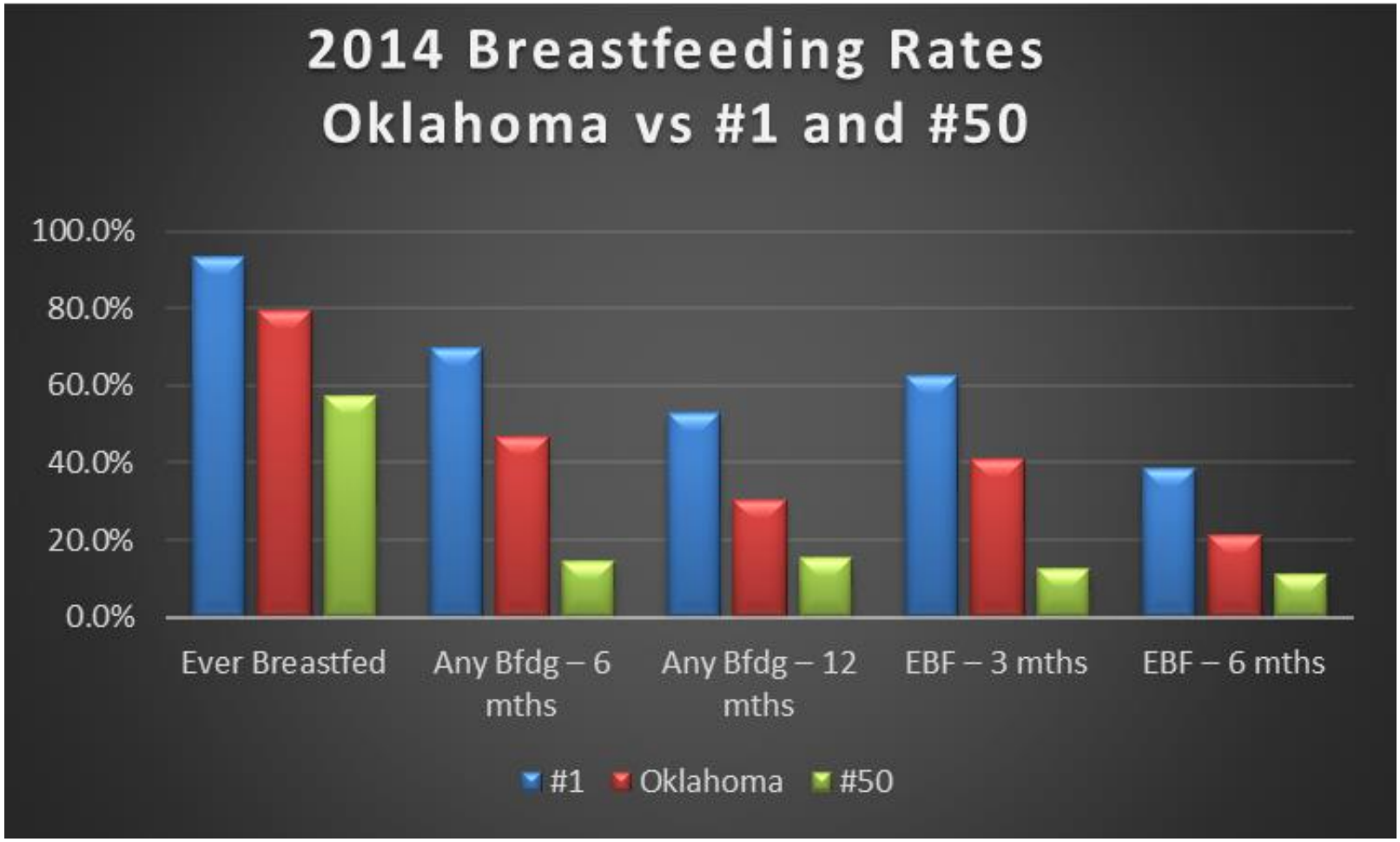
2017(CDC)	National	Oklahoma	Ranking (out of 50)
Ever breastfed	82.5%	79.2%	39th
Any Bfdg at 6 months	55.3%	36.7%	43rd
Any Bfdg at 12 months	33.7%	30.5%	33rd
EBF at 3 months	46.6%	41.0%	39th
EBF at 6 months	24.9%	21.3%	39th

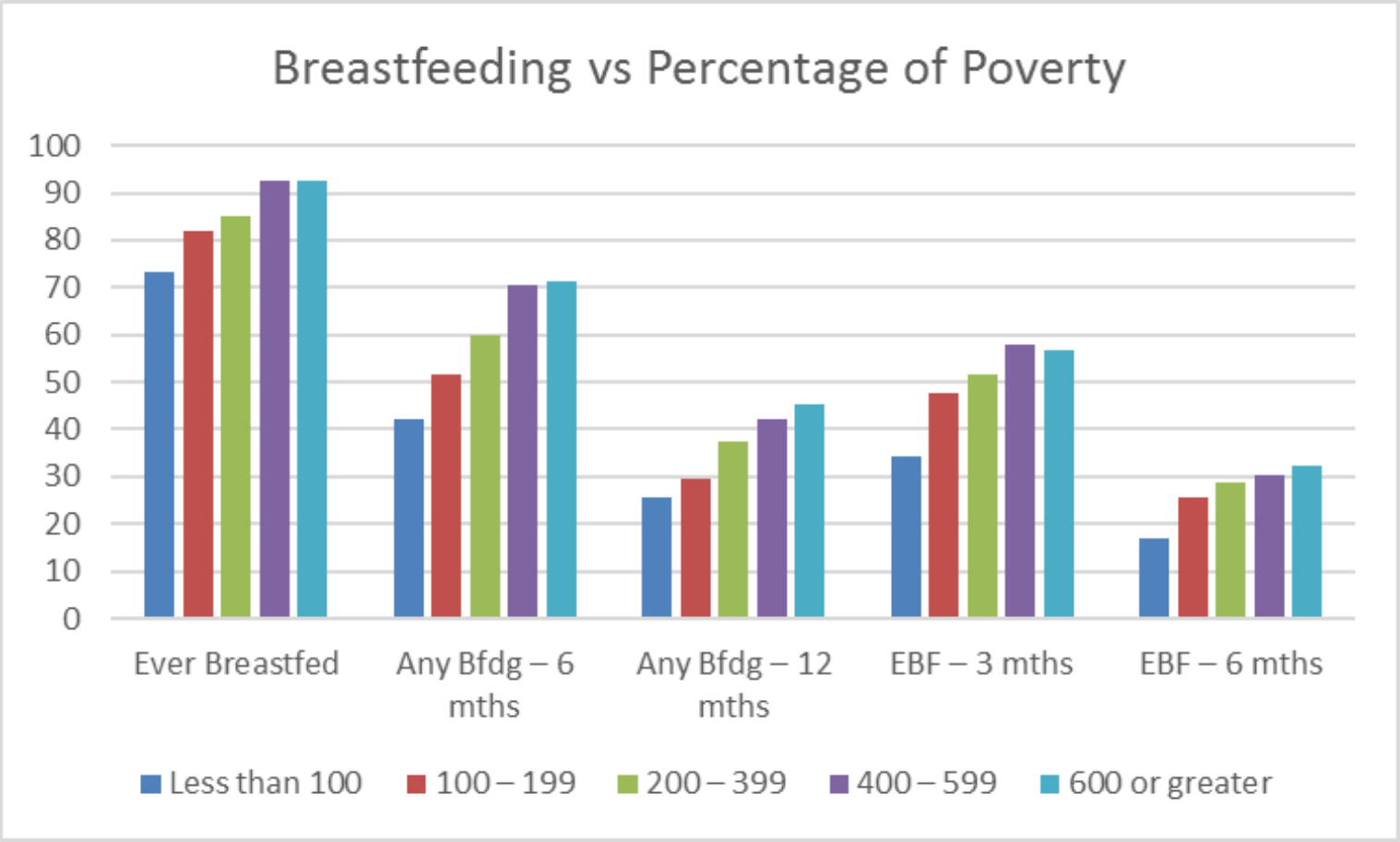

CDC Breastfeeding Rates
Babies Born in 2014
82.5%
79.2%
55.3%
46.7%
33.7%
30.5%
46.6%
41.0%
24.9%
21.3%
EVER BREASTFED
ANY BFDG – 6 MTHS
ANY BFDG – 12 MTHS
EBF – 3 MTHS
EBF – 6 MTHS
U.S.
Oklahoma

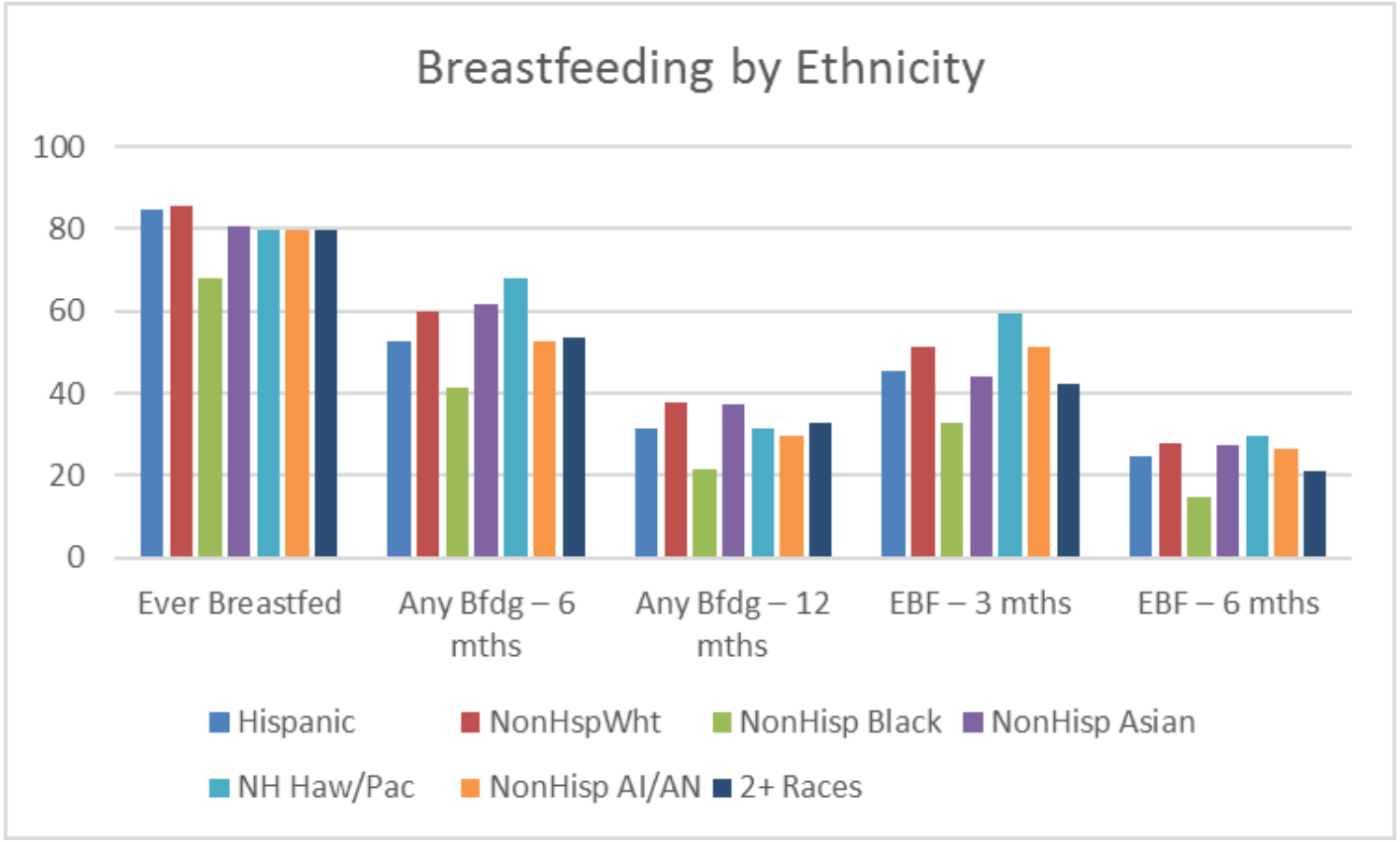

Oklahoma Any Breastfeeding Rates
Babies Born 2000-2014
100
90
80
70
60
50
40
30
20
10
0
2000
2002
2004
2006
2008
2010
2012
2014
Ever Bfd
Any 6 mths
Any 12 mths


Oklahoma Exclusive Breastfeeding Rates
Babies Born 2004-2014
100
90
80
70
60
50
40
30
20
10
0
2004
2006
2008
2010
2012
2014
EBF 3 mths
EBF 6 mths


Healthy People 2020 Goals
Oklahoma Breastfeeding Rates
100%
80%
60%
40%
20%
0%
Ever breastfed
Any Bfdg at 6 mths
Any Bfdg at 12 mths
EBF at 3 mths
EBF at 6 mths
Healthy People 2020 Goals
Oklahoma


2014 Breastfeeding Rates
Oklahoma vs #1 and #50
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Ever Breastfed
Any Bfdg – 6 mths
Any Bfdg – 12 mths
EBF – 3 mths
EBF – 6 mths
#1
Oklahoma
#50


Breastfeeding vs Percentage of Poverty
100
90
80
70
60
50
40
30
20
10
0
Ever Breastfed
Any Bfdg – 6 mths
Any Bfdg – 12 mths
EBF – 3 mths
EBF – 6 mths
Less than 100
100 – 199
200 – 399
400 – 599
600 or greater


Breastfeeding by Ethnicity
100
80
60
40
20
0
Ever Breastfed
Any Bfdg – 6 mths
Any Bfdg – 12 mths
EBF – 3 mths
EBF – 6 mths
Hispanic
NonHspWht
NonHisp Black
NonHisp Asian
NH Haw/Pac
NonHisp AI/AN
2+ Races

Baby-Friendly Updates

- Number of Baby-Friendly hospitals in U.S.:

  445

- Percent of babies born in a Baby-Friendly hospital in U.S.:

  21.7%

OPQIC

Becoming Baby-Friendly in Oklahoma

- Number of Baby-Friendly hospitals in Oklahoma:

  7

- Percent of Oklahoma babies born in a Baby-Friendly hospital:

