TEXAS
Health and Human Services

Texas Department of State Health Services

TexasAIM Summit

Holding and Building the Gains

Wednesday, December 9th 2020

8:00 AM – 12:45 PM CST

Welcome and Orientation to the Platform

Julie Stagg, MSN, RN, IBCLC, RLC, CPHQ

Healthy Texas Mothers and Babies (HTMB) Branch Manager

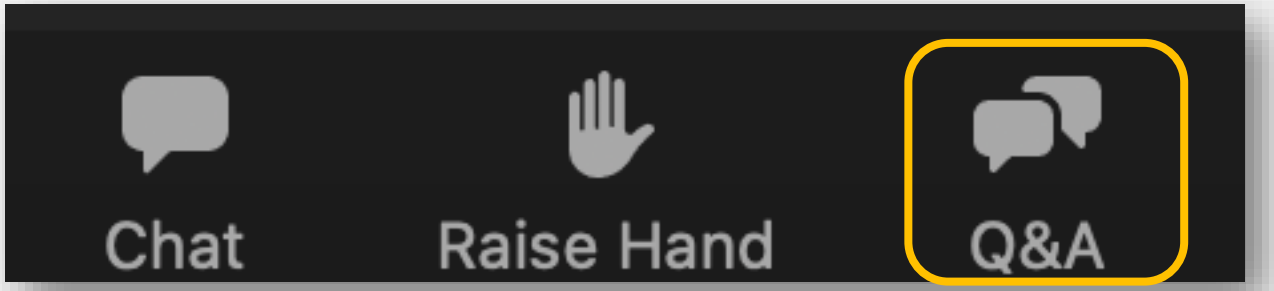
TexasAIM Program Director, DSHS

Housekeeping

- **Thank you for joining Day 2 of the TexasAIM 2020 Virtual Summit!**
- Today's Summit is being **recorded.** All conference documents, slides and recordings will be made available to you after the Summit concludes.
- **At the end of each day, please complete an evaluation survey.** A link will be shared in the chat and via email.

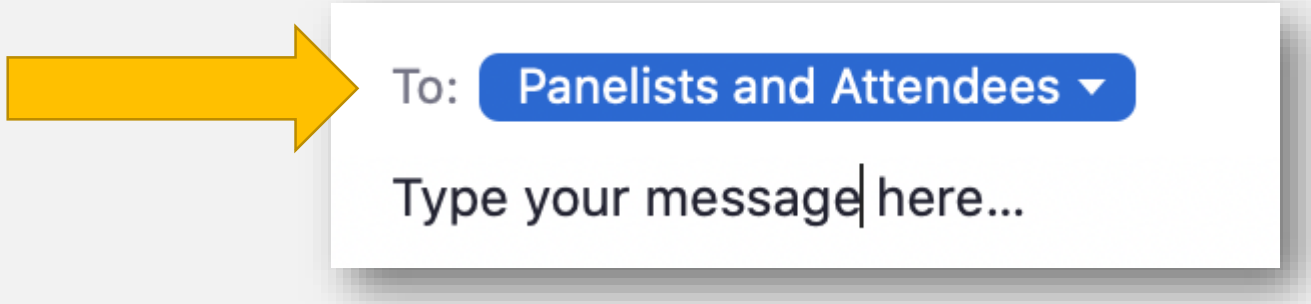
We want to hear from you!

- Your feedback is very important, and speakers want to hear from you!
- If you have questions for the panelist, please submit these in the **Q&A box**.



Interacting with Attendees

- Please use the **Chat box** to engage with the other attendees and panelists.
- When using the chat box, you can select who you want your message to go to. **Select To: Panelist and Attendees for your message to go to everyone**



Technical Difficulties

- **Tips for Technical Difficulties:**
  - Check your WiFi signal strength
  - Try restarting
  - Log off and log back on
- **For additional support, contact:**
  - Jon Gibson at jgibson@utsystem.edu, by chat or text to 512-695-4351

Continuing Education Units

Continuing Education Credits

Continuing education credit/contact hours for this event are provided by The Texas Department of State Health Services, Continuing Education Service and include the following:

Continuing Medical Education:

The Texas Department of State Health Services, Continuing Education Service is accredited by the Texas Medical Association to provide continuing medical education for physicians.

The Texas Department of State Health Services, Continuing Education Service designates this live activity for a maximum of 8.00 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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To receive continuing education credit or a certificate of attendance participants must:

- Complete registration and sign into the sessions using the Zoom link sent to you prior to the event;
- Attend all sessions for each day requesting credits for;
- Participate in education activities;
- Complete and submit evaluation at the end of each day.

Disclosure to the Learner

Commercial Support

This educational event received no commercial support.

Disclosure of Financial Interest

The following Planning Committee members and speakers for this event have disclosed financial interest(s):

- Name of Planning Committee Member/speaker- Veronica Gillispie-Bell
- Name of commercial interest- Abbvie, Inc/Lecturio GnRH
- Nature of the relationship- consultant and speaker's bureau/material support

Non-Endorsement Statement

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The speakers did not disclose the use of products for a purpose other than what it had been approved for by the Food and Drug Administration.

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Continuing Education Attendance and Evaluation

- To receive CEU credits you must attend all sessions for Day2 (12/09).
- If you are requesting CEU credits, you must complete **TODAY** the Continuing Education Evaluation for TexasAIM Summit Day 2 (12/09) that will be sent to you this afternoon.
- If you are requesting CEU credits but attending the meeting with another colleague and did NOT log into Zoom, please request your CEU Attendance Verification Package via email at TexasAIM@dshs.texas.gov and Yahaira.Rodriguez@dshs.texas.gov within 24 hours after the completion of today's events. TexasAIM team will email you an Attendance Verification Package for you to complete.

Continuing Education – Summit Objectives

At the completion of this summit, participants will be able to:

1. Describe strategies to implement practice improvements for readiness, recognition and prevention, response, and/or reporting and systems learning for prevention and management of obstetric hemorrhage and severe hypertension in pregnancy.
2. Explain state and national patient care practice recommendations and standards.
3. Identify two or more recommendations for addressing factors that contribute to preventable maternal mortality and morbidity in Texas.
4. Identify two or more actions that can be incorporated into practice to support patient-centered care.
5. Identify two actions that can be incorporated into practice to support equity in healthcare.

