MATERNAL AND CHILD HEALTH FELLOWS

DAY THREE

WELCOME BACK!

#NCSLMCHFELLOWS
GETTING READY TO REDISTRICT:
NCSL SEMINARS FOR LEGISLATORS, LEGISLATIVE STAFF AND OTHERS

These seminars are intended for legislators and legislative staff to help prepare them for this once-in-a-decade task. Everyone is welcome though!

❖ June 20-23, 2019 | Providence, R.I.
❖ Oct. 24-27, 2019 | Columbus, Ohio
❖ May 6-10, 2020 | Las Vegas, Nev.
❖ January 2021 | Washington, D.C.
AGENDA FOR TODAY

- Infant Mortality and Maternal Mortality
- Break
- Action Planning and Reflection
- Post Test
- Evaluation
- Reminders
- Wrap up by 11:30 a.m.

INFANT MORTALITY AND MATERNAL MORTALITY

MATERNAL AND CHILD HEALTH FELLOWS PROGRAM
SESSION OVERVIEW

- Purpose
- Introductions
- State Response: Louisiana’s Efforts to Reduce Infant Mortality
- Maternal Mortality in the US
- Question & Answer Opportunity

NATIONAL EXPERTS

- Dr. Lynne Coslett-Charlton
  - Pennsylvania District Legislative Chair, The American College of Obstetricians and Gynecologists
- Jane Herwehe, MPH
  - Data Action Team Lead, Bureau of Family Planning, Office of Public Health, Louisiana Department of Public Health
Perinatal Health and Infant Mortality in Louisiana

Jane Herwehe, MPH
Office of Public Health
Bureau of Family Health

Louisiana’s Population (2016)

Total Population
- 4,681,666 residents
  - 51% female, 49% male
  - 16% female headed families with no husband present

Women of Reproductive Age
- 40% (946,144) of our 2.4 million resident women are age 15 to 44 years

Race - Ethnicity
- 59% non-Hispanic white
- 32% non-Hispanic black
- 5% Hispanic
- 4% non-Hispanic other race

Poverty and Children
- Median income $26,099
- Median income $76,410
- 63% Married no children
- 79% Married with children
- 38% Single, female no children
- 49% Single, female with children
Concentrated Disadvantage

Measures Community Well-Being

- Uses five census variables to rank census tracts within the state (75\textsuperscript{th} percentile)
- Percent of households with children < 18 years old located in areas of highly concentrated disadvantage
- Linked to low social capital
  - Communities with highly concentrated disadvantage have less ability to improve neighborhood conditions, limit neighborhood violence, and intervene in the community for the common good
- Highly concentrated disadvantage areas are linked to poorer outcomes, including overall health, mental health, teen pregnancy and adolescent delinquency, and long-term early individual mortality

Birth Outcomes

Live Births, Fetal Deaths, Infant Characteristics, Mortality
Pregnancy Intention

- Unintended pregnancy is declining in Louisiana
  - 45% (2012) to 37% (2016)
  - Intended: range 41% to 51%
  - Unsure ~15% annually
- Decline observed for both mistimed and unwanted pregnancies

- Opportunities exist

- Offering full range of contraceptive methods with counseling on moderately to most effective methods

Data source: Louisiana PRAMS; note that these data reflect women who have given birth in 2016, not all reproductive age

Live Births

- ~63,000 annually (2016=63,242)
  - ~99% of births occurring in Louisiana are resident women
  - 65.5% Medicaid eligible in 2016

- Little fluctuation annually
Fetal Deaths

- 350-400 reported per year, on average
- Relatively little change over time, overall
- No clear pattern by gestational age group
  - So few reported at 39+ weeks, hard to evaluate
- No clear pattern by geographic region
  - Regions 3 and 5 often on the higher side
  - Regions 7 and 8 often on the lower side
- Persistent black-white disparity (about double, potentially widening)
  - Lower fetal mortality under 28 weeks gestation among black women
  - Greatest disparity at 37-38 weeks gestation and at 39+ weeks for past 2 years

Preterm Birth

- 7,707 preterm births in 2017
- Pronounced geographic and racial disparities persist
- Louisiana 2016 rank = 49
- Required Reduction: \( \sim 2,400 \)^*  

^* To achieve ranking in the top 25% of US states
Repeat Preterm Birth

- Among women who have delivered preterm, about (1 in 3) deliver preterm again in a subsequent birth.
- “39 week variables” indicate about 1/2 were premature rupture of the membrane (PROM) or spontaneous active labor.