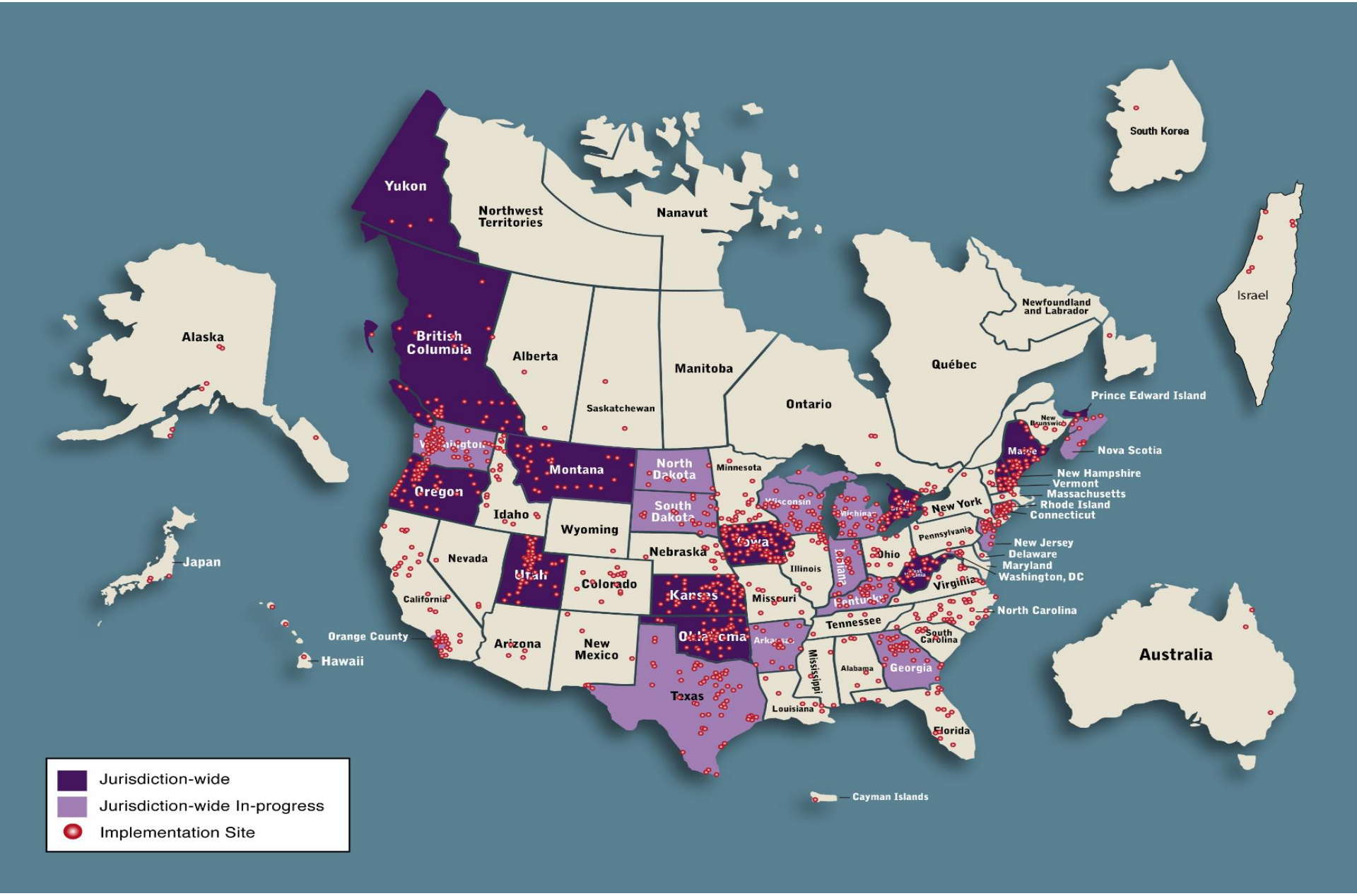
  15.3%

1 hospital assessment pending

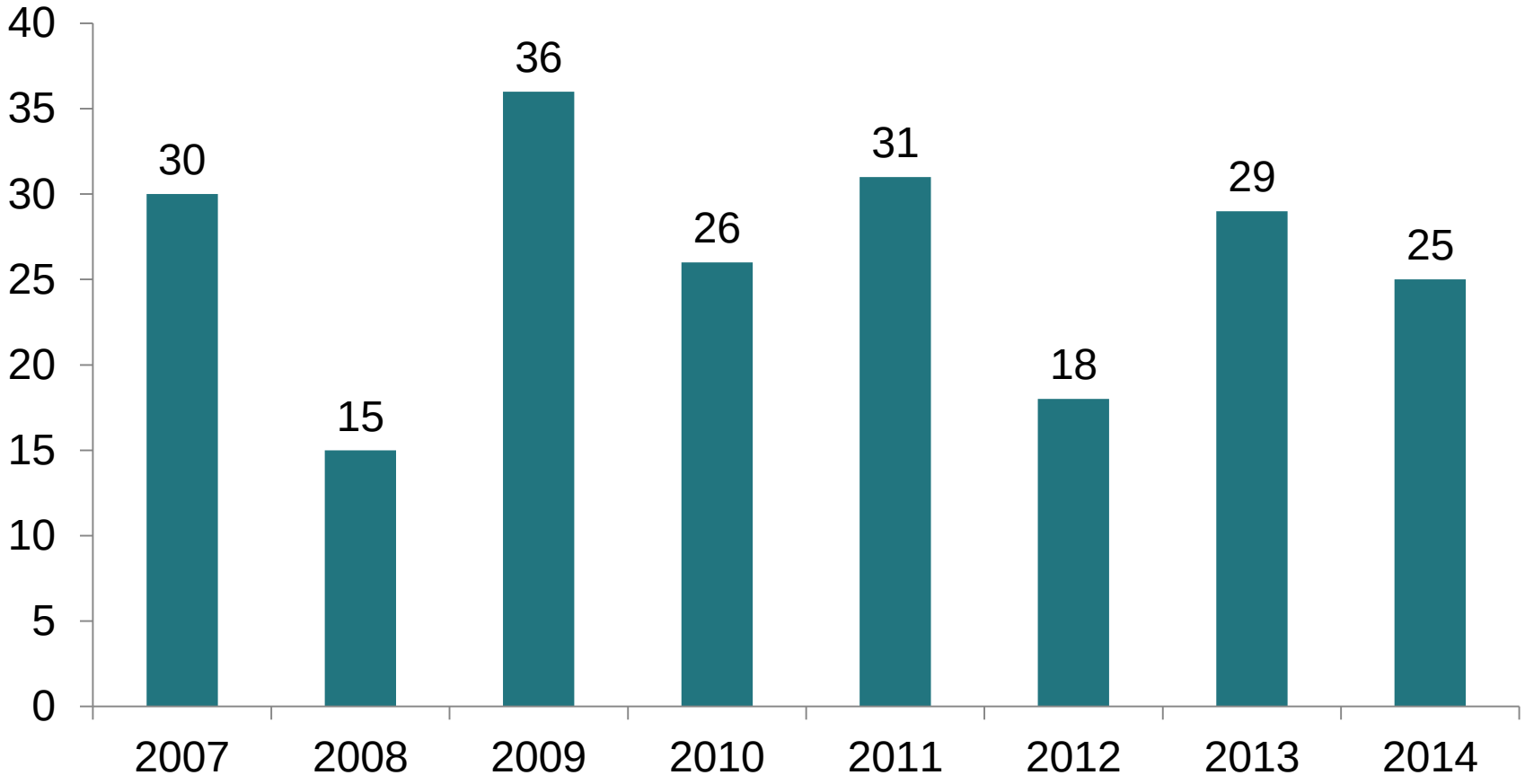
ABUSIVE HEAD TRAUMA

41 out of 51 OK birthing hospitals participating

For more information go to www.opqic.org/initiatives/pfl/aht


Yukon
Northwest Territories
Nanavut
South Korea
Alaska
British Columbia
Alberta
Manitoba
Saskatchewan
Ontario
Québec
Newfoundland and Labrador
Israel
Prince Edward Island
New Brunswick
Nova Scotia
Maine
New Hampshire
Vermont
Massachusetts
Rhode Island
Connecticut
New York
Pennsylvania
New Jersey
Delaware
Maryland
Washington, DC
Virginia
North Carolina
South Carolina
Georgia
Florida
Tennessee
Kentucky
West Virginia
Ohio
Michigan
Wisconsin
Illinois
Indiana
Missouri
Arkansas
Mississippi
Alabama
Louisiana
Texas
Oklahoma
Kansas
Nebraska
South Dakota
North Dakota
Minnesota
Montana
Wyoming
Colorado
New Mexico
Arizona
Utah
Nevada
Idaho
Oregon
California
Japan
Orange County
Hawaii
Australia
Cayman Islands
Jurisdiction-wide
Jurisdiction-wide In-progress
Implementation Site

Number of abusive head trauma cases* among infants: Oklahoma 2007-2014

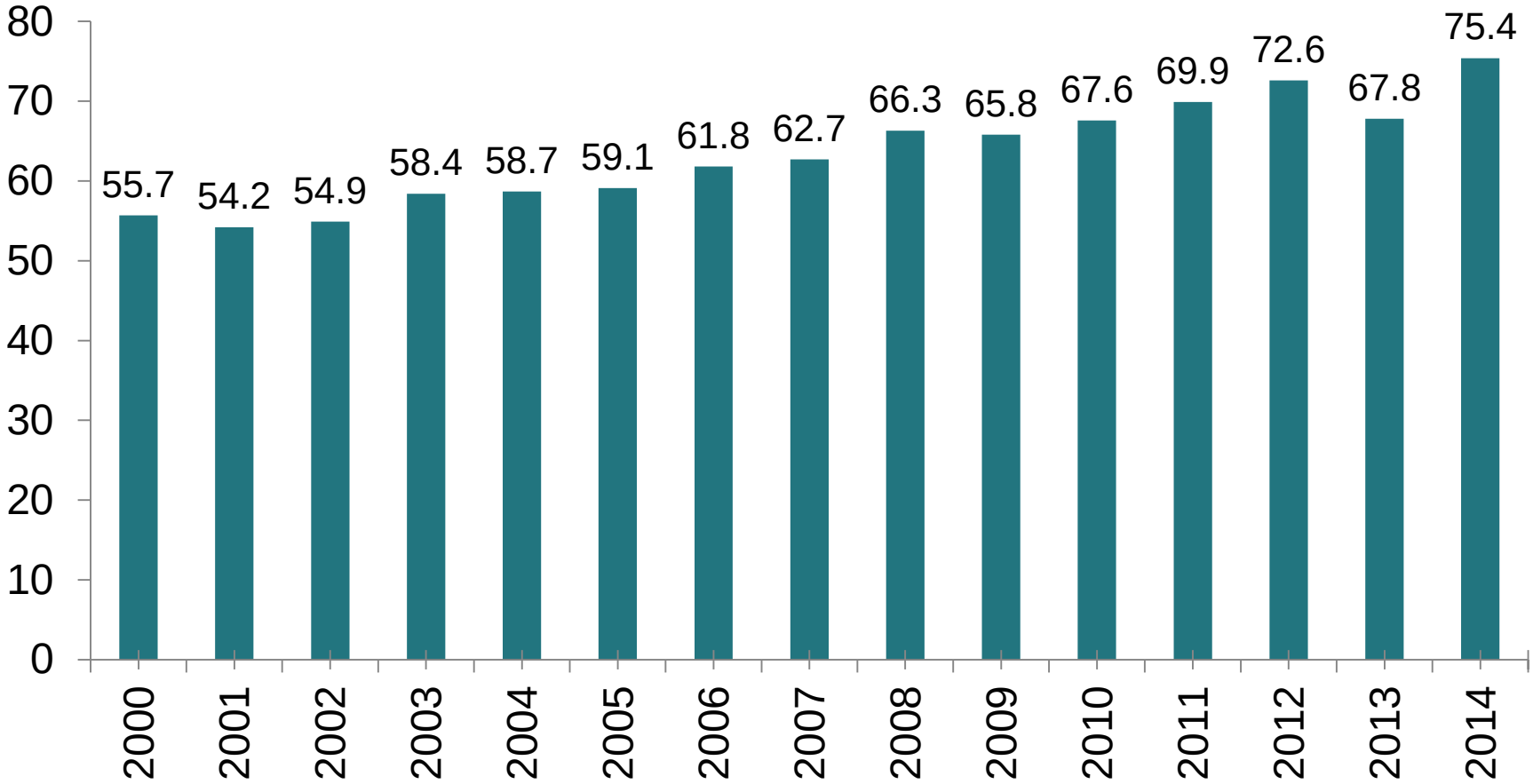


*Includes fatal and near-death cases

Source: Injury Prevention Service

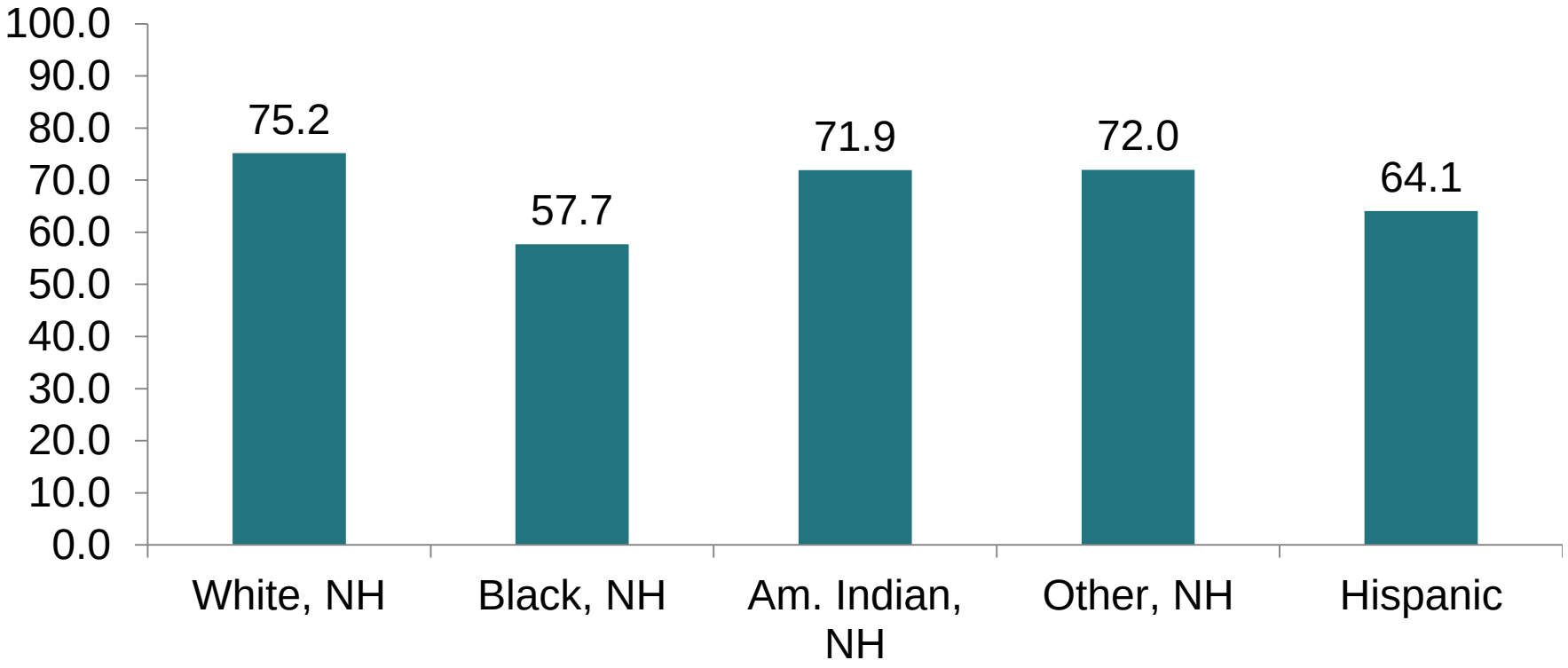
INFANT SAFE SLEEP

Percent of infants most often laid on back to sleep: Oklahoma, 2000-2014



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Percent of infants most often laid on back to sleep, by race/Hispanic origin: Oklahoma, 2014