TexasAIM 2020 Summit

Monday
Leadership Meeting

- Administrative and clinical leadership
- Abbreviated review of OBH success
- Introduction to HTN and team needs
- Encourage ongoing support for hospital teams

Tuesday
OBH Bundle

- Celebration of OBH bundle progress
- Enter sustainability mode for this work
- Discuss alignment with state and national priorities

Wednesday
HTN bundle

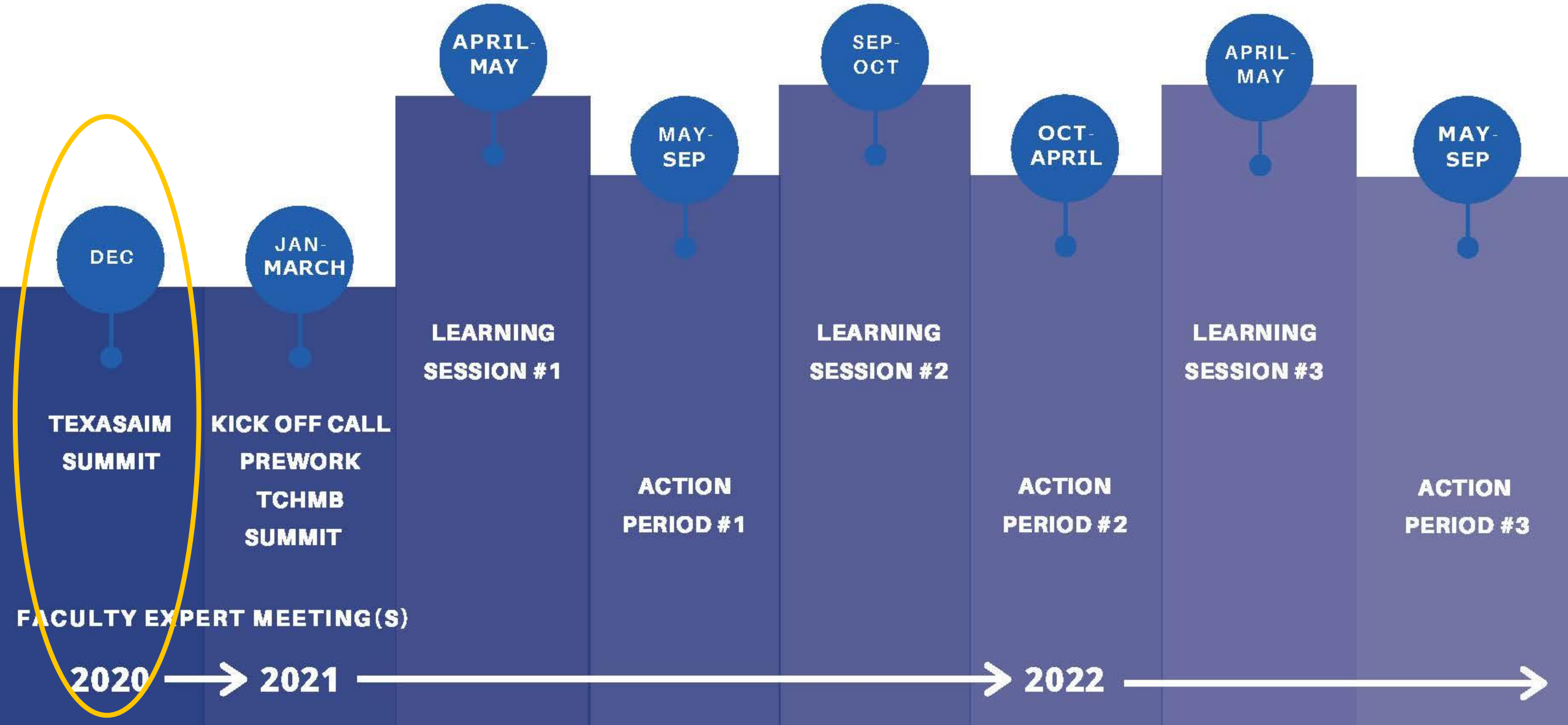
- Roll-out of HTN Bundle
- Review data behind why this bundle is important for Texas
- Discuss equity work within HTN Bundle
- Patient and family support

Today's Agenda

- Setting the Stage for the Severe Hypertension in Pregnancy Bundle
- Integrating and Centering Health Equity into Bundle Implementation and Process Improvement
- Centering Survivor Voices for Patient and Family Support
- The Next Phase of the Journey: The TexasAIM Plus Severe Hypertension in Pregnancy Learning Collaborative

