Why Family Physicians are Ideally Suited to Reduce Maternal Mortality

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Disclosures

• Dr. Toy is Medical Director for the ACOG Levels of Care Designation Program in Texas. He does not receive any financial renumeration from the designation program.

• Chloe Denham is a first-year medical student at McGovern Medical School who has had an interest in maternal mortality for many years and has no financial disclosures.
Objectives

By the end of this educational activity, the participant should be better able to:

1. US & TX Maternal mortality rate vs. other developed countries.
2. List most common causes of maternal mortality in Texas.
3. Recommended CDC maternal morbidity conditions
4. Interventions impacting maternal M&M.
5. QAPI to reduce maternal M&M to their healthcare setting.
6. Family physicians’ unique role in reducing maternal M&M
Part 1: US & TX Mat Mortality Rates
US Maternal Mortality Rate

Deaths per 100,000 live births
**The U.S. Is The Only Developed Nation With A Rising Maternal Mortality Rate**

By Anna Almendrala
OSU/MSDS EM/STEM R&D | December 7, 2017

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**U.S. Sees Biggest Increases In Maternal Death Rates In Developed World Since 1990**

U.S. maternal mortality ratio per 100,000 live births, 1990-2013

Source: The Institute for Health Metrics and Evaluation/The Lancet
Bottom Line

• All other developed countries have seen a DECREASED Maternal Mortality RATE
• BUT US is seeing an INCREASE (double in last 15 years)!
• We should aim for < 9 deaths/ 100,000 live births
• Instead, US is about **25-30 per 100,000 live births**
Texas

Deaths per 100,000 live births

Data sources:
Texas Department of State Health Services, Center for Health Statistics, Death Files, 2005-2014.
State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013.
Racial Disparities are Heart-wrenching!

Prepared by: Office of Program Decision Support, Division for Family and Community Health Services, Texas Department of State Health Services, 07/21/2017.
Data Source: Death and Birth Files, Center for Health Statistics, Texas Department of State Health Services.
MMR - computed within 42 days following the end of pregnancy, using ICD-10 codes A34, O00-O95, O98-O99.
OBJECTIVE: To more accurately estimate the 2012 maternal mortality ratio for Texas using an enhanced method for identifying maternal deaths.

METHODS: This population-based descriptive study used both data matching and record review to verify pregnancy or delivery within 42 days for 147 deaths with obstetric cause-of-death codes, and used data matching alone to identify additional maternal deaths within the same timeframe. Crude maternal mortality ratios were calculated for confirmed maternal deaths overall, by race and ethnicity, and by age. These maternal mortality ratios were compared with maternal mortality ratios computed using obstetric cause-of-death codes alone (standard method).

RESULTS: Fifty-six maternal deaths were confirmed to have occurred during pregnancy or within 42 days postpartum. Using our enhanced method, the 2012 maternal mortality ratio for Texas was 14.6 maternal deaths per 100,000 live births, less than half that obtained using the standard method (n=147). Approximately half (50.3%) of obstetric-coded deaths showed no evidence of pregnancy within 42 days, and a large majority of these incorrectly indicated pregnancy at the time of death. Insufficient information was available to determine pregnancy for 15 obstetric-coded deaths, which were excluded from the 2012 maternal mortality ratio estimate; however, had these deaths been included, the resulting maternal mortality ratio would still be significantly lower than that reported using the standard method.

CONCLUSION: Relying solely on obstetric codes for identifying maternal deaths appears to be insufficient and can lead to inaccurate maternal mortality ratios. A method enhanced with data matching and record review yields more accurate ratios. Results likely have national implications, because miscoding of obstetric deaths with the standard method may affect the accuracy of other states’ maternal mortality ratios.

