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Abridged Transcript September 10, 2020 ACOG District VIII Maternal Mortality Work Group

Attendees: 62

Welcome – by Sharon Phelan and Suzanne Burlone

Introduction of Julie Z.

Title of slide presentation – Attached

Questions to Julie

In MMRIA, where we can enter locations, will it be possible to eventually look at the data based on distances from home, birthing hospital, closest hospital that is a non-birthing hospital, and other issues unique to rural locations. Yes – with geo-mapping this will be possible.

Our state is in the early stages of the MMRC process. Is it possible to have someone from the CDC (e.g. Julie) come to the first meeting to provide guidance? What kind of support can CDC provide? Julie notes she often attend a state's kick off meeting – especially now that many are virtual. Julie and her team can go through a fake case with them, walk through the decision forms, help with hiring abstractors, etc. In fact, in the lead up, the CDC will help the epidemiologist and explain the data. In short, the CDC is prepared to provide a lot of support and resources. It was also stressed to be sure to engage with the PHD and HRSA groups involved in the MMR activities since they are already doing many of these.

ACOG has a priority to extend postpartum care to 12 months. However, the role of the ob provider during these 12 months has not been well defined. It seems that the data from MMRIA would help in creating this guidance. For example, the role of the provider and accessing care for substance use disorder may be one. Do you have any recommendations for postpartum care? Julie did not have any specific ideas but agreed that data from will help in defining this role. Others noted postpartum depression is an additional situation that would benefit from prolonged care.

How much of the depression cases with drug use or suicide play into the pregnancy related deaths, especially the later ones? Julie notes that many of the more populated states with larger numbers do not review many of these types of deaths due to shear volume. The more rural, especially Western States have included these in their reviews and determine many are pregnancy-related.

Question regarding suicide. Are these due to pre-existing depression, lack of support or other underlying conditions? The Utah criteria for reviewing suicide/mental health deaths and determining pregnancy related or only associated status might be helpful. These criteria will be published in the October edition of Obstetrics and Gynecology. These criteria will be encouraged as a standard approach for the District VIII reviews of mental health deaths. It is encouraged to try to stay with the data we have and not extrapolate ideas that are not in the records. Then we review the history of the course of the mental illness and try to decide if the pregnancy caused it, contributed to it worsening, or had no impact. We find that the pregnancy often contributes to the mental health status that leads to the suicide or drug misuse. The criteria used in Utah and published by them is not definitive and the Utah

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team welcomes feedback on how it is working as well as suggestions for modification and further development.

Comment: not to forget the other groups involved in maternity care including AAFP, ACNM, AWHONN, IHS and tribal groups and other community members.

Updates by District VIII Sections

Alaska – Margaret Young

We do both maternal and child health reviews since numbers are fortunately small. We are just working to implement MMRIA into our process, and have 6 cases entered. We are doing our meetings virtually right now. One strength of the program is that we have been doing reviews for almost 30 years. This gives us more experience in doing reviews, but makes it harder to adopt new systems such as MMRIA and best practices suggested by the CDC. We are working on more training for committee members on implicit bias and vicarious trauma. We are working to get recommendations refined to be in a good active format, and to be clear for how to improve outcomes. We are working to expand the committee to more community and multidisciplinary involvement while working to maintain the required 75% medical involvement (per regulation) to allow them to qualify for Medical Review Committee umbrella for protection.

Alberta- Karen Bailey

We have studied MM since 1936 in the province. We have moved to include perinatal deaths as well as postpartum deaths. We have a multispecialty committee to include members from all the specialties that are involved in women's care around pregnancy and the newborn period. We have included QI folks with their unique perspective on quality care. In addition, there is an Internal Medicine specialist to provide an internist perspective. Standardized forms and long experience with virtual meetings (members can be 900 nautical miles apart) encourages consistency and inclusion. We are only sending electronic records. We are unlikely to convert current data collection system to MMRIA, but there may be a way to convert data to enter into MMRIA. However, that would be a major undertaking.