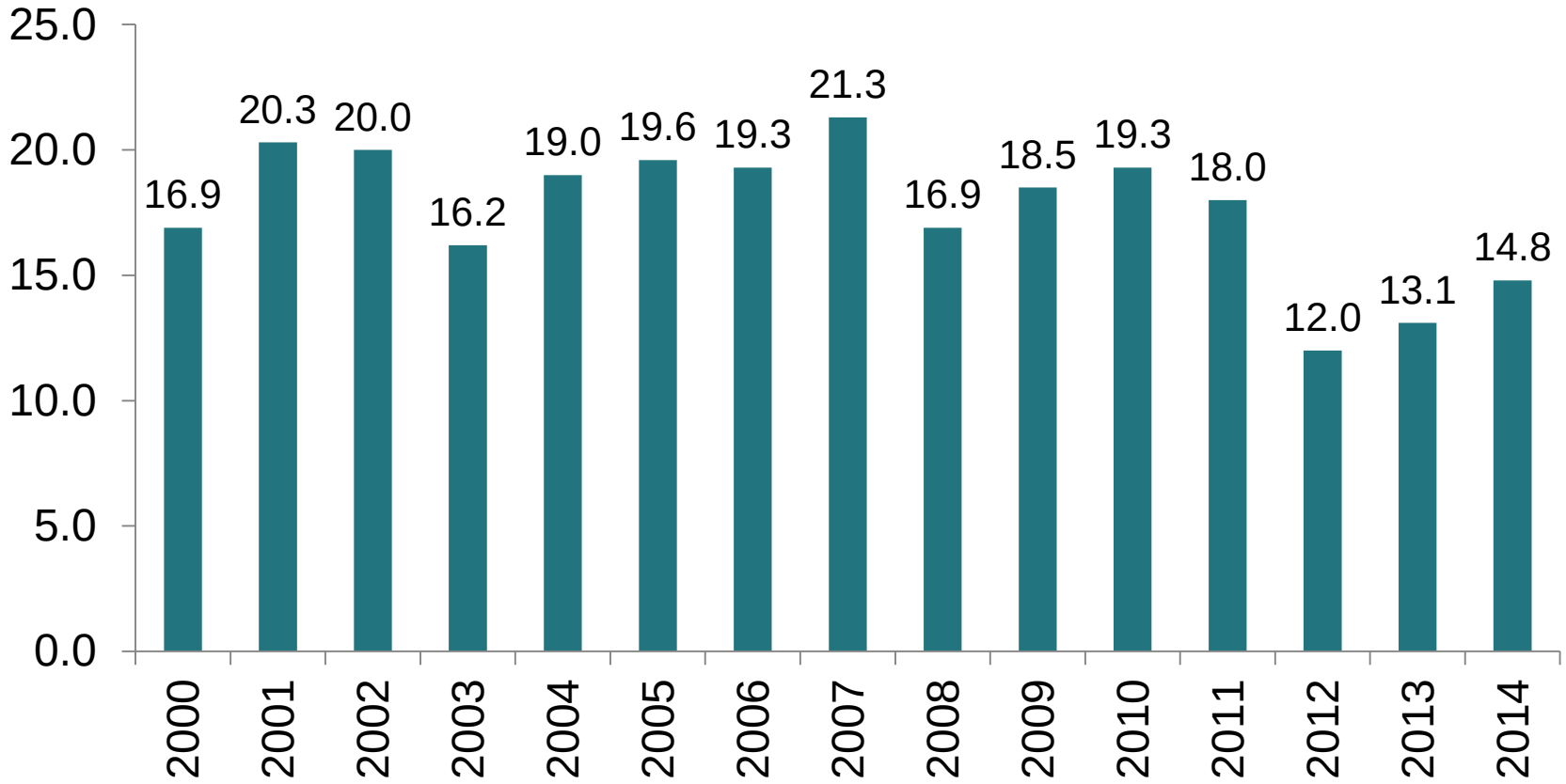
NH = non-Hispanic
Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Safe Sleep

- 25 hospitals participating in Oklahoma State Department of Health Hospital Sleep Sack Initiative
- Participating hospitals average more than 36,000 deliveries/year
- For more information, visit opqic.org/safesleep

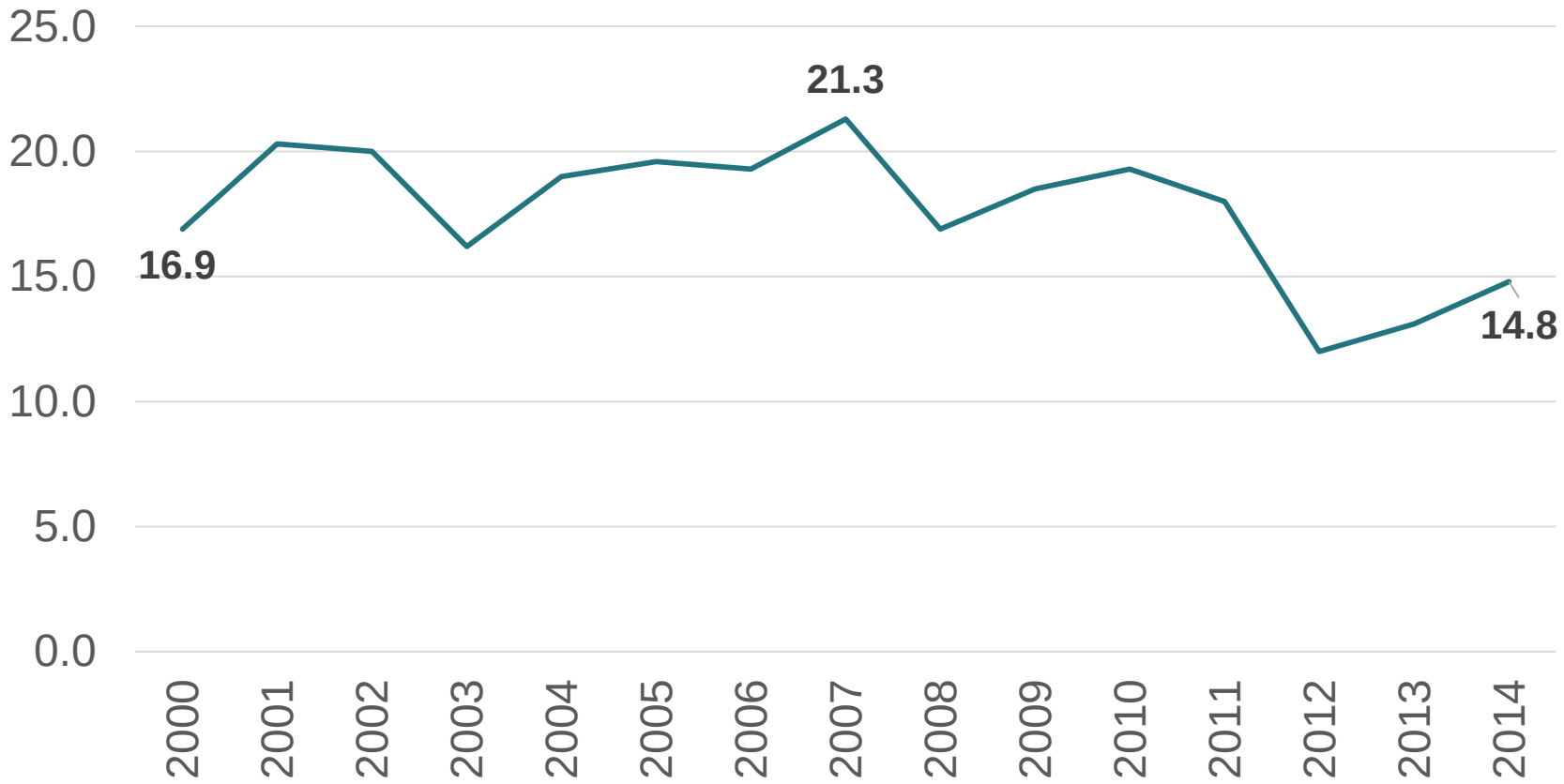
TOBACCO CESSATION

Percent of women smoking in the last trimester of pregnancy: Oklahoma 2000-2014



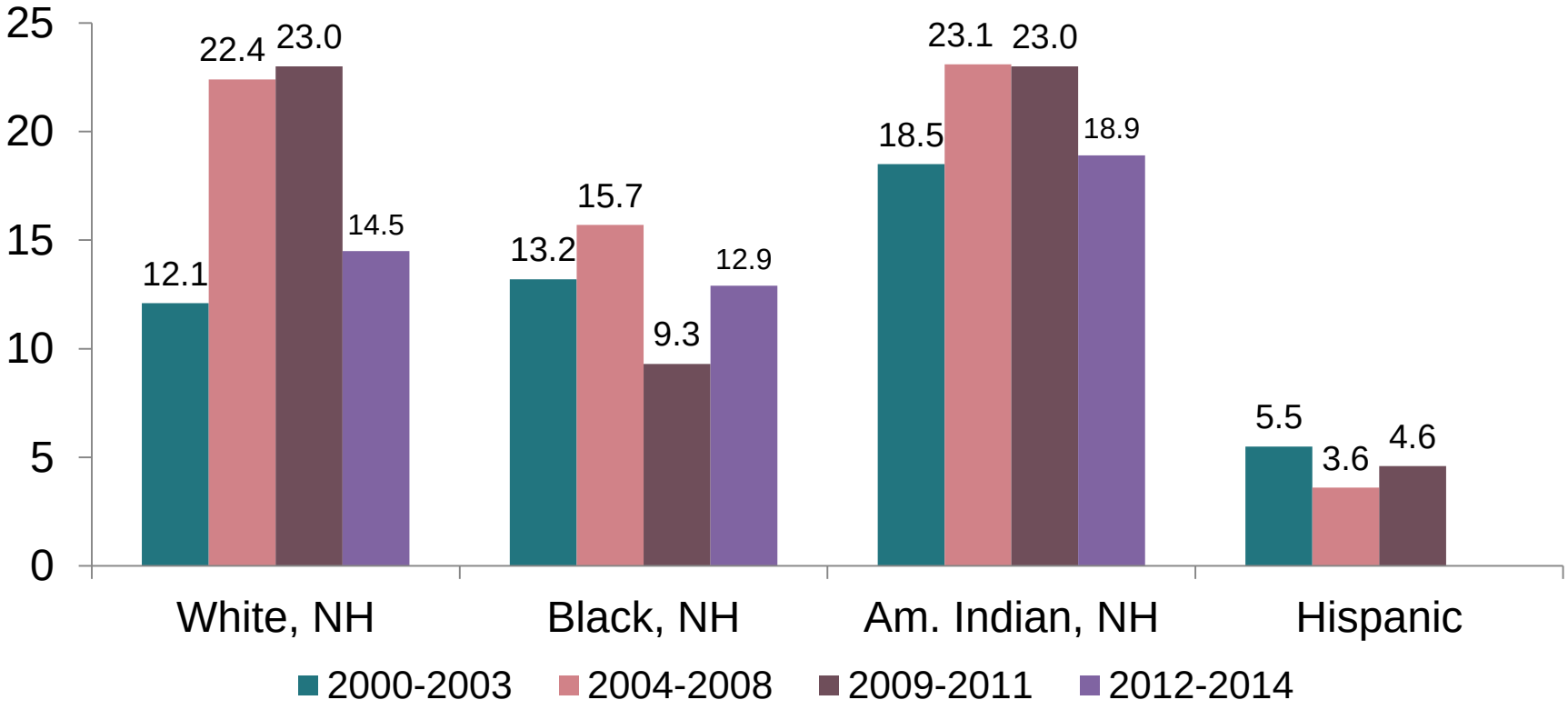
Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Percent of women smoking in the last trimester of pregnancy: Oklahoma 2000-2014



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Percent of mothers who smoked during last 3 months of pregnancy, by race: Oklahoma, 2000-2014



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Oklahoma HealthCare Authority

Patient's
Name_____
Date_____

"5As" Tobacco Cessation Counseling

Beginning time: _____

Ask every patient about tobacco use (1 minute):

- ☐ Patient does not smoke.
- ☐ Patient recently quit smoking.
- ☐ Patient is a light smoker (fewer than 25 cigarettes per day). ☐ Patient
- ☐ a heavy smoker (25 or more cigarettes per day).