(Obstet Gynecol 2018;131:762–9)

DOI: 10.1097/AOG.0000000000002565
Death Certificate Data Unreliable: Improved

Maternal deaths in Texas

A new study by researchers at the Texas Department of State Health Services corrects a widely-reported 2016 report that overstated the number of maternal deaths in Texas in 2012. Data from the new report:

2012 Texas Maternal Deaths by Race ...

- White: 18 (32.1%)
- Black: 12 (21.4%)
- Hispanic: 21 (37.5%)
- Other: 5 (8.9%)

... Compared to all births in Texas

- White: 36.4%
- Black: 11.3%
- Hispanic: 47.8%
- Other: 6.3%

2012 Texas Maternal Deaths by Age of Mother

- 24 or younger: 12
- 25-34: 28
- 35 or older: 16

Bottom line: Texas is about lower 1/3 of nation, about 25-30/100,000 live births
Part 2: Causes of Maternal Death in Texas
Maternal Mortality and Morbidity Review Committee


A new study by researchers at the Texas Department of State Health Services entitled Identifying Maternal Deaths in Texas Using an Enhanced Method, 2012 has found the number of maternal deaths in Texas in 2012 was actually less than half the number previously reported. The peer-reviewed research, published in the journal Obstetrics & Gynecology, determined there were 56 maternal deaths among Texas residents compared with 147 reported in national statistics. The article may be viewed at this link.

Background and Purpose

The Maternal Mortality and Morbidity Task Force was created by Senate Bill 495, 83rd Legislature, Regular Session, 2013, which added Texas Health and Safety Code Chapter 34, Maternal Mortality and Morbidity Task Force. The name of the Task Force was changed to the Texas Maternal Mortality and Morbidity Review Committee by Senate Bill 750, 86th Legislature, Regular Session, 2019 in alignment with the federal Preventing Maternal Deaths Act of 2018.

The multidisciplinary review committee within the Department of State Health Services (DSHS) will study maternal mortality and morbidity. The review committee:

- studies and reviews cases of pregnancy-related deaths and trends in severe maternal morbidity,
- determines the feasibility of the review committee studying cases of severe maternal morbidity, and
- makes recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

The review committee and DSHS must submit a joint report on the findings of the review committee and recommendations to the governor, lieutenant governor, speaker of the House of Representatives, and appropriate committees of the Texas Legislature by...
Task Force Report

Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report

As Required by Chapter 34, Texas Health and Safety Code, Section 34.015

Maternal Mortality and Morbidity Task Force

September 2018
Summary of Recommendations:

1. Increase access to health services during the year after pregnancy and throughout the interconception period to improve the health of women, facilitate continuity of care, enable effective care transitions, and promote safe birth spacing.
2. Enhance screening and appropriate referral for maternal risk conditions.
3. Prioritize care coordination and management for pregnant and postpartum women.
4. Promote a culture of safety and high reliability through implementation of best practices in birthing facilities.
5. Identify or develop and implement programs to reduce maternal mortality from cardiovascular and coronary conditions, cardiomyopathy and infection.
6. Improve postpartum care management and discharge education for patients and families.
7. Increase maternal health programming to target high-risk populations, especially Black women.
8. Initiate public awareness campaigns to promote health enhancing behaviors.
9. Champion integrated care models combining physical and behavioral health services for women and families.
10. Support strategies to improve the maternal death review process.
Finding #2 — The leading causes of pregnancy-related death in 2012 included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy.
Finding #2 — The leading causes of pregnancy-related death in 2012 included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy.

Finding #3 — Black women were more likely to experience pregnancy-related death in 2012.
Finding #2 — The leading causes of pregnancy-related death in 2012 included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy.

Finding #3 — Black women were more likely to experience pregnancy-related death in 2012.

Finding #13 — The increased risk for maternal death among Black women exists regardless of income, education, marital status, or other health factors.
Finding #5 — Most pregnancy-related deaths were potentially preventable. 80% preventable!!
Finding #5 — Most pregnancy-related deaths were potentially preventable.  

Finding #6 — A complex interaction of personal, provider, facility, systems and community factors contributed to maternal death.
Finding #8 — Hemorrhage and Cardiac Event were the two most common causes of death while pregnant or within 7 days postpartum.
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Finding #9 — The majority of maternal deaths occurred more than 60 days postpartum.
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Finding #9 — The majority of maternal deaths occurred more than 60 days postpartum.