Birth Weight

- Louisiana typically ranks among the worst of US states low birth weight.
- About half of very low birth weight (VLBW) births result in infant deaths.
Infant Mortality Over Time

- Decreased for much of 1990s
- Brief period of increase
- Continued decrease since about 2004
- Important racial and geographic disparities persist
- Distribution of timing of 2017 infant deaths

IMR (per 1,000 births)

APC = Annual percent change

Post-neonatal
3.5, N=213 (48%)

Neonatal
3.8, N=231 (52%)

Cause-Specific Infant Mortality

Prematurity Related Infant Mortality

- Louisiana rate was ~33% higher than the US rate of 211.4 in 2014
- Prematurity accounted for 33% of infant deaths in Louisiana in 2016, down from 38% in 2014

Sudden Unexpected Infant Death (SUID) Related Infant Mortality

- Louisiana rate was ~50% higher than the US rate of 87.2 in 2014
- SUID has accounted for ~20% of infant deaths in Louisiana each year

Louisiana rate was ~33% higher than the US rate of 211.4 in 2014
SUID has accounted for ~20% of infant deaths in Louisiana each year
Infant Mortality and Race

- Louisiana exceeds the US rate for infant mortality for both major race groups, however the rate for black women in Louisiana has been more similar to the US rate during several of these years.
- The disparity ratio in Louisiana was 2.6 in 2017
  - ranged from 1.9 (2004, 2008, 2009, 2014) to 2.6 (2017) over time
  - US disparity ranged from 2.2 to 2.5
- From 2001-2015, the average annual percent decrease was
  - 1.9% - LA white
  - 1.3% - US white
  - 2.1% - LA black
  - 2.0% - US black
Focused Interventions to Reduce Infant Mortality

- Medicaid policy changes for contraception access
- Integration of reproductive health services into primary care
- Contraception (intention and spacing)
  - Education and access to a range of contraceptive methods for women interested in contraception
  - Patient-centered counseling on most to moderately effective methods
  - Same day access to Long Acting Reversible Contraceptives (LARC)
- Smoking cessation esp. for residents of reproductive age
- Prevention, early identification and Treatment of sexually transmitted infections (STI)
  - Screening and treatment for all women of reproductive age
  - Multiple time points during pregnancy
- Nutritional counseling through WIC
- Prevention of Preterm birth:
  - Improve preconception health - well visits
  - Working to make sure 17P is available for eligible women

Focused Interventions...

- Early elective delivery / C-section
  - Eliminate early non-medically indicated deliveries
  - Reduce Nulliparous, Term, Singleton, Vertex (NTSV) C-sections
- Risk appropriate care for VLBW infants
- Decreasing adverse maternal outcomes
  - Maternal Mortality Review (PAMR)
  - LaPQC-Hospital quality initiatives through use of standardized protocols and unit drills for early identification and reduction of obstetric hemorrhage and severe hypertension / preeclampsia
- Robust family support and coaching- Nurse Family Partnership and Parents as Teachers
- Infant sleep environment
  - Campaigns
  - Family-centered risk reduction approach addressing modifiable behaviors and practices to reduce infant mortality
  - Inclusion of fathers
- Elevating importance of social determinants and factors (poverty, stress, depression, housing status, discrimination, economic stability, etc)
- Fetal Infant Mortality Review (FIMR)
Takeaways for Policy Makers

• Get to know your Title V program and support its priorities and programs

• Utilize the principles of ethical practice of public health - Public Health Leadership Society www.phls.org

• Conduct a health impact assessment - For more information - the Healthy Community Design Team at healthycommdesign@naccho.org

• View all policy decisions through an equity lens and weigh how local decisions can impact infant mortality (think social determinants of health!)

https://partnersforfamilyhealth.org/
The Maternal Mortality Crisis in the US

How state legislatures can impact improving maternal health outcomes.