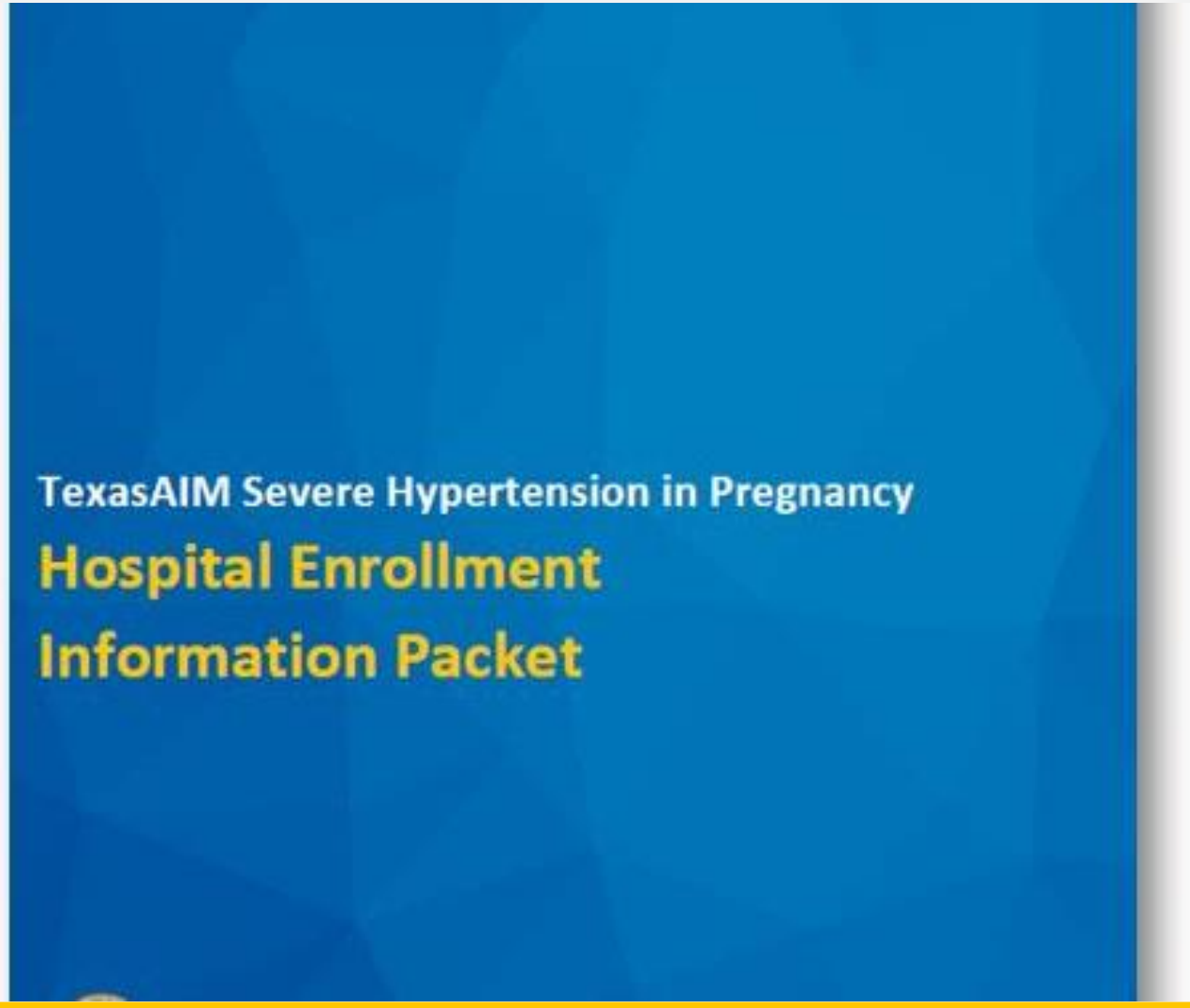
TexasAIM Safe Care for Every Mother

HTN Learning Collaborative Timeline



Materials available on Basecamp

https://public.3.basecamp.com/p/yftEZsUkMwdDpZDBbieyK2WU



THANK YOU UT TYLER TCHMB TEAM

Setting the Stage for the Hypertension Bundle

Patrick Ramsey, MD, MSPH

Lisa Hollier
MD, MPH

Ann Borders
MD, MSc,MPH

Christine Greer, RN

Sherry Jones
MD, MPH

Barbara O'Brien
MS, RN

April Adams, RN

Stacy Elfrink, MD

Welcome and Introductions

Setting the Stage for the Maternal Hypertension Bundle

Lisa M Hollier, MD, MPH, FACOG

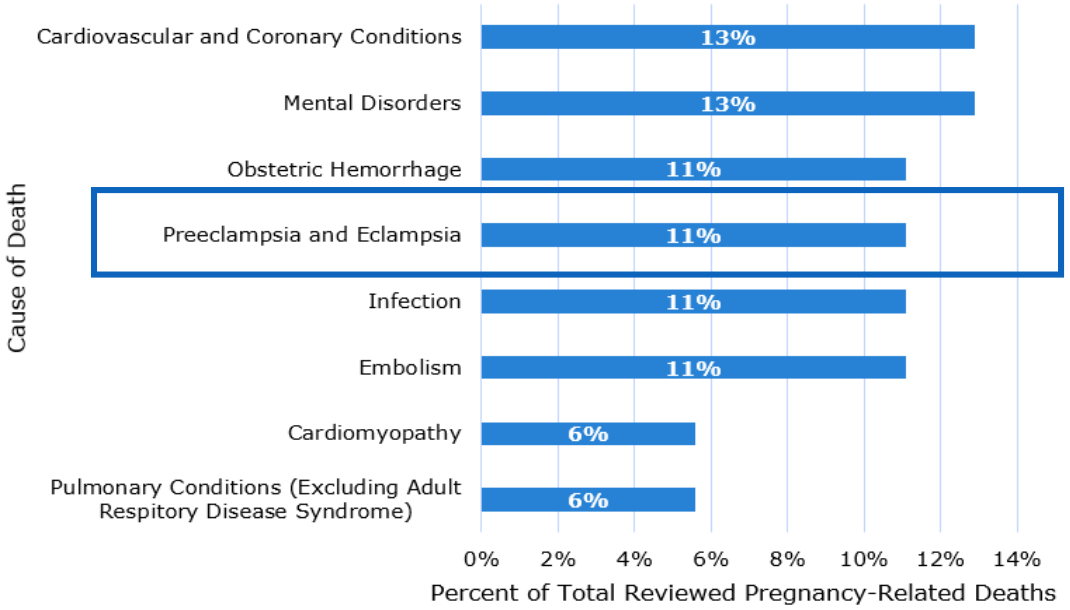
12/7/2020

Pregnancy-Related Death Case Review Findings

Cause of Death

Eight underlying causes of death accounted for 82 percent of all pregnancy-related death among reviewed 2013 cases.

Chart F-1: Leading Underlying Causes of Reviewed Pregnancy-Related Deaths, Texas, 2013 (N=44 of 54 Reviewed Pregnancy-Related Deaths)[i]

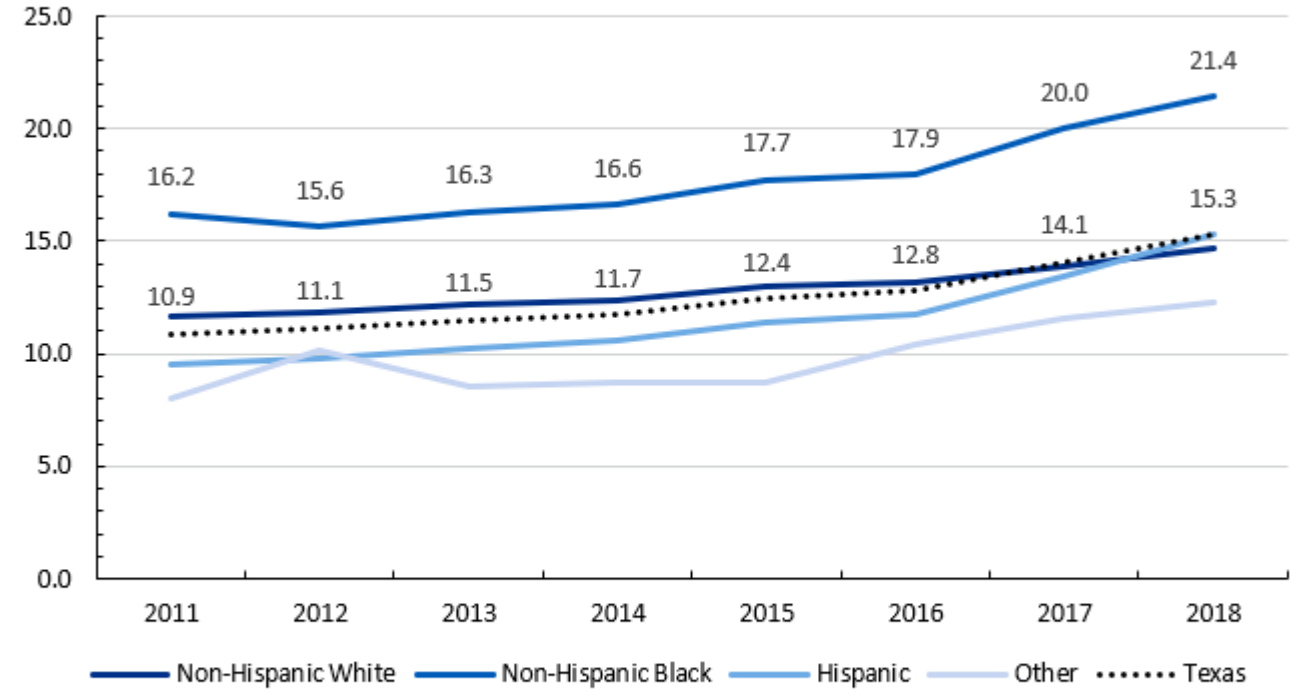


PREPARED BY: Healthy Texas Mothers and Babies Branch, Maternal & Child Health Unit, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Disparity in Hypertension

Rates of delivery hospitalizations involving hypertensive disorder were highest among Non-Hispanic Black mothers and varied by county.