Finding #10 — In 2012 to 2015, Drug overdose was the leading cause of maternal death from delivery to 365 days postpartum.
Deaths up to 365 days:
#1 = Drug OD
#2 = cardiac
Women’s Health in Texas

NOTE: Majority of deaths past 42 days!
Bottom Line: Texas’ Mat Mortality Rate High (but not as high as previously thought)

- #1 Cause within 7 days = Hemorrhage & Cardiac
- #1 Cause with 42 days = Cardiac
- #1 within 365 days = Substance use disorder (opioids)
Part 3: CDC Severe Maternal Morbidity Conditions
100-150 Severe Morbidity Cases Per 1 Death!

How Does CDC Identify Severe Maternal Morbidity?

To identify delivery hospitalizations with SMM, CDC uses administrative hospital discharge data and International Classification of Diseases (ICD) diagnosis and procedure codes. The original list of 25 SMM indicators based on the 9th Revision of ICD was published in 2012. In October 2015, the United States transitioned to the 10th Revision of ICD to code diagnoses and procedures. CDC, along with our clinical and public health partners, took the opportunity to review this new version of ICD coding to update the indicators, taking into account results from validation studies. The updated list of 21 indicators and corresponding ICD codes used to identify delivery hospitalizations with SMM for both ICD-9 and ICD-10 can be used to track SMM when using administrative hospital discharge data from October 2015 and beyond.

Appendix 2. Severe Morbidity Indicators and Corresponding ICD-9-CM/ICD-10-CM/PCS Codes during Delivery Hospitalizations.
The table below includes the list of 21 indicators and corresponding ICD codes used to identify delivery hospitalizations with SMM.

<table>
<thead>
<tr>
<th>Severe Maternal Morbidity Indicator</th>
<th>DX or PR</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>ICD-10 short</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>I22.0, I22.1, I22.2, I22.6, I22.9</td>
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<tr>
<td>2. Aneurysm*</td>
<td>DX</td>
<td>441.xx</td>
<td>I71.00 - I71.03, I71.1, I71.2, I71.3, I71.4, I71.5, I71.6, I71.8, I71.9, I79.0</td>
<td>I71.xx*</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>I79.0*No I71.7 code exists, so ICD-10 list encompasses all possible I71 codes</td>
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<tr>
<td>3. Acute renal failure</td>
<td>DX</td>
<td>584.5, 584.6, 584.7, 584.8, 584.9, 669.3x</td>
<td>N17.0, N17.1, N17.2, N17.8, N17.9, C59.4</td>
<td>N17.x, C99.4</td>
</tr>
<tr>
<td>4. Adult respiratory distress syndrome</td>
<td>IVY</td>
<td>518.9y, 518.92, 518.97, 518.98, 799.1</td>
<td>J80.0, J80.2, J80.9, J80.2, J98.21, J96.21, J96.22, R99.2</td>
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<tr>
<td>5. Antepartum fluid embolism</td>
<td>DX</td>
<td>673.1x</td>
<td>O88.11x*, O88.12 (chd/birth), O88.13 (a/abort), O88.14 (preeclampsia)</td>
<td>O88.1x</td>
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<td></td>
<td></td>
<td></td>
<td>* x11th, 2nd and 3rd trimester</td>
<td></td>
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<tr>
<td>6. Cardiac arrest/ventricular fibrillation*</td>
<td>DX</td>
<td>427.41, 427.42*, 427.5</td>
<td>I46.2, I46.3, I46.9, I49.01*, I49.02**</td>
<td>I46.x, I49.0x</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Ventricular flutter</td>
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<tr>
<td></td>
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<td></td>
<td>** Ventricular fibrillation</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>*** Ventricular flutter</td>
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</tbody>
</table>