Lynne Coslett-Charlton, MD FACOG
American College of Obstetrics and Gynecology District III Legislative Chair
Maternal Mortality in the United States

1. US has a higher rate of maternal mortality than any other developed country
2. As many as 60% of maternal deaths in the US are estimated to be preventable
3. Non-hispanic black women are 3 to 4 times more likely to lose their lives while pregnant or post partum compared to non-hispanic white women
4. For every maternal death in the US, there are 100 women who experience severe maternal morbidity “near misses”
Possible explanations for the rising US rate

Older new mothers with more complex medical histories

50% of pregnancies are unplanned….and many complex health issues are not addressed prior to conception

Increased cesarean section rates, leading to higher comorbidities with current and future pregnancies

Fragmented health care delivery systems, system failures, and access issues

Why are mothers dying in the US?

Hemorrhage

Cardiovascular and coronary conditions

Cardiomyopathy

Infection

Opioid abuse - overdose and suicide
Maternal Mortality Review Committees (MMRC)

Multidisciplinary groups of local experts in maternal and public health, as well as patient and community advocates, that closely examine maternal death cases and identify locally-relevant ways to prevent future deaths.

Traditional public health surveillance using vital statistics can tell us about trends and disparities but MMRCs are intended to comprehensively evaluate each death and identify OPPORTUNITIES FOR PREVENTION.
Maternal Mortality Review Committees

33 States have MMRCs.

14 states (8 including PA in 2018) passed laws establishing MMRCs since 2016.

Laws provide authority to access records and keep data and proceedings confidential.

Most state laws require annual reports to the Legislature including prevention recommendations.

MMRC

For each death:

1. Not pregnant at time of death
2. Pregnant at time of death
3. Not pregnant at time of death but delivered within 42 days
4. Not pregnant at time of death but delivered within 43 days to 1 year
5. Unknown if pregnant
MMRC

Review all maternal deaths and ask 6 key questions:

1. Was the death pregnancy-related?
2. What was the underlying cause of death?
3. Was the death preventable?
4. What factors contributed to the death?
5. What are the recommendations and actions that address the contributing factors?
6. What is the anticipated impact of these actions if implemented?
CDC report on MMRC data from 9 states

Colorado, Delaware, Georgia, Hawaii, Illinois, North Carolina, South Carolina, Ohio, and Utah

680 maternal deaths were reported
237 deaths were found to be pregnancy related

- 38% while pregnant
- 45% within 42 days
- 18% within 43 days - 1 year
WHY ARE PREVENTABLE MATERNAL DEATHS OCCURRING?

1. Patient lack of knowledge of warning signs of trouble
2. Misdiagnosis or insufficient treatment
3. System failures
Racial disparities

Social determinants of health must be considered when evaluating maternal mortality.

Studies have shown that socioeconomic status and geography or location may be related to maternal death (access issues, resource availability).

Racial disparities in maternal death rates are evident and health equity will be incorporated in MMRC discussions.

AIM (Alliance for Innovation in Maternal Health) patient safety bundle addresses racial disparities, focusing on provider education on implicit bias and addressing patient's language and cultural needs.
California Maternal Quality Care Collaborative

Possible preventative deaths: Hemorrhage 70%, Preeclampsia 60%

Developed toolkits for hospitals which once implemented resulted in a 21% reduction in maternal deaths

By 2013 maternal deaths fell to 7/100,000 women, mirroring results in other industrialized nations such as France and Canada

Alliance for Innovation in Maternal Health (AIM)

ACOG (American College of Obstetrics and Gynecology) led initiative to form a national alliance of clinicians, hospital administrators, patient safety organizations, and patient advocates.