Advise all smokers/tobacco users of the consequences of tobacco use (1 minute):

- ☐ Encourage recent quitters to continue abstinence.
- ☐ Present strong, compelling evidence that is relevant to the patient about the importance of quitting.
  - *Coughing*
  - *Shortness of breath*
  - *Premature signs of aging*
  - *Cardiovascular disease*
  - *Lung and other forms of cancer*
  - *Emphysema*
  - *Respiratory disease*
- *Women who smoke have a higher risk of never becoming pregnant.*
- *Women who smoke during pregnancy have a greater chance of complications*

Oklahoma Tobacco Helpline

1-800-QUITNOW

provides *free* support *24/7* for your patients who use tobacco products

Helping Patients Quit

- **Your hospital can enroll in the Oklahoma Hospital Association's *Hospitals Helping Patients Quit* program**

- Assists hospitals in putting processes in place to help parents of neonates and hospitalized children to quit tobacco
- Includes addressing secondhand smoke in the home that affects children
- Includes addressing third hand smoke – odors and residue on parental clothing and home surfaces – that affect infants and children;

- **Call Joy Leuthard at 405-427-9537**

PRECONCEPTION-INTERCONCEPTION

focus forward

oklahoma

Focus Forward Oklahoma Mission

to decrease unintended pregnancies in Oklahoma by increasing access to and utilization of long-acting reversible contraception (LARC)

Program Funding

- The program is supported by state and federal dollars.
- Special thanks to our private donors for putting up the state share for the program.
  - George Kaiser Family Foundation
  - David and Jean McLaughlin
  - Anonymous Donor

Program Overview

- We are using three primary strategies to support the mission of the program.
  - Policy Change
  - Communication
  - Education

POLICY CHANGE

- For the policy strategy we have focused on OHCA policies related to LARC.
  - In 2016 we conducted a review of OHCA policies related to LARC.
  - This resulted in a policy change that removed restrictions on LARC from the State Plan Amendment. This change is currently under CMS review.

See next slide for current & proposed language

POLICY CHANGE

CURRENT

Long acting reversible contraceptives (LARC) are reimbursable once per recipient as per the recommendation noted in the package insert for each respective device. For intrauterine and implantable devices, if removal and/or re-implantation at the same or different incision site is performed prior to the typical duration noted in the device's package insert, reimbursement is available for the removal only.

PROPOSED

Family planning services and supplies are covered for individuals of childbearing age when medically appropriate and medically necessary.

COMMUNICATION

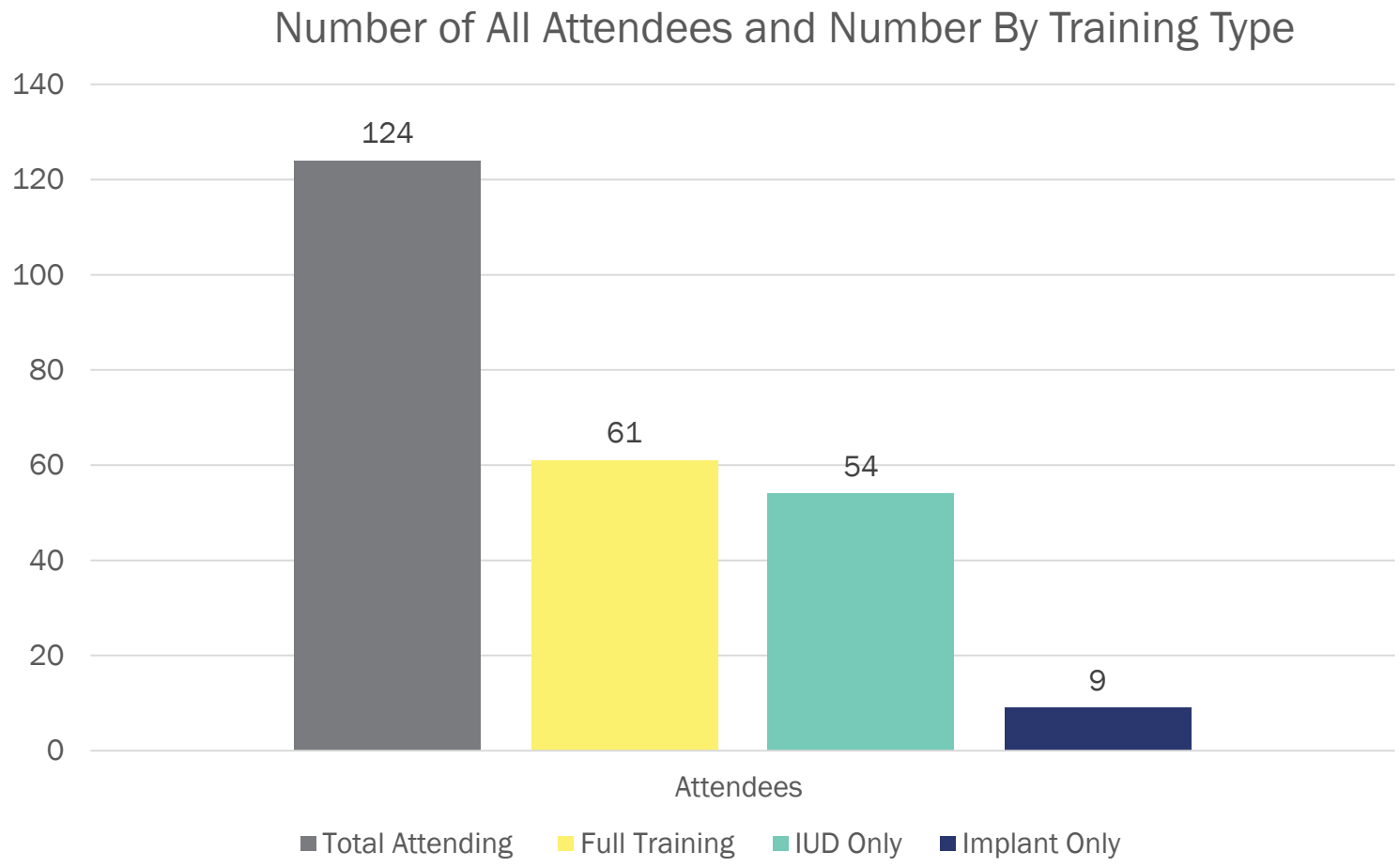
- For the communication strategy we have focused on outreach and the development of a website.
  - Website – In Development
  - Outreach - Ongoing

focus forward oklahoma

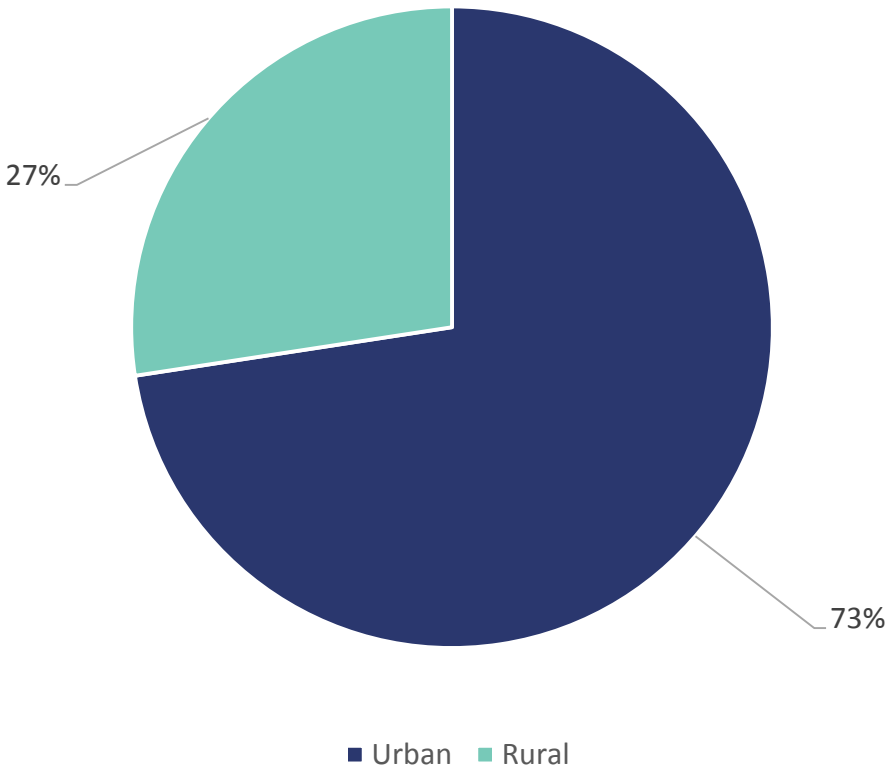
EDUCATION

- For the education strategy we have focused on LARC provider skills training.
  - We conducted 11 LARC provider skills training sessions in July and August.
  - We trained 124 providers.

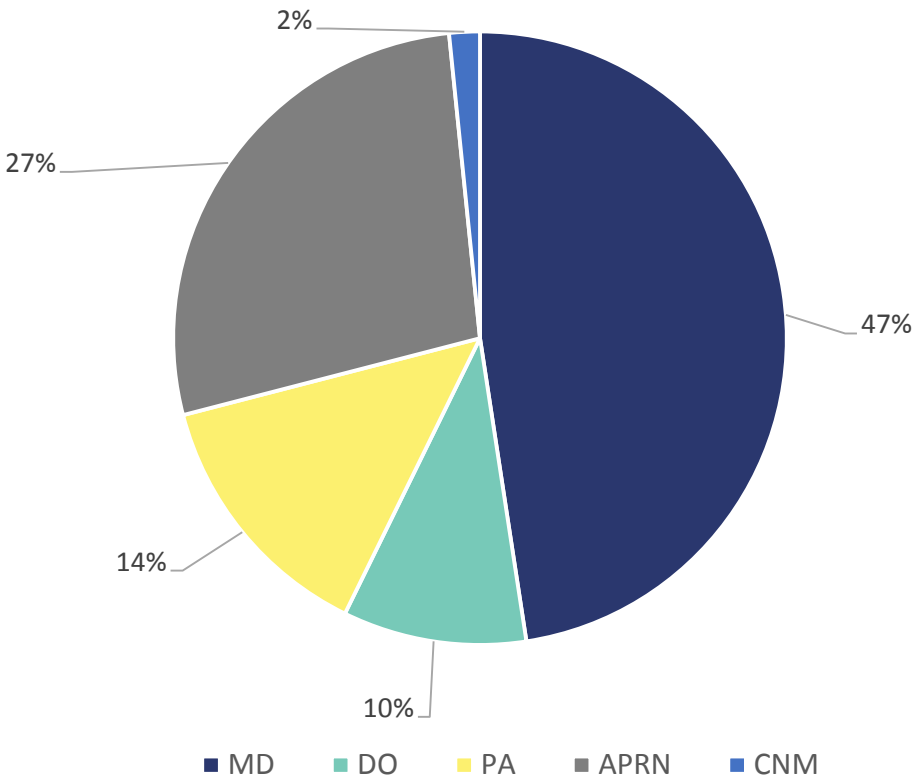
See next slides for additional information on LARC provider trainings attendees


Number of All Attendees and Number By Training Type
140
120
100
80
60
40
20
0
124
61
54
9
Attendees
Total Attending
Full Training
IUD Only
Implant Only

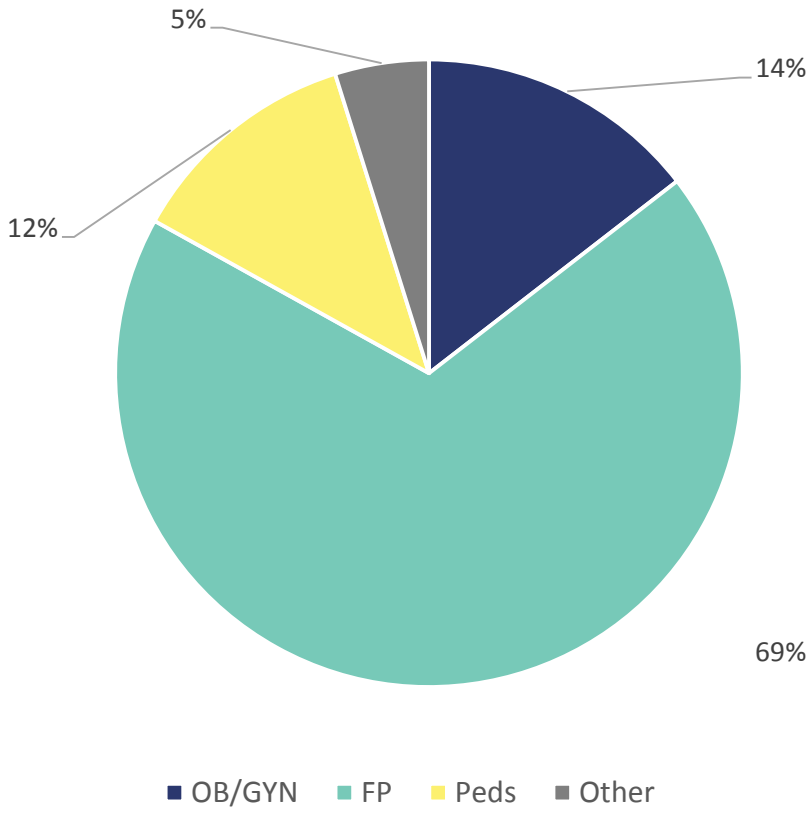
Percentage of All Attendees by Practice Location