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html
<table>
<thead>
<tr>
<th>7. Conversion of cardiac rhythm</th>
<th>DX</th>
<th>99.6x</th>
<th>SA2204Z, SA12012</th>
<th>SA2204Z, SA12012</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Disseminated intravascular coagulation</td>
<td>DX</td>
<td>286.5, 286.9, 666.3x</td>
<td>D65, D66.8, D68.9, O72.3*</td>
<td>D65, D66.8, D68.9, O72.3</td>
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<td>--------------------------------</td>
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<tr>
<td>9. Eclampsia</td>
<td>DX</td>
<td>642.6x</td>
<td>O15.00, O15.02</td>
<td>O15.03, O15.1, O15.2, O15.9</td>
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<tr>
<td></td>
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<td></td>
<td>O14.22 – HELLP syndrome (HELP); second trimester, O14.23 – HELLP syndrome (HELP); third trimester. HELLP syndrome is not included currently ranges in severity, more research is needed.</td>
<td>O15. X</td>
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<tr>
<td>10. Heart failure/arrest during surgery or procedure</td>
<td>DX</td>
<td>997.1</td>
<td>I97.120, I97.121, I97.130, I97.131, I97.710, I97.711</td>
<td>I97.122x, I97.133x, I97.710, I97.711</td>
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<tr>
<td>11. Puerperal cerebrovascular disorders</td>
<td>DX</td>
<td>430.xx, 431.xx, 432.xx, 433.xx, 434.xx, 435.xx, 437.xx, 671.5x, 674.0x, 997.02</td>
<td>I60.0x, I60.1x, I60.2, I60.3x, I60.4, I60.5x, I60.6, I60.7, I60.8, I60.9; I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9; I62.0x, I62.1, I62.9, I63.0x, I63.1x, I63.2x, I63.3x, I63.4xx, I63.5xx, I63.6, I63.8, I63.9; I64.0x, I64.1x, I64.2x, I64.3x, I64.4x, I64.5x, I64.6, I64.7, I64.8, I64.9; I67.0, I67.1, I67.2, I67.3, I67.4, I67.5, I67.6, I67.7, I67.8xx, I67.9; I68.0, I68.2, I68.8; O22.51, O22.52, O22.53, I97.810, I97.811, I97.820, I97.821, O87.3</td>
<td>I60.xx-x88.xx, O22.51, O22.52, O22.53, I97.81x, I97.82x, O87.3</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>I68.9 – included but should not be captured if this is not a valid code.</td>
<td></td>
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<tr>
<td>12. Pulmonary edema / Acute heart failure</td>
<td>DX</td>
<td>518.4, 428.1, 428.0, 428.21, 428.23, 428.31, 428.33, 428.41, 428.43</td>
<td>J81.0, I50.1, I50.20, I50.21, I50.23, I50.30, I50.31, I50.33, I50.40, I50.41, I50.43, I50.9</td>
<td>J81.0, I50.1, I50.20, I50.21, I50.23, I50.30, I50.31, I50.33, I50.40, I50.41, I50.43, I50.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>J81.0; Add 5th character: 0=unspecified 1=acute 2=chronic 3=acute on chronic</td>
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</tbody>
</table>

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

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Examples of Severe Mat Morbidity

- Acute MI
- Aneurysm
- Acute renal failure
- Acute Respiratory Distress Syndrome (ARDS)
- Amniotic fluid embolism
- Cardiac arrest/V fib
- Disseminated intravascular coagulopathy (DIC)
- Eclampsia
- Heart Failure
Examples of Severe Mat Morbidity (Cont.)

- Ventilation
- Hysterectomy
- Transfusion $\geq 4$ units
- Air and thrombotic embolism
- Sickle cell crisis
- Shock
- Sepsis
- Severe anesthetic complications
Severe Maternal Morbidity (SMM) in Texas
Overall and Top Causes, 2014

*AIM Patient Safety Bundle is available for this condition.