Figure H-4: Delivery Hospitalization Involving Hypertensive Disorder Rates by Race/Ethnicity, Texas, 2011-2018[i]

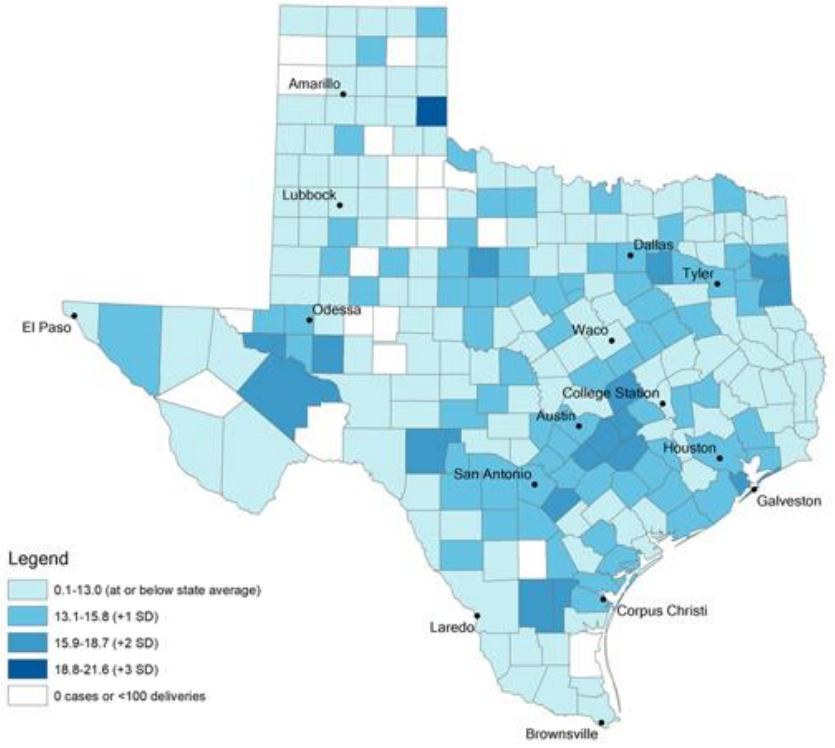


[i]PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Disparity in Hypertension

Rates of delivery hospitalizations involving hypertensive disorder were highest among Non-Hispanic Black mothers and varied by county.

Figure H-5: Rate of Delivery Hospitalization Involving Hypertensive Disorder per 10,000 Delivery Hospitalizations by County of Residence, Texas, 2013-2018[i]



[i]PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

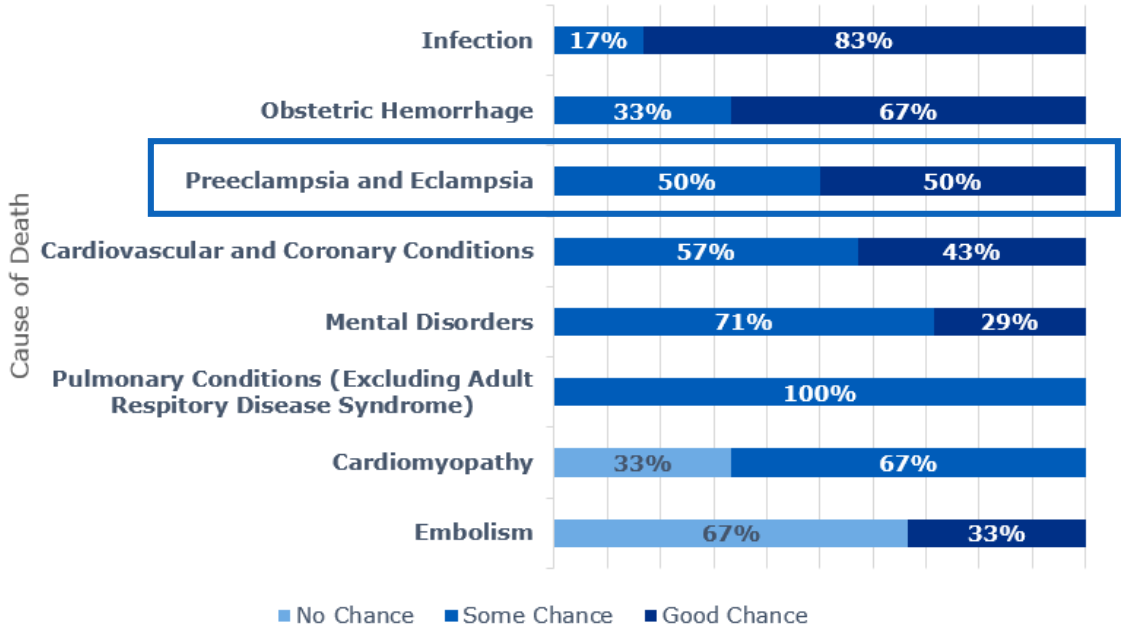
Preventability

Most pregnancy-related deaths were preventable.

89 percent of the reviewed pregnancy-related deaths in 2013 were *preventable*.

A death is considered *preventable* if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, community, provider, or systems factors.