Percentage of All Attendees by Credentials



Percentage of All Attendees by Specialty

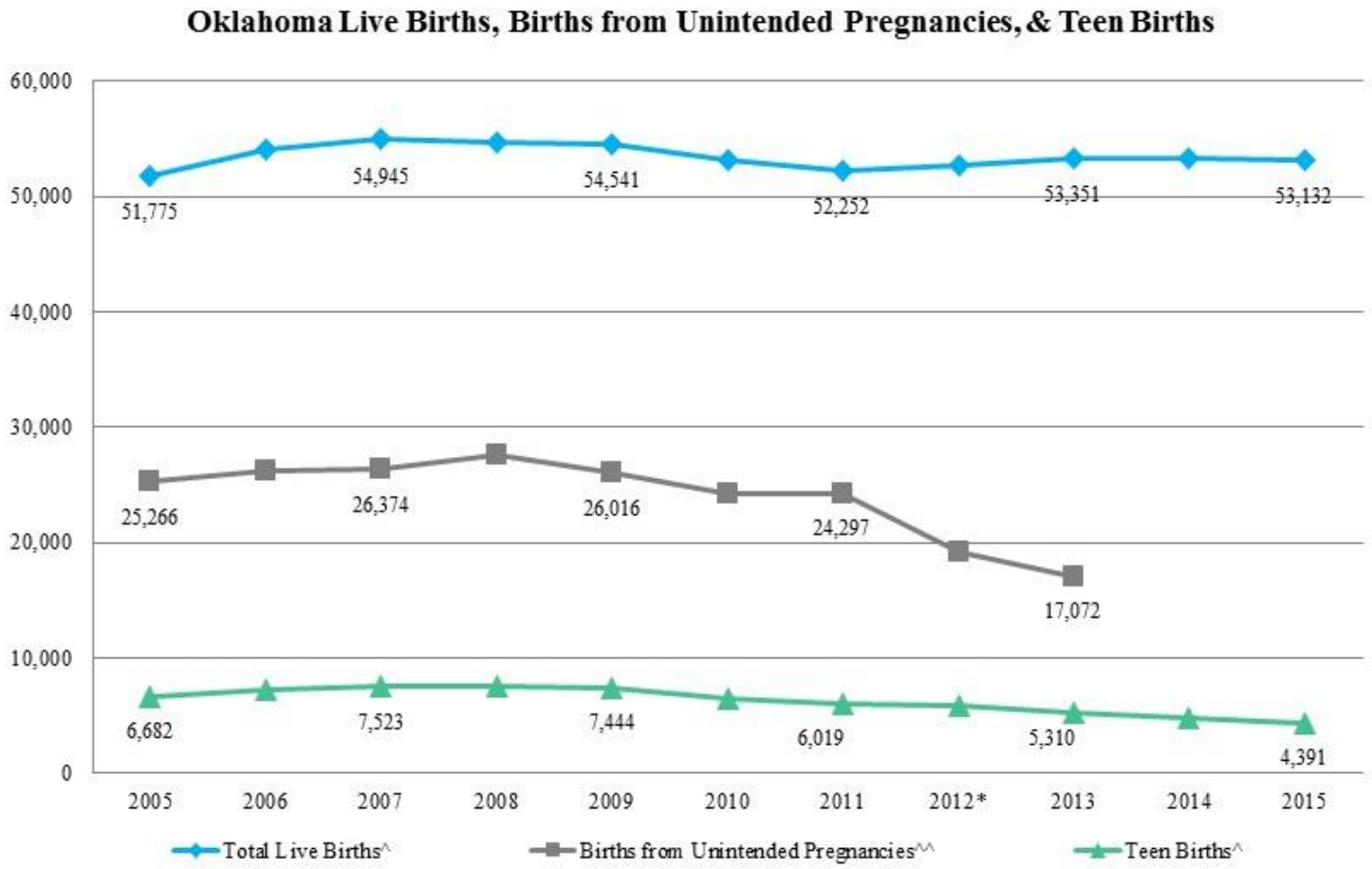


Program Evaluation

- **Long-Term (Outcome) Objectives**
  - Unintended Pregnancies
  - Teen Pregnancies
- **Short-Term (Impact) Objectives**
  - SoonerCare LARC Utilization
  - SoonerCare LARC Providers

LONG-TERM (OUTCOME) METRICS

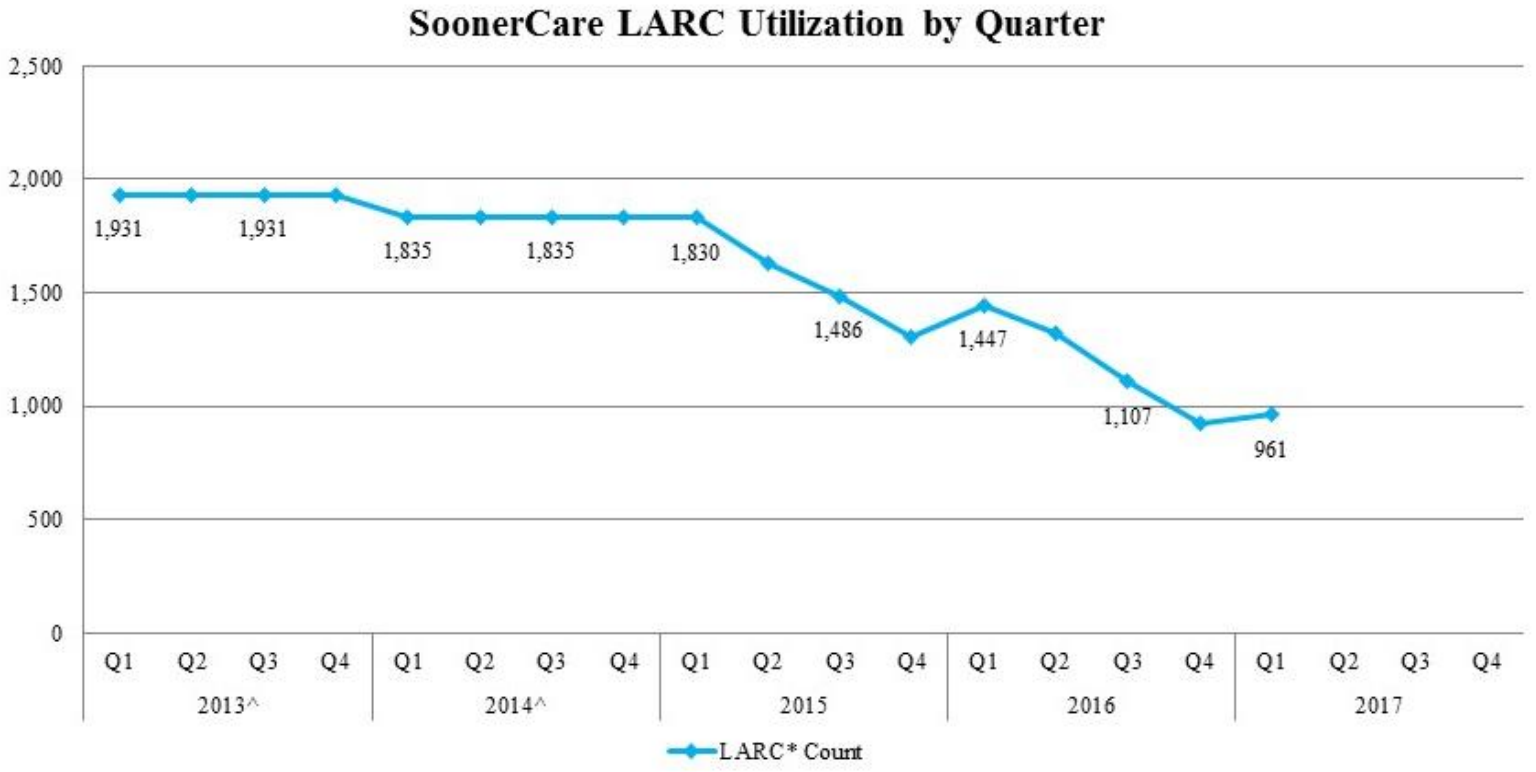
The following graph shows the long-term (outcome) metrics for the program. The Oklahoma Live Births and Teen Births were taken from OK2SHARE and the Births from Unintended Pregnancies were taken from PRAMS data.



^Oklahoma live birth and teen birth data taken from OK2SHARE.
^^Oklahoma births from unintended pregnancies taken from PRAMS reports. PRAMS data only available through 2013.
*In 2012 a "Not Sure" option was added to the choices on PRAMS questionnaires. These changes create inconsistency across reporting years.

SHORT-TERM (IMPACT) METRICS

The following graphs show the short-term (impact) metrics for the program. The first graph shows the SoonerCare LARC utilization by quarter and the second graph shows the number of SoonerCare contracted providers with contraception and LARC claims.

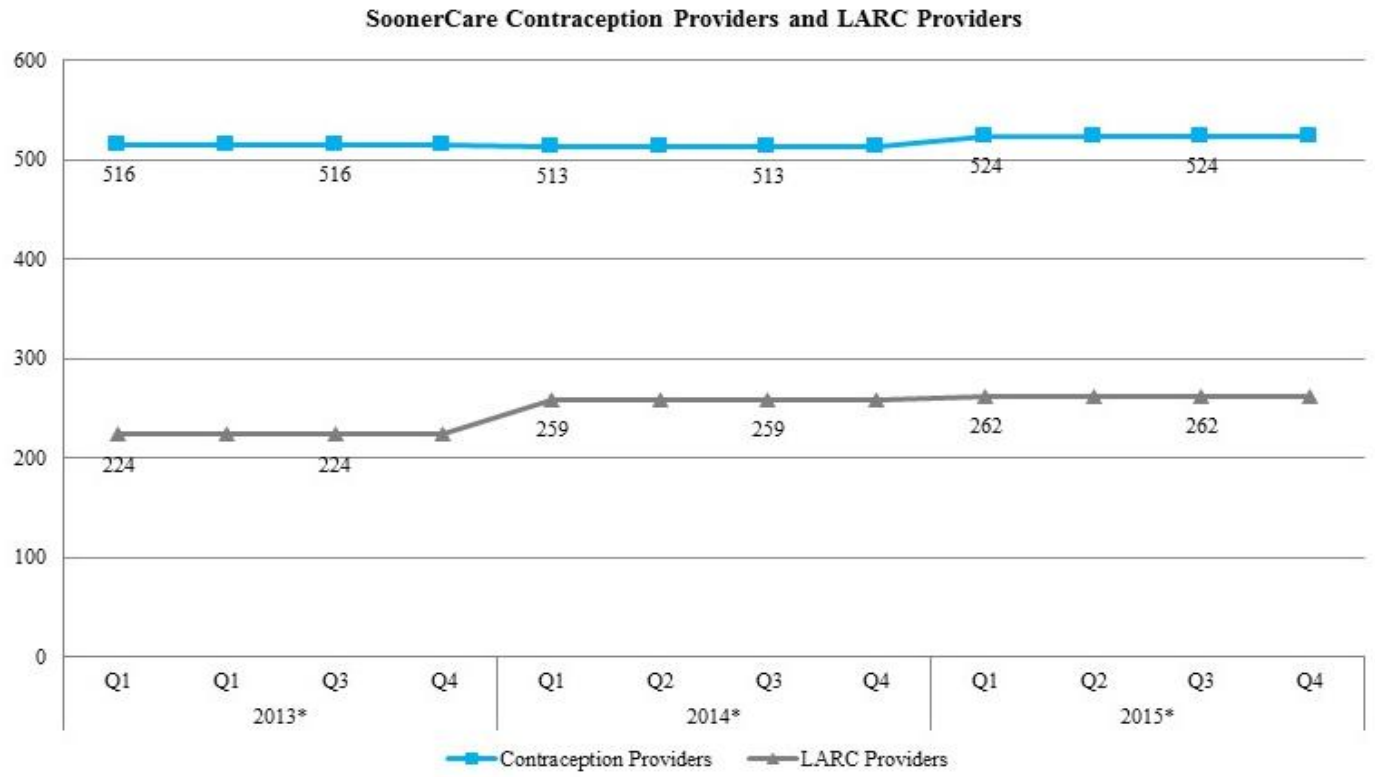


LARC counts are unduplicated members who had either an Implant or an IUD during the year/quarter as a paid claim. Members are females 11 to 55 who were enrolled in SoonerCare or Insure Oklahoma during the year indicated and had a paid claim for contraception or a LARC.
^Calendar year 2013 and 2014 numbers are based on calendar year data and divided evenly among the 4 quarters in a year. Starting with Calendar Year 2015, data collection has been quarterly. Providers have up to 6 months from the first date of service to submit a claim and an additional 6 months after the submission to resubmit in the event of a denied or voided claim. As a result, counts for the quarter may not match up to counts obtained for a year.

Census data population estimates for 2015 indicate that there are 1,132,644 females ages 10-54 living in Oklahoma. SoonerCare provided coverage for 321,795 women between the ages of 11-55 during SFY 2015. Of these 321,795 female members, 51,165 has contraception claims in Calendar Year 2015. The percentage of female members ages 11-55 with the potential for a contraceptive claim is ~28.4% of the 1,132,644 females of reproductive age living in Oklahoma. The actual percentage of female members ages 11-55 with a contraceptive claim in 2015 is ~5% of the 1,132,644 females of reproductive age living in Oklahoma. Please note that Census data population estimates are for ages 10-54 and OHCA data is for ages 11-55.

SHORT-TERM (IMPACT) METRICS

The following graphs show the short-term (impact) metrics for the program. The first graph shows the SoonerCare LARC utilization by quarter and the second graph shows the number of SoonerCare contracted providers with contraception and LARC claims.



Providers are contracted with OHCA to provide services to SoonerCare and Insure Oklahoma members. Providers were determined from the Rendering ID, Billing ID, or Prescribing ID, whichever one was available and most descriptive. In the case a Rendering ID was not available, the Billing ID was used. In the event of a pharmacy claim, the Prescribing ID was used. Contraception providers are an unduplicated count of providers who had paid claims for contraception for female members aged 11 to 55 during the calendar year. Out of the Contraception Providers, counts of the providers who had at least one paid claim for a Long-Acting Reversible Contraception (LARC) are indicated by LARC Providers.

*Data collected was for the calendar year and overall counts were duplicated across each quarter. Data subsequent to 2015 include quarterly breakdowns based on the paid claim's first date of service.

focus forward

oklahoma

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MATERNAL MORTALITY

Definitions Related to Maternal Mortality

- **Maternal Mortality:** The death of a woman ***while pregnant or within 42 days*** of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but *not from accidental or incidental causes*.(WHO Definition)

- **Pregnancy Related Deaths:** The death of a woman ***while pregnant or within 1 year*** of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management *but not from accidental or incidental causes*. Ratio used in OK for reporting purposes-denominator of 100,000 live births.

- **Pregnancy Associated Deaths:** The death is the death of any women, from *any cause,* ***while pregnant or within 1 year*** of termination of pregnancy, regardless of duration and the site of pregnancy.