Data Source: Hospital Inpatient Discharge Public Use Data File, 2014
Prepared by: Maternal & Child Health Epidemiology

TX DSHS Maternal M&M Task Force
Part 4: Evidence-based Interventions to Improve Mat M&M (Look to Calif)
California has bucked America's maternal mortality trend

*Maternal deaths per 100,000 live births*

SOURCE: California Department of Public Health
Creating Change at Scale
Quality Improvement Strategies used by the California Maternal Quality Care Collaborative

Cathie Markow, RN, MBA\textsuperscript{a,b}, Elliott K. Main, MD\textsuperscript{a,c,*}

KEY POINTS

- Engagement of as many partners as possible in a quality improvement project leads to collective impact.
- Availability of a rapid-cycle low-burden data center is an important support for quality improvement activities.
- National safety bundles and tool kits provide guidance but need to be individualized to meet local resources.
- Working with other hospitals in a formal quality collaborative is an effective way to rapidly improve care.
Four Keys to Change

- **Tool Kits**: Evidence-based tool kits on leading causes of preventable maternal morbidity and mortality.
- **Maternal Data Center**: Near real-time benchmarking data to support hospitals’ quality improvement.
- **Implementation**: Coaching on how to implement best practices and sharing among member hospitals.
- **Engagement**: Engaging partners around aligned goals and promoting patient awareness.

*Fig. 1. The CMQCC 4 key principles for driving change.*
Principle #1: Engage as Many Partners as Possible: Collective Impact is Powerful

Fig. 3. Power of collaborative action leading to collective impact. This has been a key ingredient for the success of all of the CMQCC quality collaboratives. MOD, march of dimes; Prof Orgs (natal and Local), professional organizations (national and Local); EED, early elective delivery.

California Maternal Quality Care Collaborative, 2018
Principle #2: Maternal Data Center to Inform and Manage Quality Improvement

Fig. 5. Hospital variation of NTSV cesarean rates. All 248 California (CA) hospitals, 2015.

Range: 11%—77%
Median: 25.1%
Mean: 25.6%

National target = 23.9%

42% of CA Hospitals meet national target
Principle #3: Tool Kits: Guidance on Best Practices
Principle #4: Implementation Guidance for Successful Engagement and Improvement

• Engagement by medical staff and nursing staff (clinical)
• QI experience and leadership
• Webinars, mentorship, collaboration, partnerships
Part 5: QAPI IS THE KEY

From www.CMS.gov
EMS/Trauma Systems Website

EMS-Trauma Systems

NEW!

Sign up to receive announcements by email regarding the EMS Trauma Systems program. This feature will serve as a tool to increase communication with stakeholders regarding new information added to the website.

Customer Service Survey

We value your feedback. Please take our online customer service survey at [https://www.surveymonkey.com/r/RLUsurvey](https://www.surveymonkey.com/r/RLUsurvey). Thank you.

Welcome to the homepage of the DSHS program that regulates EMS and trauma systems in Texas. This website contains information about EMS certification and licensure, trauma designation, how to contact us and more.

Special message for military personnel and veterans

Emergency Guidance Regarding Professional and Business License and Certification Renewal Applications in Texas Counties Under The Governor’s Disaster Declaration

In accordance with section 418.016 of the Texas Government Code, the Office of the Governor temporarily suspended all necessary DSHS statutes and rules pertaining to professional and business licenses or certification renewal applications, including the suspension of any late fee...
Maternal Levels of Care Designation

The purpose of the Maternal Levels of Care Designation is to implement House Bill 15, 83rd Legislature, Regular Session, 2013, which added Health and Safety Code, Subchapter H, Hospital Level of Care Designations for Neonatal and Maternal Care, Sections 241.181 - 241.197. House Bill 3433, 84th Legislature, Regular Session, 2015 amended Health and Safety Code, Chapter 241 and requires the development of initial rules to create the neonatal/maternal level of care designation by March 1, 2018. The maternal levels of care designation rule became effective on March 1, 2018 and the designation for maternal level of care is an eligibility requirement for Medicaid reimbursement beginning September 1, 2020.

Rules

The maternal designation rule, effective March 1, 2018 is found at the Texas Administrative Code, Title 25, Chapter 133, Subchapter K.