Chart F-3: Degree of Preventability for Top Underlying Causes of Reviewed Pregnancy-Related Deaths by Rating of Chance to Alter Outcome, Texas, 2013 (N=44 of 54 Reviewed Pregnancy-Related Deaths)[i]



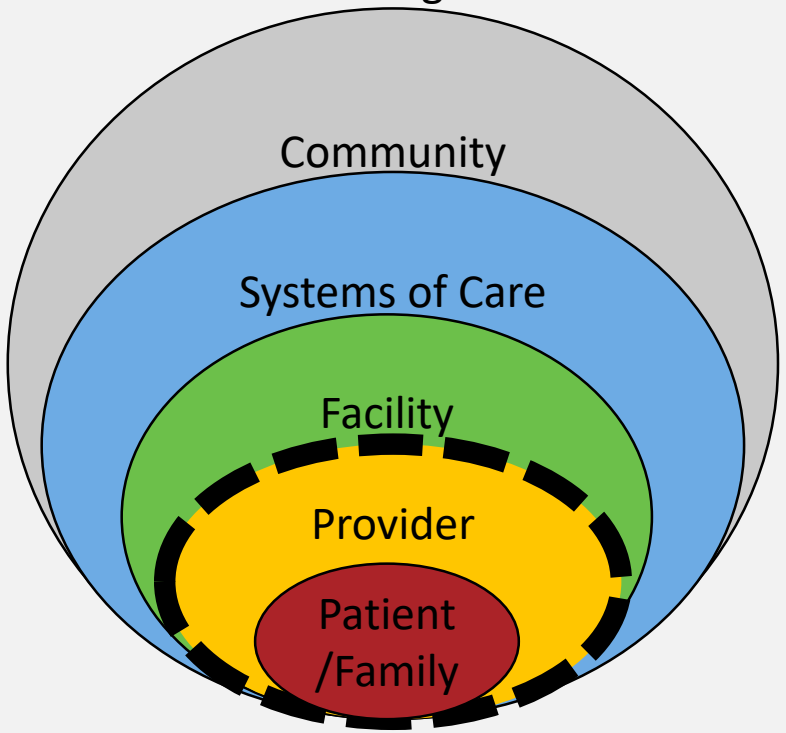
PREPARED BY: Healthy Texas Mothers and Babies Branch, Maternal & Child Health Unit, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Contributing Factors

Top Contributing Factors Identified by the Texas Maternal Mortality and Morbidity Review Committee: Provider Domain (24%)

1. Clinical Skill/Quality of Care (22%)
2. Lack of Continuity of care (14%)
3. Delay - referring for care, treatment, or follow up care/action (13%)
4. Knowledge- inadequate education, knowledge or understanding (14%)
5. Failure to screen/inadequate assessment of risk (13%)

Domains of Contributing Factor Themes in a Social-Ecological Model

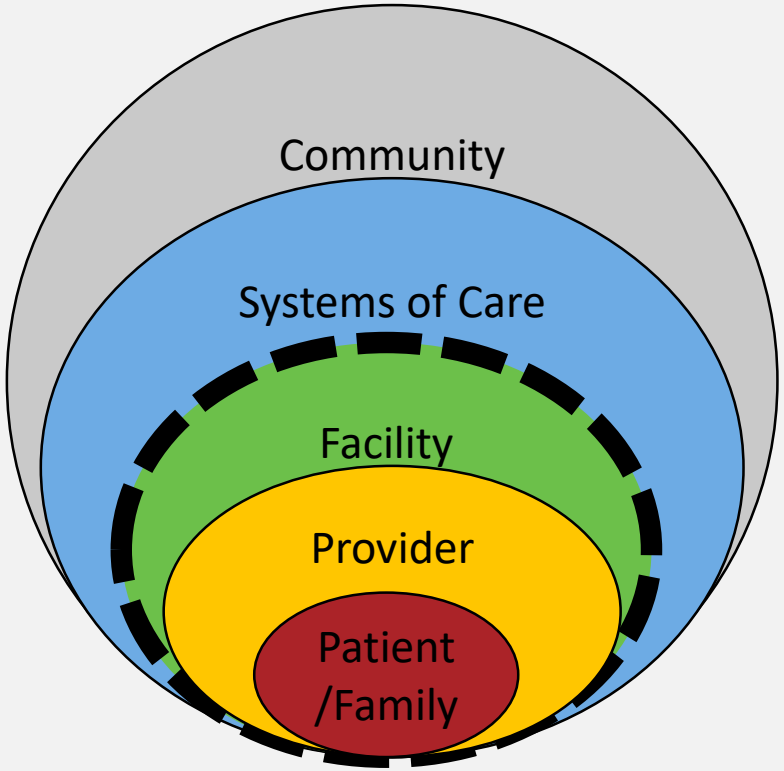


Contributing Factors

Top Contributing Factors Identified by the Texas Maternal Mortality and Morbidity Review Committee: Facility Domain (17%)

1. Lack of Continuity of Care (17%)
2. Clinical Skill/ Quality of Care (14%)
3. Delay (13%)
4. Lack of Standardized Policies and Procedures (11%)
5. Lack of knowledge regarding the importance of the event or of treatment or follow-up (10%)

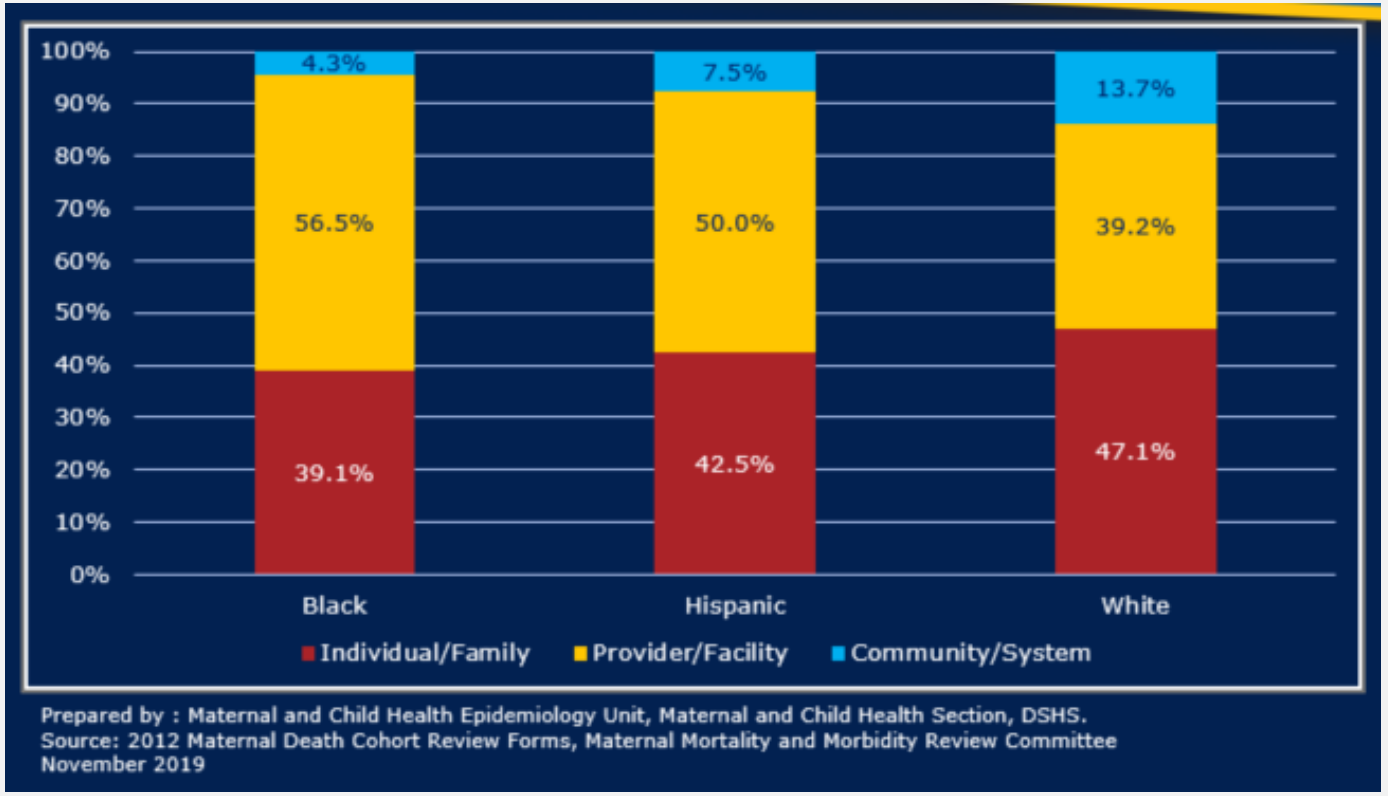
Domains of Contributing Factor Themes in a Social-Ecological Model