Arizona – Clarke Bear

We are working towards summarizing into a report all the 2016-2017 reviews for the governor and legislature. Two biggest challenges have been access to medical records and the ability to hire support staff. The ERASE grant really has helped. Now with full time abstractors and support staff the abstractions are much more detailed. We are now working on medical records access and working with Health Information Exchange to get records, as well as with other groups such as Child Safety program and Trauma System. We are working on incorporating a tool - Health Equity Dashboard – to get more of a socio-economic perspective and metrics. This is helping to develop more robust recommendations. Now we are working more towards toward implementing recommendations. As an AIM state we are

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implementing the Hypertension bundle. We are partnering with Arizona Maternal Health Innovation program to launch a media campaign on the warning signs in pregnancy.

British Columbia - Petra Selke

Congratulated the group. We both in BC and in Canada do not have a mandate to do this type of review. Joined the meeting for fact-finding and collaboration.

Colorado – Shivani Bhatia

We are proud of our committee members and diversity of our committee, including an addiction medicine specialist. We have been reviewing maternal deaths since the 1950's, and our committee has been housed in the DOH for close to 30 years. This move has helped to shift the conversations to the public health issues and the entire public health system. Recently we published a report of our work, which covered 2014-2016 data. This focused on the issue of systemic racism that hampers the public health system. Systemic racism is the driving force behind many outcomes and maternal mortality around the world. The report has some rigorous recommendations to shift this with system changes. A focus now is to be sure affected groups are engaged– Indigenous, Black, and postpartum women. It is important to get their stories and perspectives.

Hawaii – Stacy Tsai

The chair of the committee reported. We started to do the comprehensive reviews for 2016 data and are now doing 2018 cases. The Covid pandemic has forced virtual meetings which challenges the committee to continue our former approach. We have implemented the Utah criteria in addition to adding mental health and social service personnel to the committee to help determine pregnancy relatedness with suicides and overdoses. A problem is implementing recommendations. The perinatal collaborative in Hawaii is in its infancy. The hospital association is focused on Covid so there has been no assistance. We are trying to become an AIM state and are working to allow data sharing as required by AIM. We are using hospital discharge data for severe maternal morbidity.

Idaho – Xenya Poole

We are one year old and have finished the draft of our first report. It is being circulated for edits prior to being released for the legislature and general public. We are getting ready for our second meeting and reviewing deaths within a year of occurrence. We have gotten access to PMP data. We are having trouble implementing recommendations since we do not have a perinatal collaborative. We also have small numbers to try to determine patterns, and are dealing with the challenges of a virtual meeting platform.

Montana – Drew Malany

We are barely getting started. We are implementing MMRIA and working closely with the CDC for training and guidance. We are collaborating with Utah to help with the process much like Wyoming has.

Nevada - Vickie Ives

The MMRC was just established last May through legislation. We will have our first case review next week and are required to get our first report out by December. We are not an ERASE state but are getting a good deal of support from the CDC. State funding is tight. The committee size is capped at 12

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members by the legislature which makes a multidisciplinary committee makeup difficult. We became an AIM state recently and will be launching the first bundle this fall.

New Mexico – Katrina Nardini

Some of the highlights include – we did get an ERASE grant which has helped greatly. We just upgraded to the MMRIA cloud and uploaded 80 reviewed cases. We review all maternal deaths averaging about 20/year. We have had two virtual meetings that went well and anticipate continuing this format for the near future. We hope to have the 2018 cases completed by January 2021. We have a Redcap data base in which we capture more of the details of motor vehicle deaths (a major cause) in hopes that we can explore these in comparison with the Department of Transportation general data. We are also expanding membership to non-clinical members which will require a modification to our legislative mandate. There is an increasing focus on health disparities and racism including using the Texas trigger tool. We are in the process creating products for the legislature and the public regarding the 2015-2017 deaths and recommendations. We are an AIM state and are doing the HTN bundle and plan to do the opioid use disorder bundle next. Based on our reviews, we are starting to collaborate with the various EMS organizations to work on improving resources for obstetric care in these settings. We are working on curating about 200+ recommendations to prepare a consolidated and rationalized list by the end of the year.

Oregon

We had our first case review meeting last month, looking at 2018 deaths. Maternal deaths average about 10 cases per year. The members of the committee have been great. There are 15 governor-appointed members. We are working with the Oregon Department of Public Health. We appreciate the help from the CDC as well other regional and national groups. It has taken some time to get active: legislative approval in 2018, committee appointments in 2019 with some administrative meetings and now finally a meeting to review cases in 2020. We are capped at 15 members by legislation. We are implementing MMRIA and want to thank Gyan from the CDC for all his support. We also have a home grown data base that is secure for remote use that we can use to bridge until we can enter data in MMRIA. We still need a framework for looking at social determinates of health and racism issues. We still have questions about across state line cases and how to maintain confidentiality. We are still finding it difficult to determine preventability. Virtual meetings have worked well for us.