Related Programs

Survey Organizations

American College of Obstetricians and Gynecologists
TETAP Maternal Services and Consultation

Advisory Council

Perinatal Advisory Council

The Perinatal Advisory Council, created by House Bill 15 of the 83rd Texas Legislature (Regular Session), develops and recommends criteria for designating levels of neonatal and maternal care, including specifying the minimum requirements to qualify for each level designation and a process for the assignment of levels of care to a hospital, makes recommendations for dividing the state into neonatal and maternal care regions, examines utilization trends in neonatal and maternal care, and recommends ways to improve neonatal and maternal outcomes.
Maternal Rule

Texas Administrative Code

TITLE 25  HEALTH SERVICES
PART 1  DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 133  HOSPITAL LICENSING

Subchapters

SUBCHAPTER A  GENERAL PROVISIONS
SUBCHAPTER B  HOSPITAL LICENSE
SUBCHAPTER C  OPERATIONAL REQUIREMENTS
SUBCHAPTER D  VOLUNTARY AGREEMENTS
SUBCHAPTER E  WAIVER PROVISIONS
SUBCHAPTER F  INSPECTION AND INVESTIGATION PROCEDURES
SUBCHAPTER G  ENFORCEMENT
SUBCHAPTER H  FIRE PREVENTION AND SAFETY REQUIREMENTS
SUBCHAPTER I  PHYSICAL PLANT AND CONSTRUCTION REQUIREMENTS
SUBCHAPTER J  HOSPITAL LEVEL OF CARE DESIGNATIONS FOR NEONATAL AND MATERNAL CARE
SUBCHAPTER K  HOSPITAL LEVEL OF CARE DESIGNATIONS FOR MATERNAL CARE
SUBCHAPTER L  CENTERS OF EXCELLENCE FOR FETAL DIAGNOSIS AND THERAPY
Texas Administrative Code

TITLE 25
PART 1
CHAPTER 133
SUBCHAPTER K
HEALTH SERVICES
DEPARTMENT OF STATE HEALTH SERVICES
HOSPITAL LICENSING
HOSPITAL LEVEL OF CARE DESIGNATIONS FOR MATERNAL CARE

Rules

§133.201 Purpose
§133.202 Definitions
§133.203 General Requirements
§133.204 Designation Process
§133.205 Program Requirements
§133.206 Maternal Designation Level I
§133.207 Maternal Designation Level II
§133.208 Maternal Designation Level III
§133.209 Maternal Designation Level IV
§133.210 Survey Team
Maternal Rule – Purpose

The purpose of this subchapter is to implement Health and Safety Code, Chapter 241, Subchapter H, Hospital Level of Care Designations for Neonatal and Maternal Care, which requires a level of care designation of maternal services to be eligible to receive reimbursement through the Medicaid program for maternal services.

Source Note: The provisions of this §133.201 adopted to be effective March 1, 2018, 43 TexReg 875
Important Points

• Designation is a formal recognition for a hospital’s maternal care capabilities and commitment to excellence that exceed minimum hospital licensure requirements.

• The hospital’s commitment is evaluated through compliance with the Texas Administrative Code (TAC) requirements.

• The Quality Assurance and Performance Improvement process is essential in the designation program to ensure patients receive appropriate and quality care during their stay in the hospital.

• Peer Review process utilized to evaluate appropriate care and patient outcomes.
The Perinatal Advisory Council (PAC)

• Established in 2013 by HB 15 of the 83rd Texas Legislature
• Charged with providing clinical recommendations to DSHS → fold them into required rules template
  • Detailed for both Neonatal levels of care and for Maternal levels of care
  • Both rules have been adopted now and the PAC (Sunset 2025) will focus on
    • Best practices
    • Trends in neonatal and maternal results post implementation of the new hospital designation programs.
• Maternal levels of care designation rule effective March 1, 2018; designation for maternal level of care is an eligibility requirement for Medicaid reimbursement beginning September 1, 2020
PAC – Role of the Family Physician

• Wide knowledge base allows for comprehensive care with low and moderate risk patients
• May serve as the Maternal Medical Director for Level I or Level II facilities
• May serve as the Primary Provider caring for the obstetric patient
• Must be available to attend all deliveries or other obstetrical emergencies at Level I or Level II facilities
Neonatal and Maternity Designations

Legislation signed into law in 2013 and 2015 and 2019:
Each hospital that provides neonatal and/or maternity care will need to undergo state designation process to receive Medicaid funds
  • Neonatal designation: by September 1, 2018
  • Maternal designation: by September 1, 2021

More Information on the Texas state website:
https://www.dshs.texas.gov/emstraumasytems/maternal.aspx
State Website

- Sign up for email updates
- Print out application to the State
- Texas Admin Code for Maternal Designation
- Survey Organizations

Applications
- Maternal Fetal P Designation

Rules
- The maternal designation rule, effective March 15, 2019 is found at the Texas Administrative Code, Title 25, Chapter 122, Subchapter K.