Contributing Factors

A complex interaction of factors contributed to disparities in maternal mortality and morbidity.

Contributing Factor Domains by Race/Ethnicity Among Pregnancy-Associated, Pregnancy-Related Deaths, 2012 (n=154)



Texas Maternal Mortality and Morbidity Review Committee Recommendations

Recommendation:

Implement statewide maternal health and safety initiatives to reduce maternal mortality and morbidity.

Recommendation:

Improve postpartum care management and discharge education for patients and families.

Thank you!

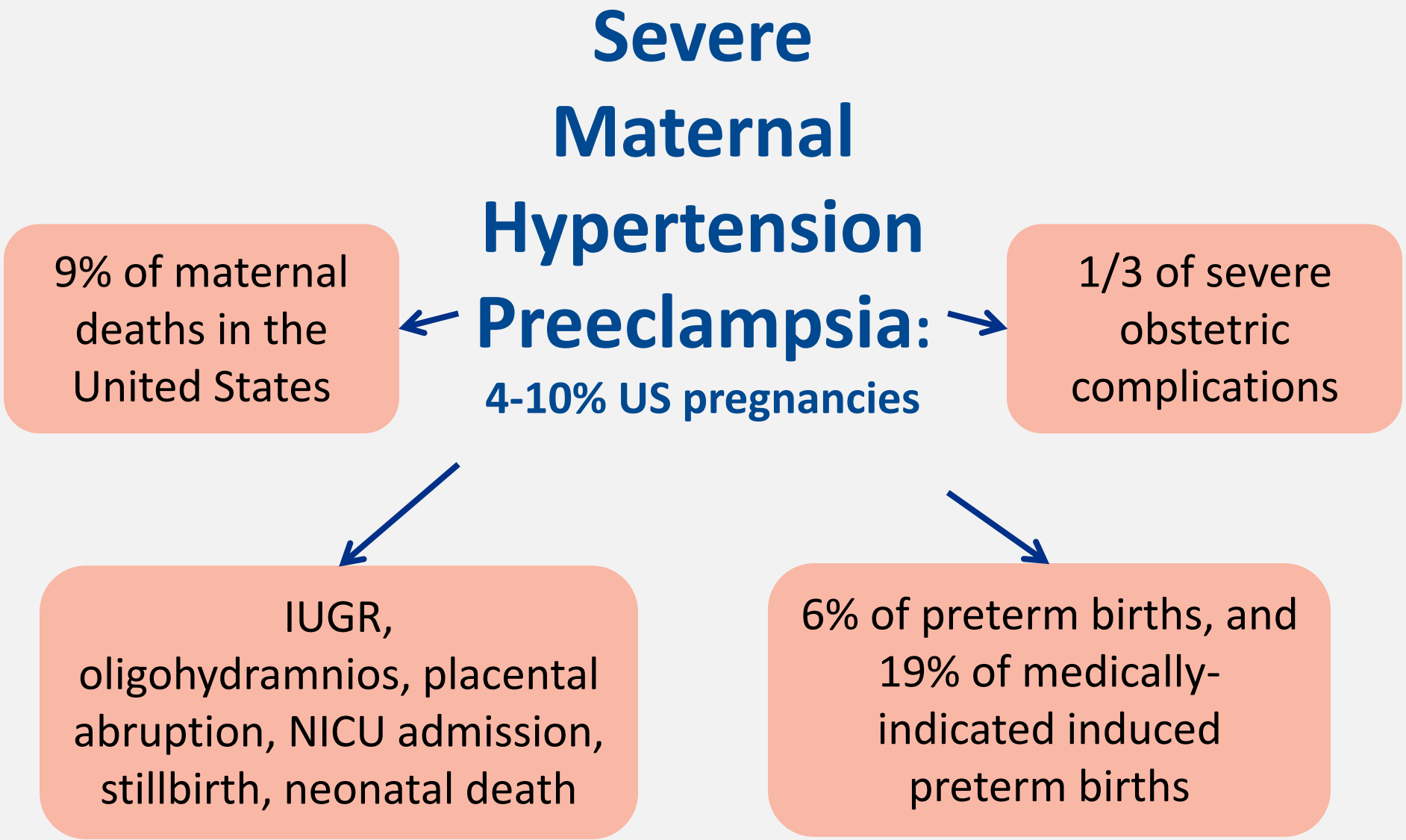
Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services:
2020 JOINT BIENNIAL REPORT

Email: maternalhealth@dshs.texas.gov

Illinois Perinatal Quality Collaborative: Maternal Hypertension Initiative

Ann Borders, MD, MSc, MPH
Executive Director,
Illinois Perinatal Quality Collaborative
Maternal-Fetal Medicine, NorthShore University Health

Why we do this work



Why we do this work

The New York Times | https://nyti.ms/2cShjiS

HEALTH

Maternal Mortality
Defying Global Tren

By SABRINA TAVERNISE SEPT. 21, 2016

The Washington Post

Wonkblog

Our maternal morta
is

By Christopher Ing

nal mortality in the u.s.