AIM creates condition-specific “bundles” which are evidence-based toolkits to improve maternal outcomes.

Examples of bundles include severe hypertension, maternal mental health, obstetric care of women with opioid use disorder, obstetric hemorrhage, and racial disparities in maternity care.
TO PARTICIPATE IN AIM STATES MUST HAVE AN ACTIVE MMRC

Building U.S. Capacity to Prevent Maternal Deaths initiative

Partnership between:

- CDC’s National Center for Chronic Disease Prevention and Health Promotion
- CDC Foundation
- Association for Maternal and Child Health Programs
- Merck for Mothers ($500 million initiative to improve maternal health)

Provides technical assistance to states to establish MMRCs and ensure they are employing evidence based practices in reviewing data
Maternal Mortality Review Information Application (MMRIA)

Application which provides complete, detailed, and organized medical and social data for MMRC use

Provides a standardized database which documents MMRC decisions and analyzes data for action

Allows grouping of regional and national data for greater impact

POTENTIAL FOR POSITIVE IMPACT

1. Adaptation of maternal levels of care for hospitals and birthing centers
2. Improve policies for prevention initiatives
3. Enforce policies and procedures for maternal hemorrhage
4. Improving policies related to patient management
Importance of the “Fourth Trimester”

18% of pregnancy related deaths occur after the traditional 6 week post partum office visit

Medicaid which accounts for almost 50% of US deliveries does not cover maternal care beyond 6 - 8 weeks postpartum, most insurers only cover one visit

40% of patients skip their post partum visit (even greater in low income populations)

ACOG Committee Opinion : “Optimizing Postpartum Care” attempts to address this issue, encouraging a culture change to more intensive postpartum management

HB 1318 The Preventing Maternal Deaths Act

Assists states in creating or expanding maternal mortality review committees

Authorizes federal funding for MMRC ($58 M for each fiscal year 2019-2023)

Signed into law December 2018
Questions?

Lynne Coslett-Charlton, MD FACOG
American College of Obstetrics and Gynecology District III Legislative Chair

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THANK YOU!

BREAK

- Self care
- Network with each other
- Reflect on content and think about your action plan
- Share your ideas with your followers

#NCSLmchfellows
ACTION PLANNING

- Write down last thoughts
- Finalize action plan

Stickies:
- Topics for future webinar/meeting

CONTENT FOR JUNE MEETING & WEBINARS

- Medicaid
  - In schools
  - Waivers
- Childhood Obesity & Nutrition
- Immunizations/Vaccinations
- Neonatal Abstinence Syndrome (NAS)
- Newborn screening
- Possibly:
  - Infertility and In Vitro Fertilization
  - Reducing Teen Pregnancy
  - Reducing Suicide
  - Home Visiting
THINK, PAIR, SHARE

- Reflect on your action plan
- Pick one thing you want to do when you get home
- Pair up with someone at your table and share

POST-ASSESSMENT

"Pull out, buddy! Pull out... You've hit an artery!"

NATIONAL CONFERENCE OF STATE LEGISLATURES
7. Complete the number sentence. Show your thinking.

53 + 25 = 78

NCSL SUPPORT AND TECHNICAL ASSISTANCE

- Periodic e-Newsletter
  - News, resources, Fellows’ activity
- Check-in email/call
- NCSL resources and publications
- Research and informational memos
- Providing testimony or helping identify and invite experts
- Supporting a hearing or informational session in your state
- Convening stakeholders in your state to hear from experts and discuss an issue
- Connecting you with national experts, other legislators, state officials, etc.
SEE YOU SOON!

- Webinar #1: Friday, March 1, 2 p.m. ET
- Webinar #2: Friday, April 12, 2 p.m. ET
- Second Meeting: June 23-25 or June 17-19 in Denver, Colo.
  - Optional meeting for HHS Chairs: June 25-27 or June 19-21