Survey Organizations
- American College of Obstericians and Gynecologists
- Texas Perinatal Services
Maternal Levels of Care Designation

Resource Documents

These tools may be used to evaluate your facilities compliance with the Maternal Level of Care that you will be applying for. The complete self-assessment tool for Level I facilities with the specific documents to be submitted in the application packet will be posted on June 1, 2018 with the application for designation.

Print out Self Assessment Forms & ACOG Obstetric Consensus Document

Watch State Webinars & PowerPoints and take notes

Level I Maternal - Self-Assessment
Level II Maternal - Self-Assessment
Level III Maternal - Self-Assessment
Level IV Maternal - Self-Assessment
Obstetric Care Consensus

Contact Us

Email: DSHS.EHS-TRAUMA@dshs.texas.gov

For technical assistance, call or email the Perinatal Program Specialist:

Shyrlace Harris - (512) 231-5748
Shyrlace.Harris@dshs.texas.gov

For process or rule clarification, please contact the following:

Designation Program Manager
Elizabeth Stevens, RN - (512) 834-6794
elizabeth.stevens@dshs.texas.gov

Texas DSHS Contact Info: Email if questions
AIM Bundles

**Obstetric Hemorrhage**

**REPEATABILITY**

Every unit
- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

**RECOGNITION & PREVENTION**

Every patient
- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

**RESPONSE**

Every hemorrhage
- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

**REPORTING/SYSTEMS LEARNING**

Every unit
- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee
Edinburgh Postnatal Depression Scale

- Validated for pregnancy, postpartum
- 60+ languages
- Score of 10 or higher = Positive
DAST (Drug Abuse Screening Test) QUESTIONNAIRE

Each item is given 1 point and interpreted as follows:
- Score 0: no problems reported
- Score 1-2: Low level – reassess at another date
- Score 3-5: Moderate level – further investigation
- Score 6-8: Substantial level – intensive assessment
- Score 9-10: Severe level – intensive assessment
Part 6: The Family Physician
Family Physicians

• Patient centered
• Work well in teams
• Flexible based on conditions
  • Well versed on cardiovascular disease
  • Well versed on substance use disorder
  • Well versed on mood disorders
  • Well versed coordinating consultants
Because Most Maternal Deaths Occur After 60 Days...

Role play exercise

• Ms. CD is a 25-year-old G1 P1 woman who brings in her 4-month-old baby for a well child exam.
Family Physicians... Perfectly Positioned to Reduce Maternal Mortality

...BECAUSE FAMILY DOCS

* KNOW PRIMARY CARE
* UNDERSTAND DISEASES THAT PUT PTS AT RISK
* SEE THE CHILDREN...
* ARE GREAT COMMUNICATORS!
Conclusions

1. US & TX Maternal mortality rate RISING vs. other developed countries (FALLING) – aim for < 9/100,000 live births

2. List most common causes of maternal mortality in Texas.
   - < 7 days = hemorrhage & cardiac
   - #1 within 42 days = cardiovascular
   - #1 within 365 days = substance use (opioids)

3. Recommended CDC maternal morbidity conditions
   - 100-150 severe morbidity for every mortality
Conclusions (Cont.)

4. Interventions impacting maternal M&M (CA Collaborative)
   • Evidence and Toolkits
   • Quality & Data
   • Stakeholders

5. QAPI to reduce maternal M&M to their healthcare setting.
   • AIM Bundle for PPH
   • Apply Edinburgh Dep Scale
   • DAST score

6. Unique role of family physicians in maternal M&M
   • Primary Care
   • See children
   • Great communicators
Questions?