Maternal Mortality Ratio

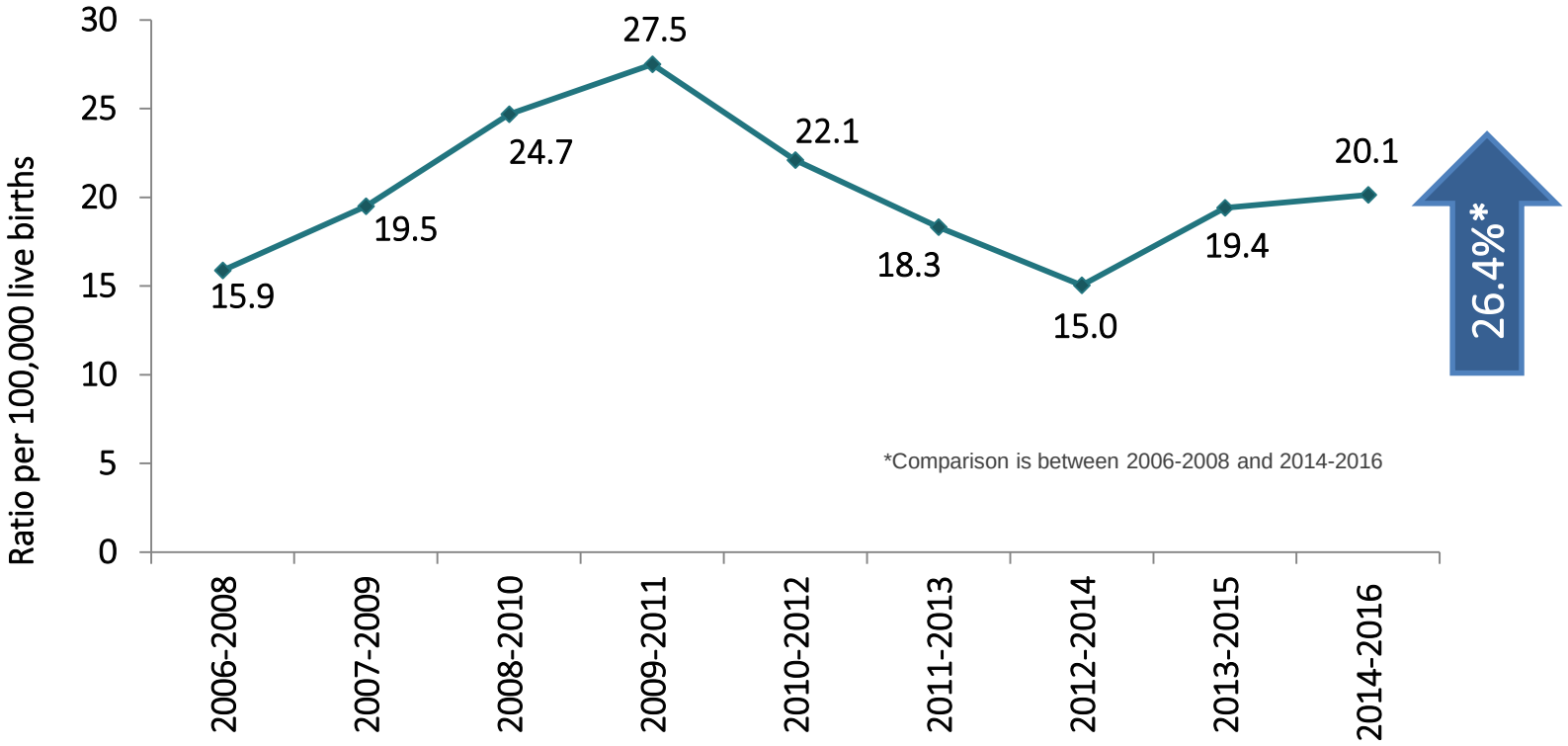
- Healthy People 2020 Goal = 11.4

  - 2014-2016 Oklahoma Maternal Mortality Ratio* for maternal deaths within 42 days of termination of pregnancy was ***20.1***

*MMR = number of maternal deaths (while pregnant or within 42 days of end of pregnancy) excluding accidents and incidental causes per 100,000 live births

Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics

Oklahoma 3 Year Maternal Mortality Ratio* for Maternal Deaths within 42 Days of Termination of Pregnancy, Oklahoma 2006-2016



*Due to newly formed data criteria some ratios may have shifted from previous presentations.
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics

Maternal Mortality Ratio

- Healthy People 2020 Goal = 11.4

  - 2014-2016 Oklahoma Maternal Mortality Ratio* for maternal deaths within 42 days of termination of pregnancy was ***20.1***

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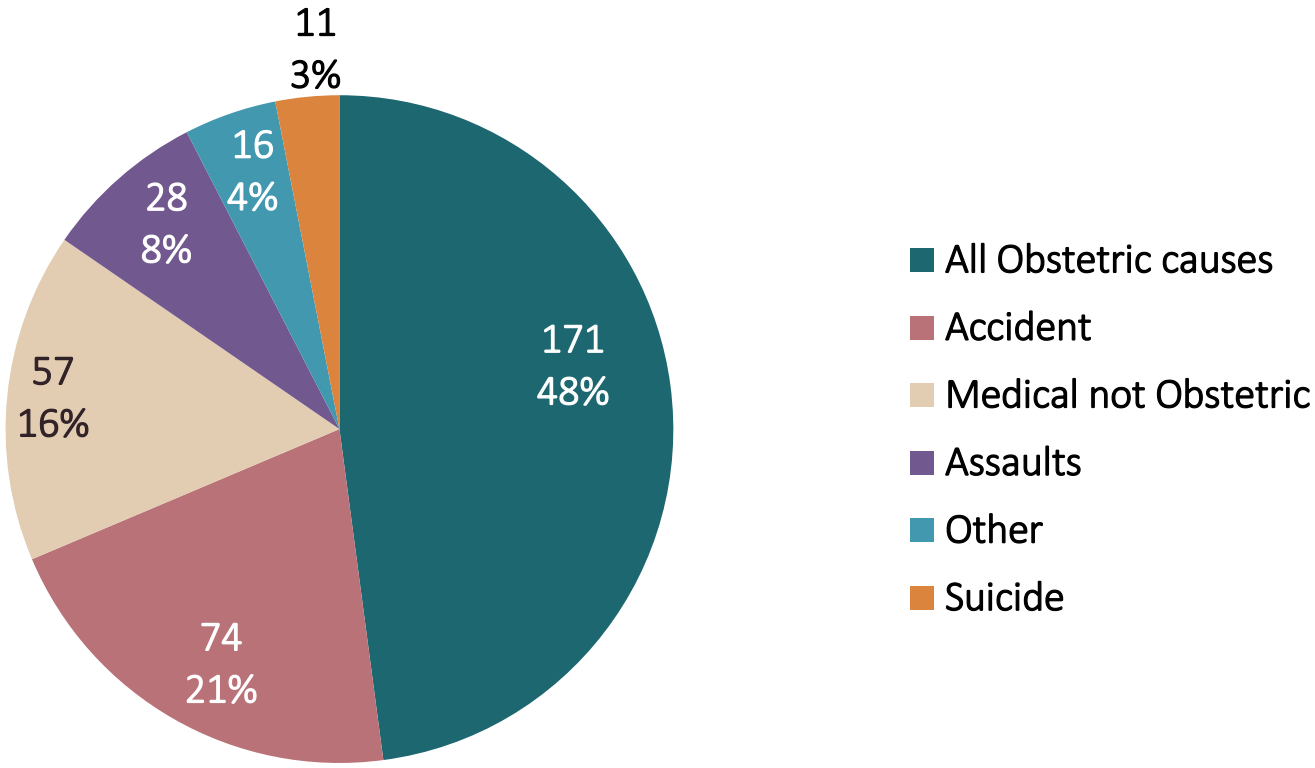
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics

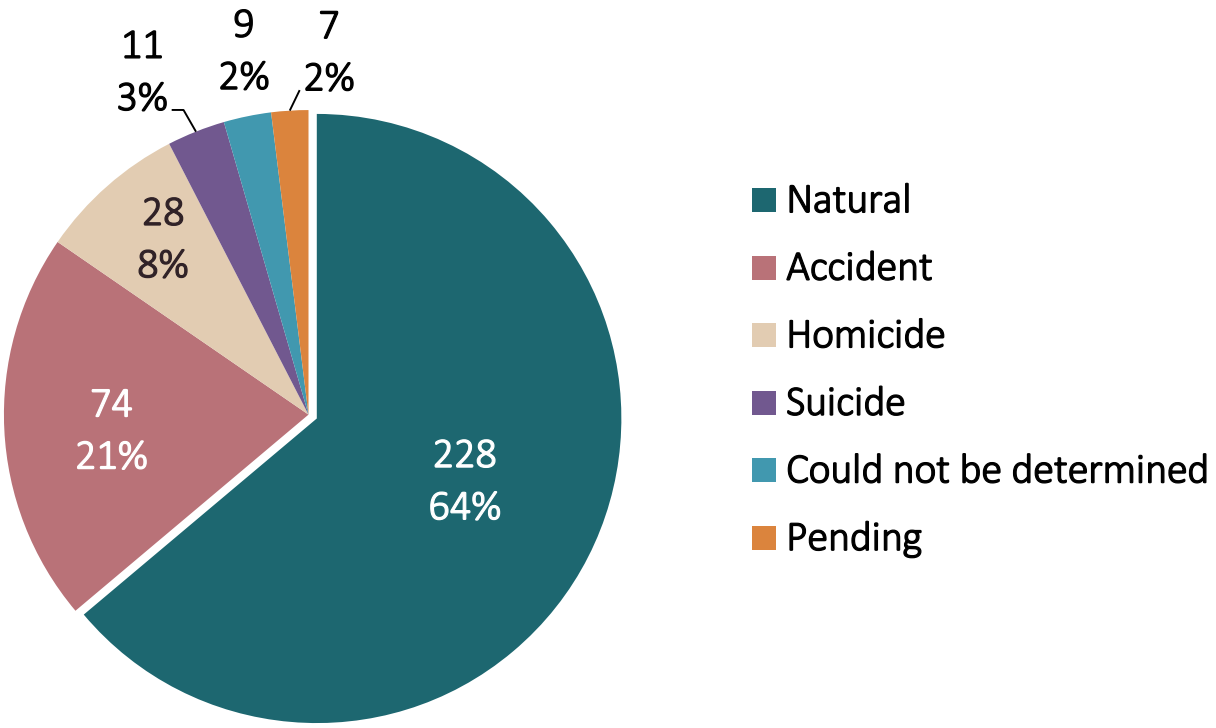
Percentage of *Pregnancy Associated* Deaths by Manner of Death, Oklahoma 2004-2016



Pregnancy Associated: The death of any woman, from any cause, while pregnant or within one calendar year of termination of the pregnancy, regardless of duration and the site of the pregnancy

Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics

Percentage of *Pregnancy Associated* Deaths by Manner of Death, Oklahoma 2004-2016



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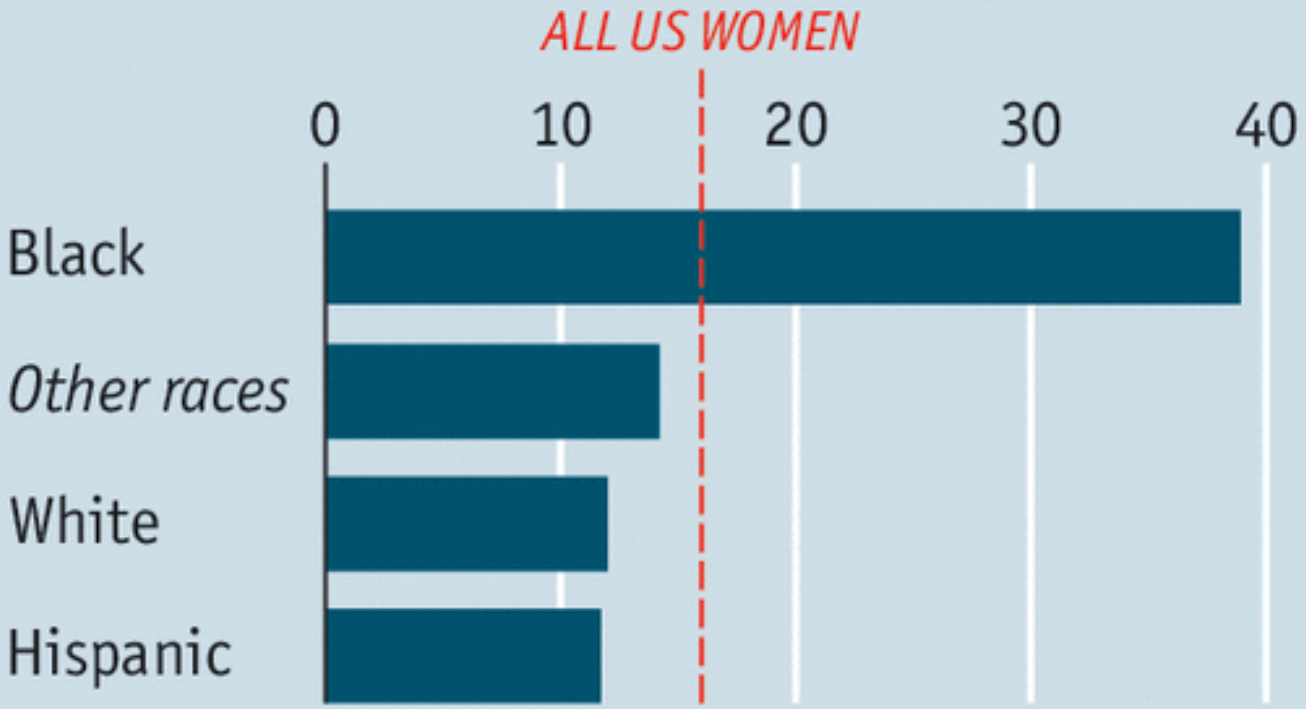
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics

The colour of risk

United States maternal mortality rate, 2006-10

Per 100,000 live births



Sources: Creanga *et al*, *Obstetrics & Gynecology*

Maternal Mortality Review

- Began as a joint effort between the OSDH and OSMA
- Originated in 1950
  - **Maternal Mortality Ratio** in 1950 – 95.1/100,000 live births;
  - By 1979, decreased 91.5% to 8.1
  - 2014-2016 the **Maternal Mortality Ratio** for maternal deaths within *42 days of termination of pregnancy was* ***20.1***
- After several years of inactivity, OSDH re-established the Maternal Mortality Review Committee in 2009