Hemorrhage, Don't Clean Up':
From Mothers Who Almost Died

NINA MARTIN RENEE MONTAGNE FROM

npr

SPECIAL SERIES
lost mother

Giving Birth. Shalon Irving's Story
Explains Why

NINA MARTIN RENEE MONTAGNE

irth

By ALEXANDRA SIFFERLIN September 27, 2016

Importance of Timely Treatment of Severe Maternal Hypertension

- Primary cause of maternal death is hemorrhagic stroke caused by untreated severe hypertension
- National guidelines recommend timely treatment of severe hypertension < 60 min to reduce maternal stroke and severe maternal morbidity, endorsed by ACOG
- Alliance for Innovation on Maternal Health (AIM) Severe Hypertension in Pregnancy Maternal Safety Bundle

ILPQC Maternal Hypertension Initiative

Aim: Reduce the rate of severe morbidities in women with severe preeclampsia, eclampsia, or preeclampsia superimposed on pre-existing hypertension by 20% by December 2017

Approach: 4 key goals

1. **Reduce time to treatment**
2. **Improve postpartum patient education**
3. **Improve postpartum patient follow up**
4. **Improve provider & RN debrief**

- 110 hospital teams - May 2016 kick off to December 2017
- 106 Hospitals submitted data for over 17,000 women who experienced severe maternal HTN across the initiative
- Sustainability started January 2018
- 86 teams have submitted sustainability data

Project Aims

By December 2017, for all women with confirmed severe maternal HTN across participating hospitals:	Goal
Increase the proportion of women treated for severe HTN in < 60 minutes	≥ 80%
Increase the proportion of women receiving preeclampsia education at discharge	≥ 80%
Increase the proportion of women with follow-up appointments scheduled within 10 day of discharge	≥ 80%
Increase the proportion of cases with provider / nurse debriefs	≥ 50%
Reduce the rate of severe maternal morbidity (SMM)	↓20%

How do we improve care?

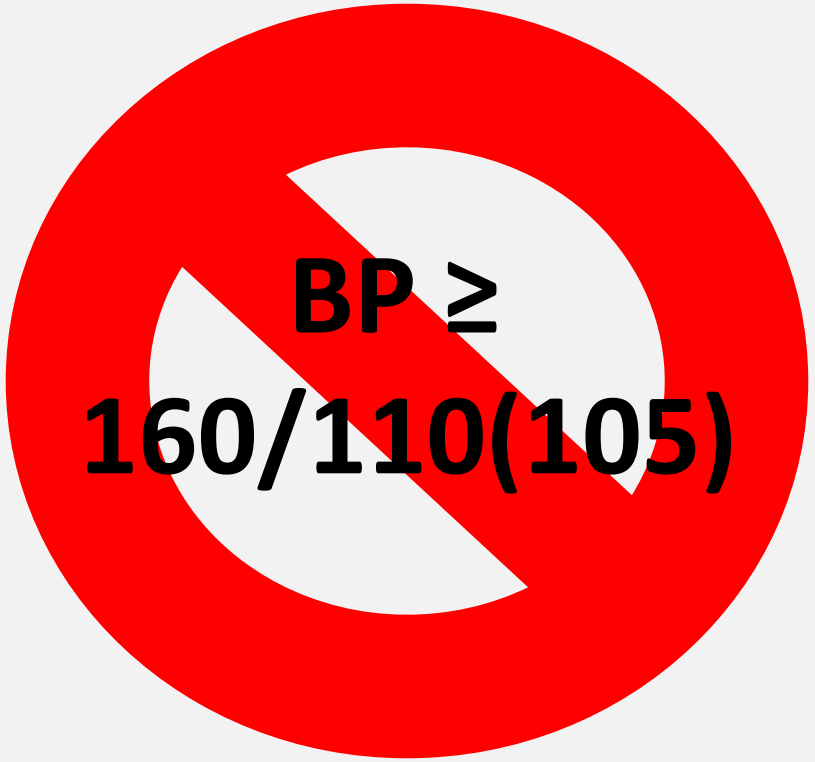
- Early recognition of hypertension and correct diagnosis during and after pregnancy
- Reduce time to treatment of severe range blood pressure, 160/110(105)
- Provide patient education and appropriately timed follow up
- Implementation of evidence based protocols for treatment and management of severe HTN / preeclampsia / eclampsia

Key Clinical Pearl: 160/110 vs. 160/105

Controlling blood pressure
is the optimal intervention
to prevent deaths due to stroke
in women with preeclampsia.

The critical initial step in decreasing maternal morbidity and mortality is to administer **anti-hypertensive** medications as soon as possible (< 60 minutes) of documentation of persistent (retested within 15 minutes) BP ≥160 systolic, and/or ≥105-110 diastolic

Clark SL, Hankins GD. Preventing maternal death: 10 clinical diamonds. Obstet Gynecol 2012;119:360–4.