Utah/Wyoming – Marcela Smid

Our biggest strength is the committee membership under Tori Metz , co-chair, and the other co-chair is a neonatologist. Our abstractor is a direct entry midwife. It is a very diverse group. The members were actively recruited from rural practices, mental health, substance abuse specialist and tribal groups. We review maternal and neonatal deaths. Utah is an ERASE state. Our committee is unique in that Wyoming joined us for administrative infrastructure to review deaths in both states. Currently we are in discussions with Montana to see about a similar arrangement with that state. We assign a committee member to present the de-identified case and to help focus concerns at the review meetings. We are also placing common demographic data (such as race and ethnicity) at the end of the case to minimize any bias due to this information. We are working to follow the CDC “format” for actionable

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recommendations and have found this helpful. As an AIM state we will be launching the Opioid bundle soon. We have been able to publish our work in a medical journal, including the soon to be published "Utah criteria" for determining if suicide or overdose deaths are pregnancy related or not.

Washington – Judy Kimelman

In January 2020 we empaneled our second MMRC committee. The first reviewed deaths 2014-2018. It is anticipated by the end of 2021 we will be current with completed reviews through 2020. We have expanded to include homicides and interpersonal/domestic violence. We too have had virtual meeting given COVID and found it allowed more participations from across the state. As of 2020, the Department of Health has access to the MMRIA data base and is entering the cases reviewed. One of the strengths of the reviews is the quality activities that come out of the deliberations. We are working to strengthen the collaboration between the Indian Health organizations to better identify the issues for the Native populations and communities. The Washington Department of Health (DOH) is using the LOCATE data to survey the resources of birthing hospitals and their level of care. The DOH and Hospital Association will be rolling out a substance abuse bundle this year. The DOH is also working with suicide prevention groups to roll out a program stressing assessment and follow up on suicide risks in pregnancy and postpartum. Finally, legislature passed a bill extending obstetric coverage to 12 months postpartum. Unfortunately budget cuts secondary to COVID resulted in the governor vetoing the bill. Our weaknesses include determining the prenatal care providers and accessing prenatal medical records. This is especially true with private insurers and the Department of Defense medical records. It is hard to engage non-medical members of the committee when discussing deaths.

Wyoming: no representation at the meeting

ACNM –Jessica Anderson

Self-intro: represents Region 6 which overlaps with ACOG District VIII (AZ, CO, I.H.S, MT, NM, UT and Wyoming. She commends our efforts and accomplishments.

Also on the call was Ruth Mielke who represents Region 7 which overlaps with ACOG District VIII (AK, HI, ID, NV, OR, WA, Samoa and Guam.

ACOG – Brandi Ring

Encouraged the idea of including a resident or fellow to be on the committees as a member or at least as auditors. They are often the first line care providers in some of the deaths and their insight could be useful. If you need to identify a resident you can contact Brandi who can facilitate recruitment. It was noted that the New Mexico MMRC tried to have trainees to audit meetings as part of a complete curriculum to understand the process of MMRC and the reviews. In turn it was hoped that this would encourage these individuals to continue to stay active with the process during their careers. Unfortunately the legislation as currently written blocked the attendance of "guests". NM is trying to modify the legislation to accommodate this effort.

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HRSA- Debra Wagler on the call, did not speak

Final Thoughts

Want to stress how to provide emotional support for the committee members since this is a very stressful activity, especially now with the need for virtual meetings.

Can we do these meetings more than once a year? It is amazing the advancements of the states in District VIII.

A few discussion topics have been raised –

- 1. Dealing with across state line deaths/births/residency**
- 2. More effectively interfacing with Indian Health groups to access data, identify their challenges and resources, and develop strategies to improve care**
- 3. Identify how to access military records when a death occurs in a military hospital**

Rather than wait a full year to address these (and other) issues, another virtual meeting of the District VIII Maternal Mortality Workgroup will be scheduled for January or February of 2021.

Attachments:

1. Slides from Julie Zaharatos presentation
2. Article on Utah criteria
3. Report from the State of Colorado.