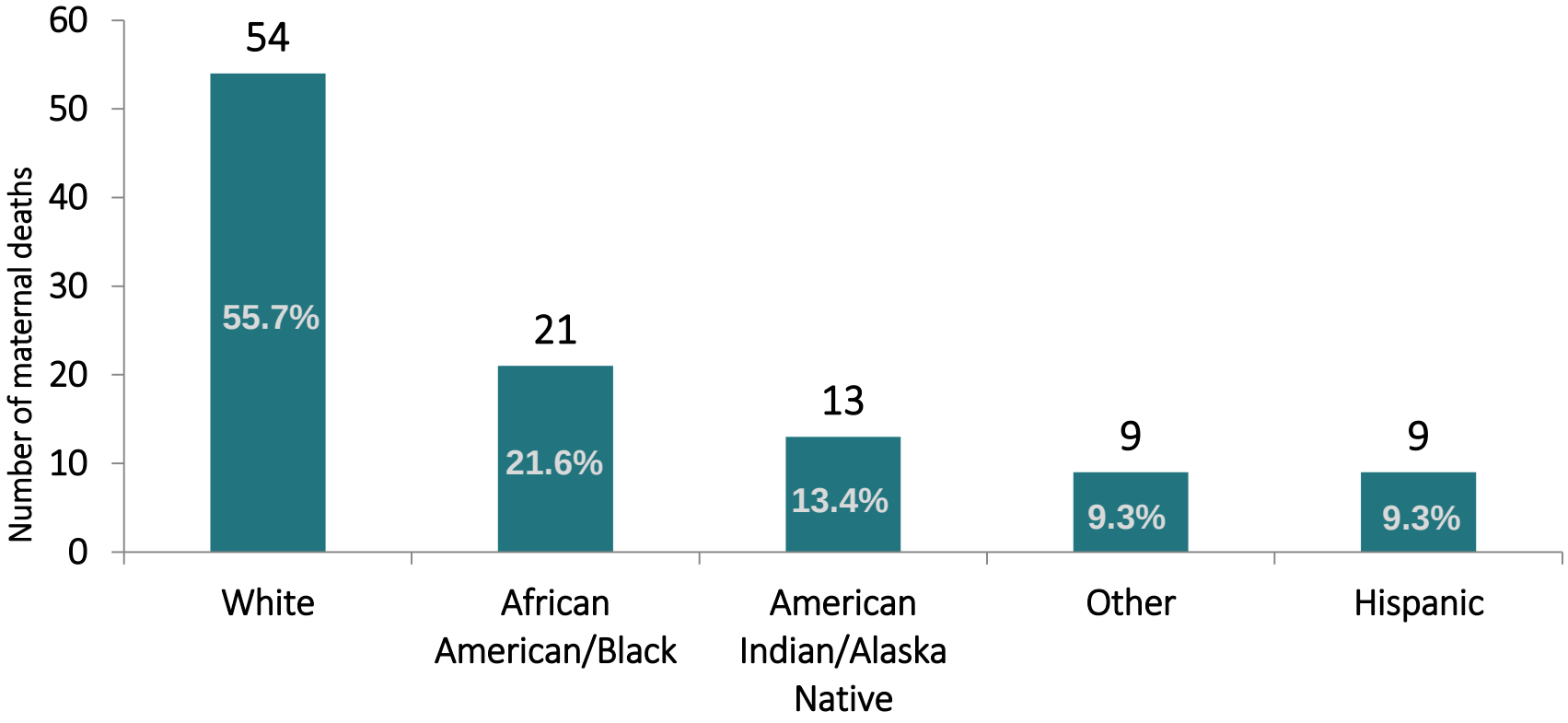
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics

Maternal Mortality Review

- 97 case reviews to date
- Age range: 16-45 years
- 20 were of an advanced maternal age (>35 years) (21%)
- Poverty: 59 cases report receiving Medicaid (64.9%)
- Health conditions most often cited, most cases listed multiple health conditions
  - Obesity (22) (BMI listed has high as 53.5) = 24.7%
  - Chronic hypertension (24) = 24.7%
  - Diabetes not gestational diabetes (13) = 13.4%
  - Cardiac problems (17) = 17.5%
  - Asthma/Pulmonary (9) = 9.3%
  - Seizure disorder (4) = 4.1%
  - Chronic pain (2) = 1.0%

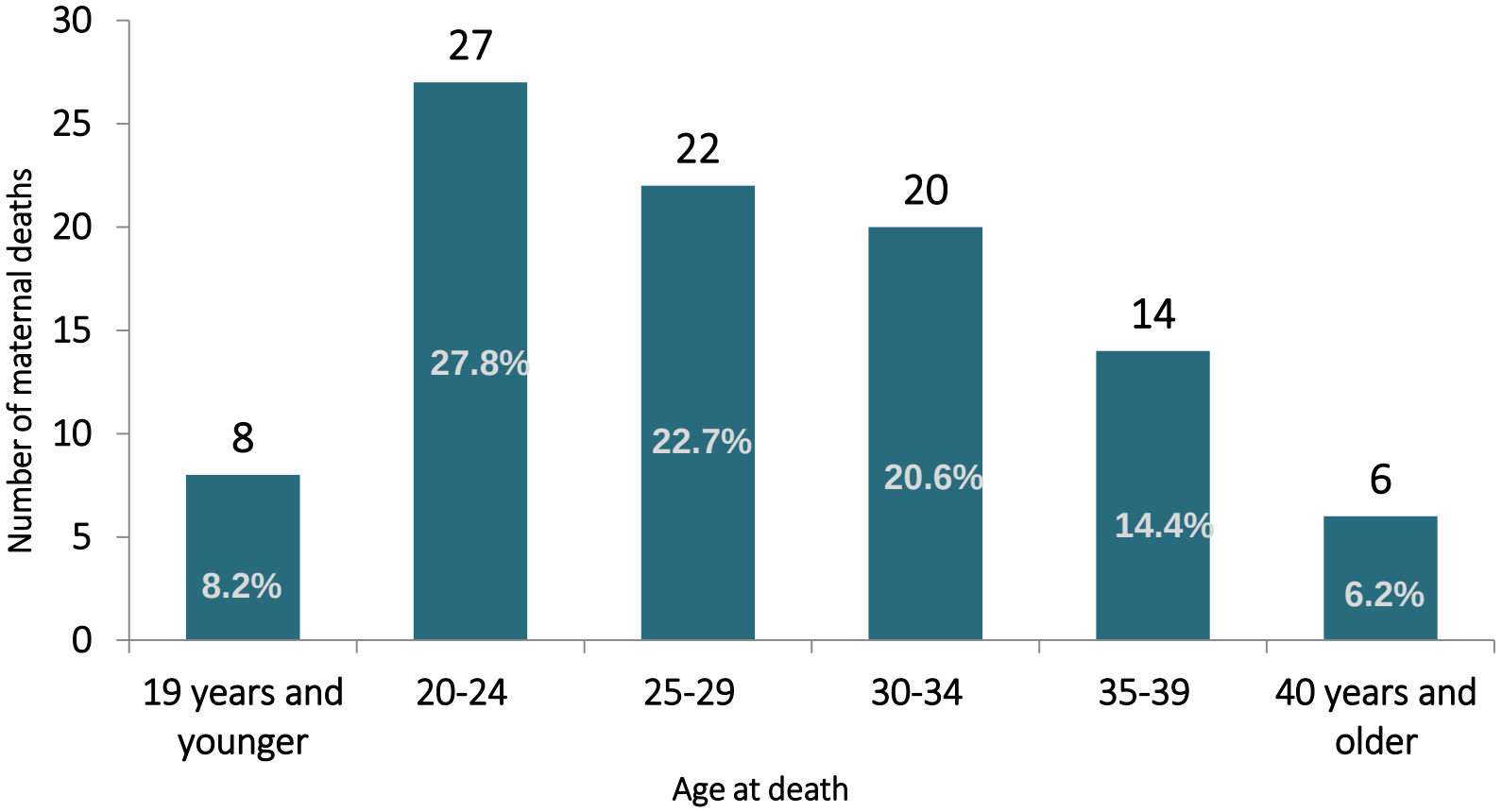
Source: Maternal Mortality Review Committee, cases reviewed since 2009

Maternal Deaths by Race/Ethnicity



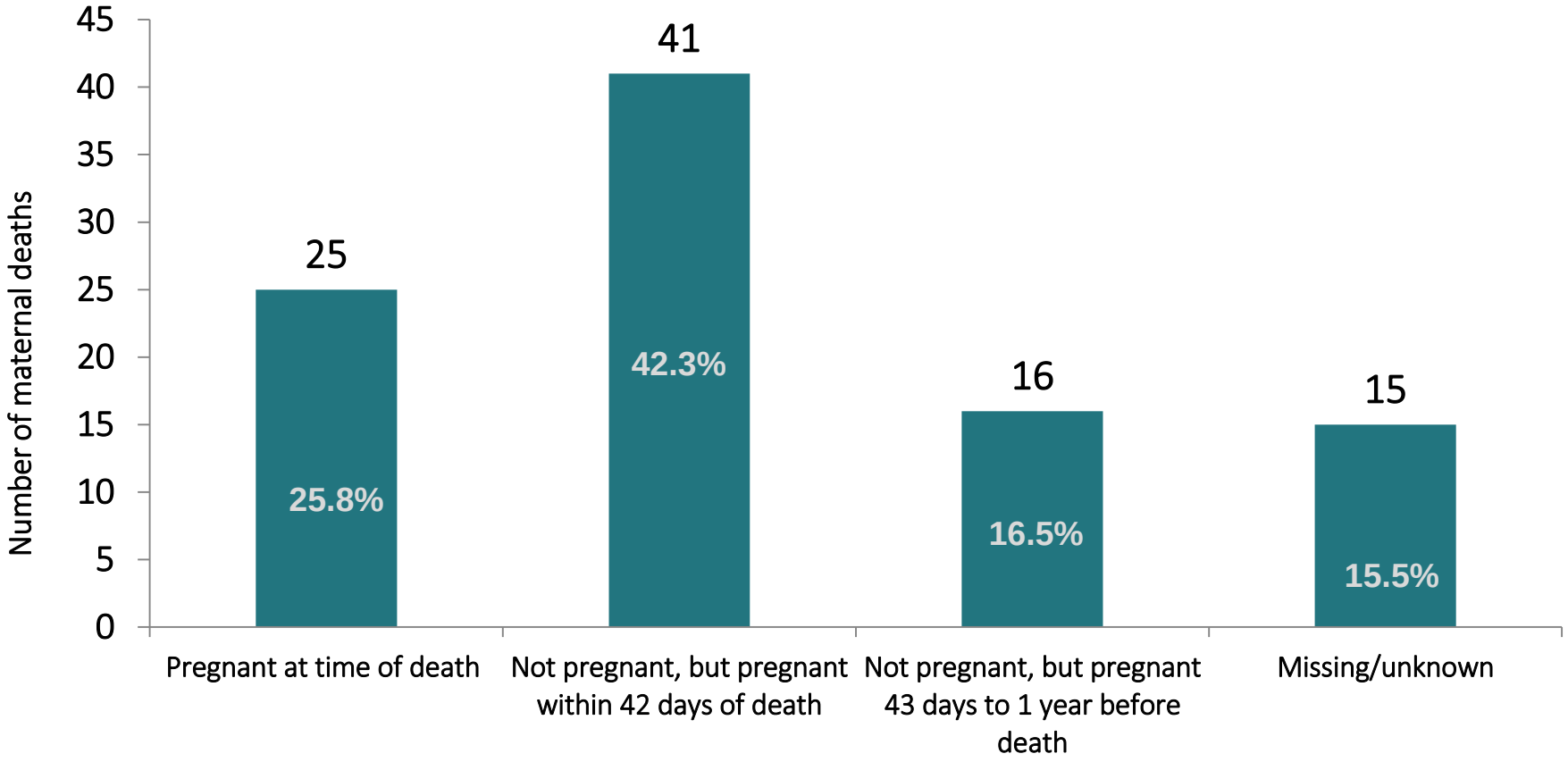
Hispanic count is not mutually exclusive of race.
Source: Maternal Mortality Review Committee, cases reviewed since 2009

Number of Maternal Deaths by Age



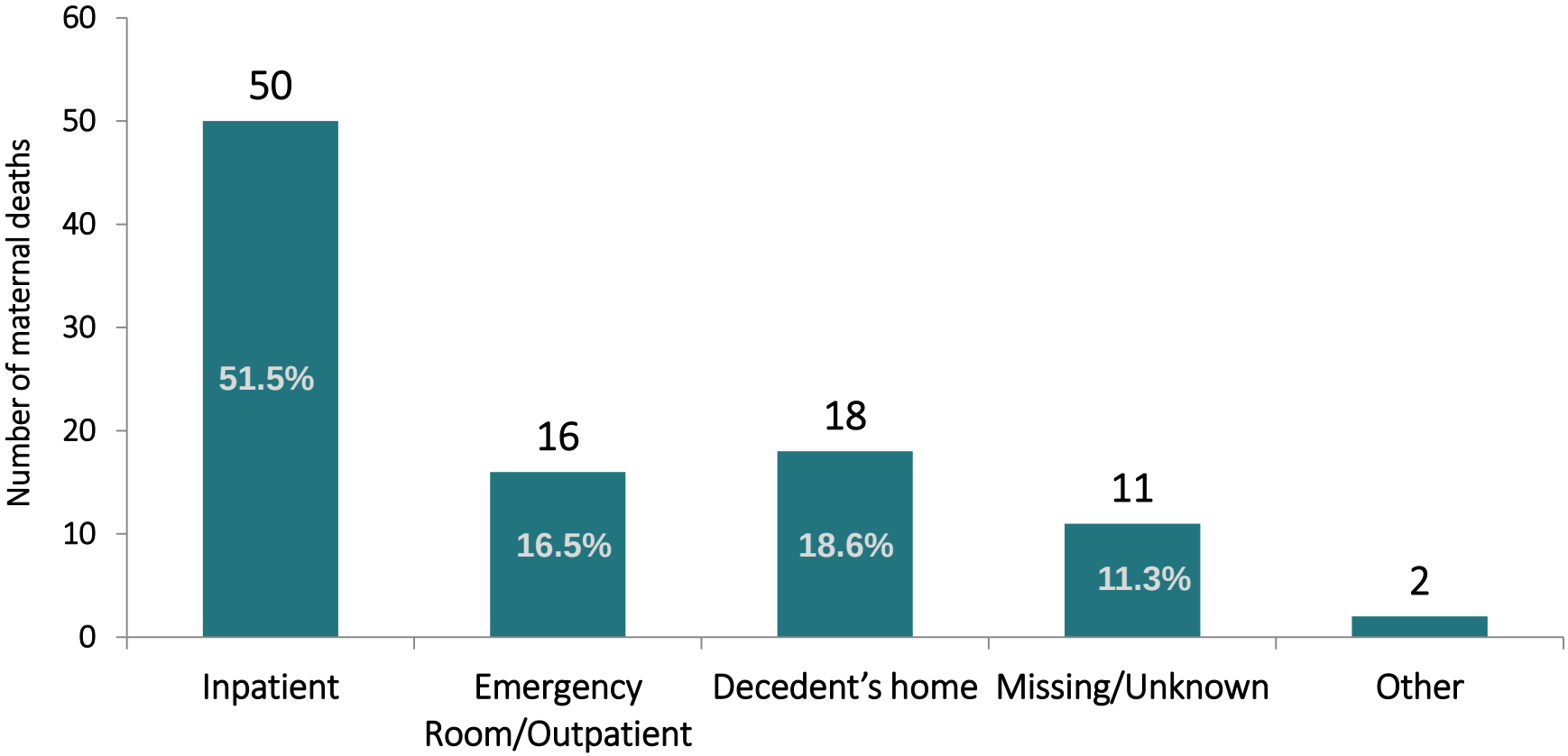
Source: Maternal Mortality Review Committee, cases reviewed since 2009

Number of Maternal Deaths by Pregnancy Status



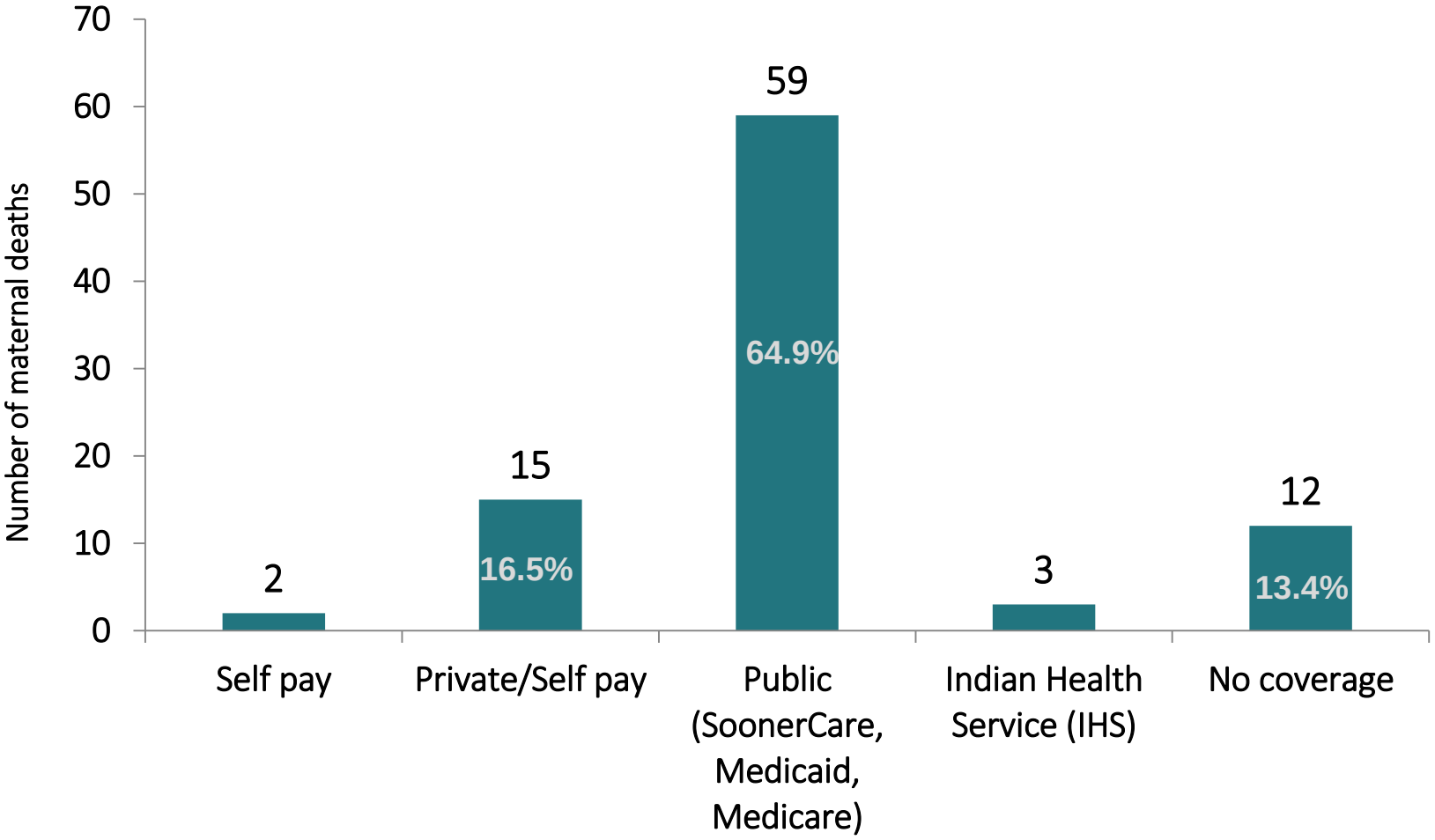
Source: Maternal Mortality Review Committee, cases reviewed since 2009

Maternal Deaths by Place of Death



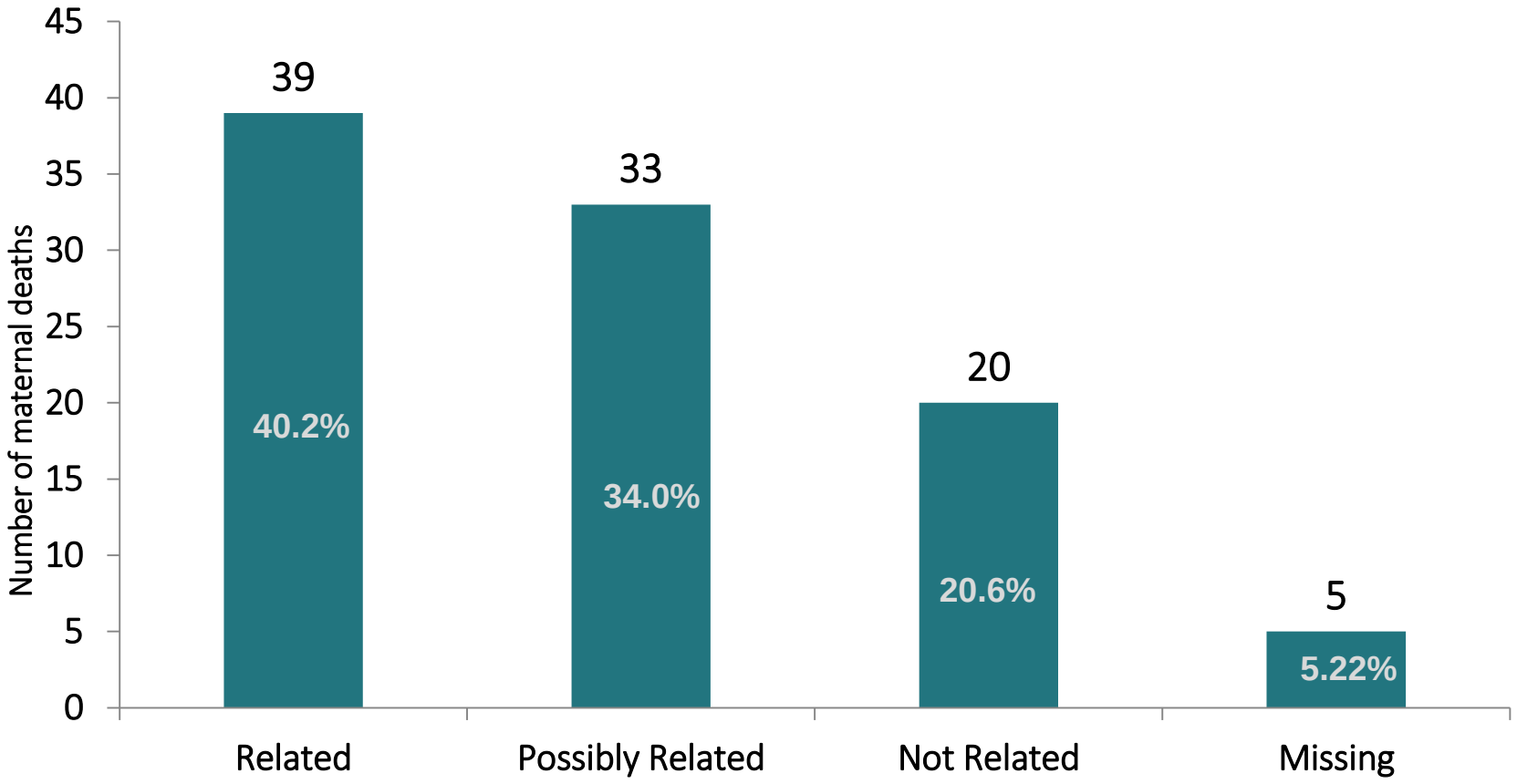
Source: Maternal Mortality Review Committee, cases reviewed since 2009

Percentage of Maternal Deaths by Pay Source



Public insurance includes those who listed multiple pay sources, including Medicaid/SoonerCare
Source: Maternal Mortality Review Committee, cases reviewed since 2009

Deaths by Pregnancy-Related Status



Source: Maternal Mortality Review Committee, cases reviewed since 2009

Maternal Morbidity

123(5):973-977, May 2014

Current Commentary

The National Partnership for Maternal Safety

Mary E. D'Alton, MD, Elliott K. Main, MD, M. Kathryn Menard, MD, and Barbara S. Levy, MD

Recognition of the need to reduce maternal mortality and morbidity in the United States has led to the creation of the National Partnership for Maternal Safety. This collaborative, broad-based initiative will begin with three priority bundles for the most common preventable causes of maternal death and severe morbidity: obstetric hemorrhage, severe hypertension in pregnancy, and peripartum venous thromboembolism. In addition, three unit-improvement bundles for obstetric services were identified: a structured approach for the recognition of early warning signs and symptoms, structured internal case reviews to identify systems improvement opportunities, and support tools for patients, families, and staff that experience an adverse outcome. This article details the formation of the National Partnership for Maternal Safety and introduces the initial priorities.

(Obstet Gynecol 2014;123:973–7)
DOI: 10.1097/AOG.0000000000000219

issued a Sentinel Alert entitled "Preventing Maternal Death"[2] and proposed various initiatives to decrease maternal mortality including case reporting and review, health care provider education, team training and drills, and thromboembolism prophylaxis.

During the past 2 years, several organizations–including the American College of Obstetricians and Gynecologists (the College), the Centers for Disease Control and Prevention, the Society for Maternal–Fetal Medicine, the Health Resources and Services Administration, the Association of Women's Health, Obstetric, and Neonatal Nurses, and the American College of Nurse-Midwives–have collaborated to identify priorities for maternal safety. Universal recognition of the need for action to reduce U.S. maternal mortality and morbidity led to the creation of the National Partnership for Maternal Safety. This report outlines a national initiative for every birthing facility

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

www.safehealthcareforeverywoman.org

Council for Patient Safety in Women's Health Care
Purpose and Function

- **Dissemination**
  - Not responsible for the development of clinical guidance
  - Serve as dissemination body for materials developed outside the confines of the Council
- **Drive Research and Encourage Exploration on Pertinent Topics**
  - Publication development to bring attention to patient safety problems and encourage action for improvement
- **Rapid Deployment**
  - Ability to remain agile and push materials out quickly though its dissemination channels
- **Multidisciplinary Collaboration**
  - Products endorsed by Council receive input from variety of stakeholders
  - Expansive network to facilitate the widespread implementation and use of endorsed materials
  - Engagement and collaboration with outside organizations to drive work

www.safehealthcareforeverywoman.org

National Partnership for Maternal Safety:
3 Maternal Safety Bundles in 3 Years

"What every birthing facility in the US should have…"

- Obstetric Hemorrhage
- Preeclampsia/ Hypertension
- Prevention of VTE in Pregnancy

*Note: The bundles represent outlines of highly recommended protocols and materials important to safe care **BUT** the specific contents and protocols should be individualized to meet local capabilities. Example materials are available from perinatal collabortives and other organizations.*

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH AIM

In 2014 the Council was awarded a 4 year cooperative agreement from the Health Resources and Services Administration (HSRA) Maternal and Child Health Bureau (MCHB)

Oklahoma is FIRST state to join AIM!

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

Alliance for Innovation in Maternal Health (AIM)

1. Partner development and strengthening
2. Maternal safety bundle implementation
3. State and national data infrastructure development
4. Reduce low risk primary Cesarean deliveries
5. Improve postpartum and interconception care
6. Reduce intrapartum and postpartum racial disparities
7. Provide intensive technical assistance

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH AIM

Goals of AIM

By the end of 2018:

1. Reduce maternal mortality by **1,000** deaths

2. Reduce severe maternal morbidity by **100,000** incidents

Oklahoma: Outcome Measures

Outcome Measure Results | Process Measure Results | Structure Measure Results | Measure Completion Assessments

Hemorrhage

Measure	2011	2012	2013	2014	2015
Severe Maternal Morbidity among All Delivering Women	2.4%	2.0%	2.1%	2.0%	1.5%
Severe Maternal Morbidity (excluding transfusion codes) among All Delivering Women	0.7%	0.7%	0.7%	0.8%	0.5%
Severe Maternal Morbidity among Hemorrhage Cases	38.4%	31.0%	32.2%	28.1%	28.5%
Severe Maternal Morbidity (excluding transfusion codes) among Hemorrhage Cases	5.7%	6.4%	6.0%	6.0%	6.0%

Preeclampsia

Measure	2011	2012	2013	2014	2015
Severe Maternal Morbidity among All Delivering Women	2.4%	2.0%	2.1%	2.0%	1.5%
Severe Maternal Morbidity (excluding transfusion codes) among All Delivering Women	0.7%	0.7%	0.7%	0.8%	0.5%
Severe Maternal Morbidity among Preeclampsia Cases	13.0%	12.3%	10.5%	10.9%	9.5%
Severe Maternal Morbidity (excluding transfusion codes) among Preeclampsia Cases	6.6%	8.3%	5.7%	6.1%	5.9%

Stay tuned….stay engaged….be a leader….support the work of the OPQIC

This is very important work…it is life-saving work…..and

The foundation of adult health is laid during pregnancy, infancy and childhood.

Adapted from Robert Block, M.D.