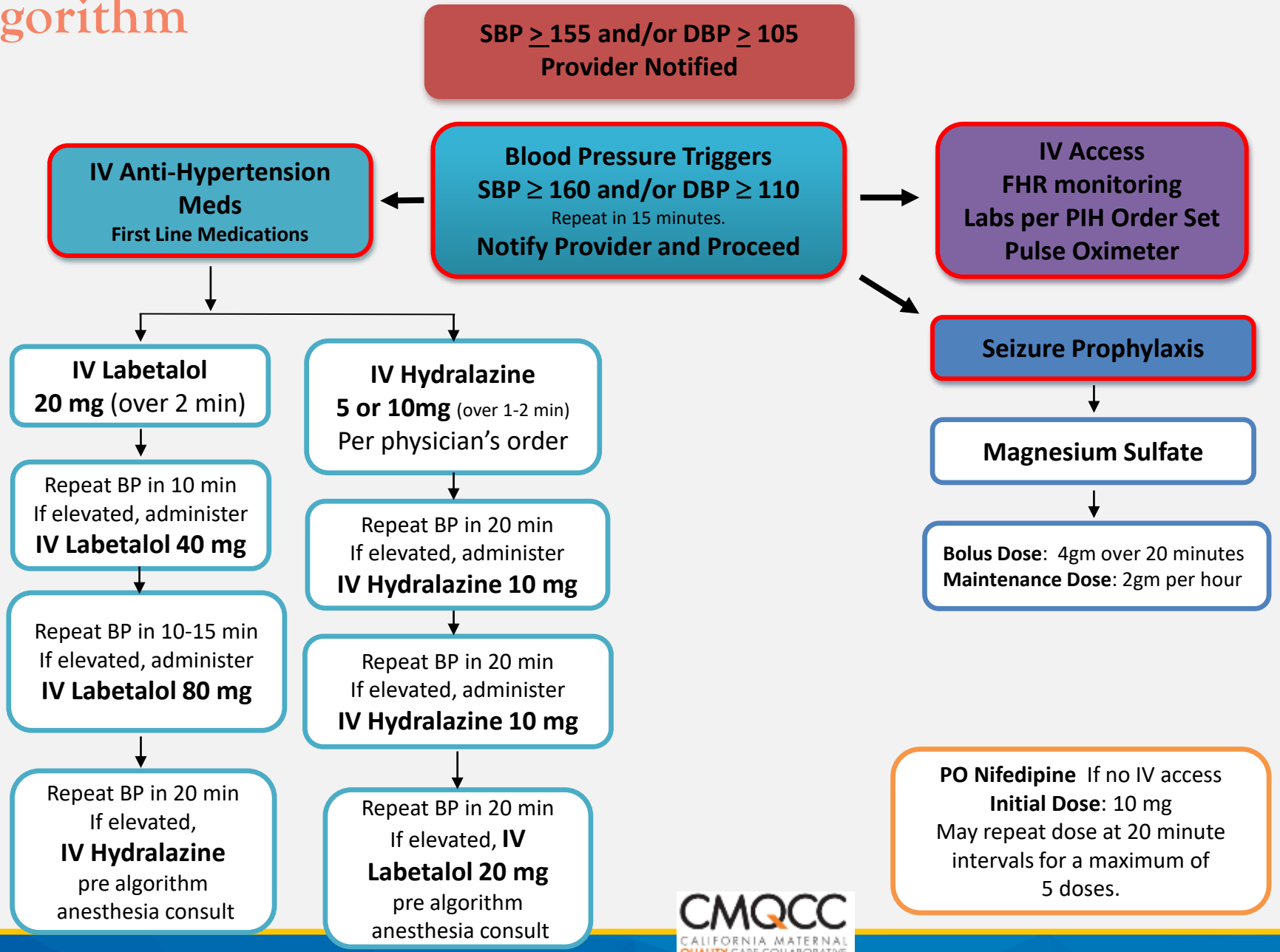
Need To Treat*

*BP persistent 15 minutes, activate treatment algorithm with IV therapy ASAP, < 30-60 minutes

Quality Improvement Focus

- Provider / staff education and standardized BP measurement
- Rapid access to medications
- IV treatment of BP's ≥ 160mmHg systolic or ≥ 110(105) mmHg diastolic within 30-60 min
- Standardize treatment algorithms / order sets
- Provider / nurse debrief time to treatment
- Early postpartum follow-up
- Standardized postpartum patient education

Severe Hypertension Treatment Algorithm



Data Collection

- Process and outcome measures collected by ongoing monthly chart review by hospital teams
- Inclusion criteria
  - All first cases of severe maternal HTN during pregnancy through 6 weeks postpartum in participating hospitals
  - Severe Maternal HTN defined as BP ≥ 160/110 persistent for ≥ 15 minutes
- Timeline
  - Baseline: October – December 2015
  - Initiative Launch May 2016
  - Monthly data collection through December 2017
  - Monthly compliance data collection ongoing

Key Measures

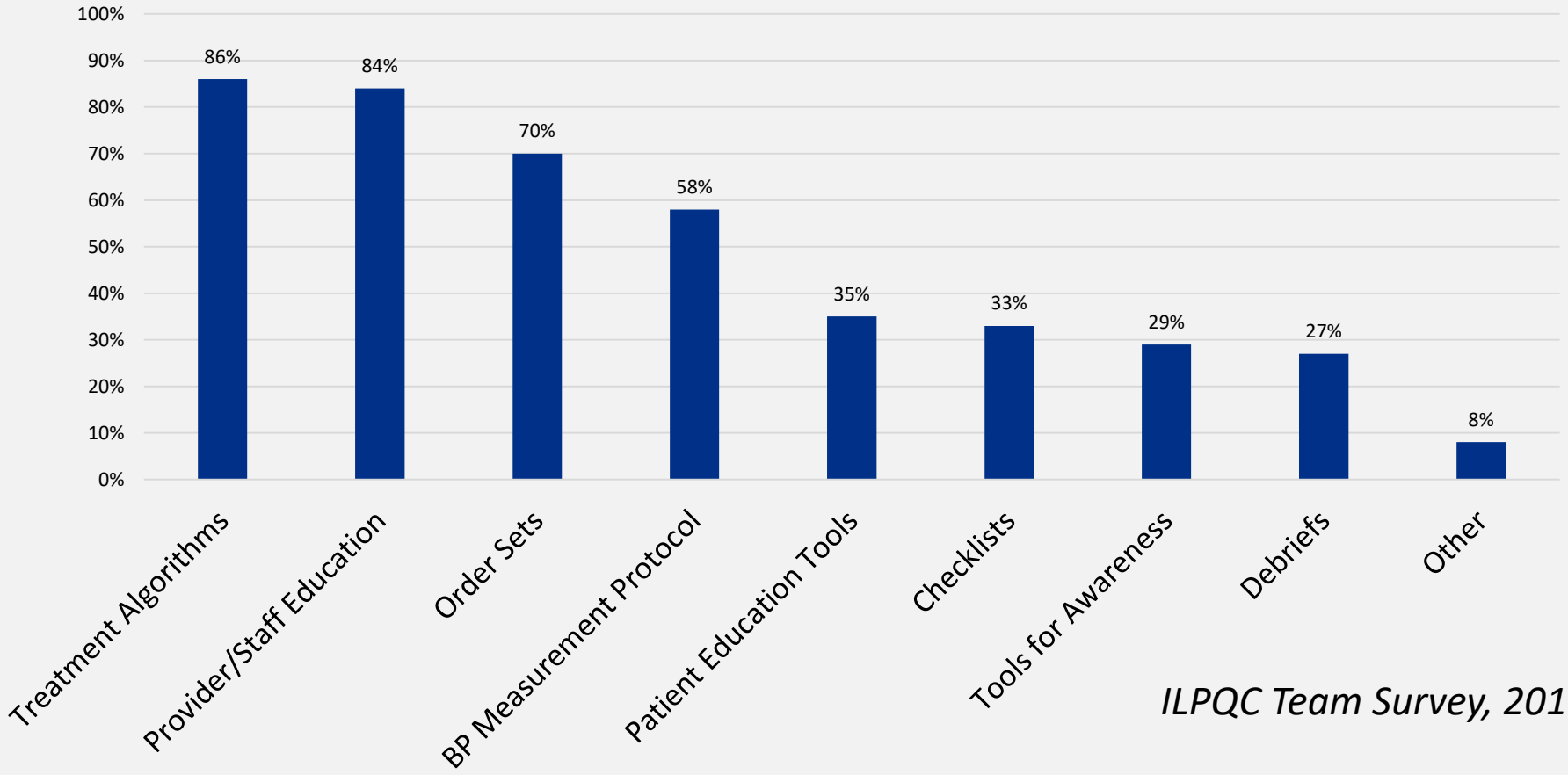
- **Outcome:** Severe Maternal Morbidity
- **Process:** Time to treatment, Patient discharge education, Patient follow up visit< 10 days, Debrief
- **Balancing:** Hypotension, Fetal heart rate
- **Structure:**
  - Facility-wide protocols for timely identification and treatment of severe maternal hypertension
  - Provider /nurse education on HTN protocols
  - Rapid access to IV medications
  - System plan for escalation of care
  - Facility-wide protocols for patient education

TEXAS Health and Human Services

Texas Department of State Health Services

Reducing Time To Treatment

Elements of Maternal Hypertensive Bundle Most Effective in Reducing Time to Treatment

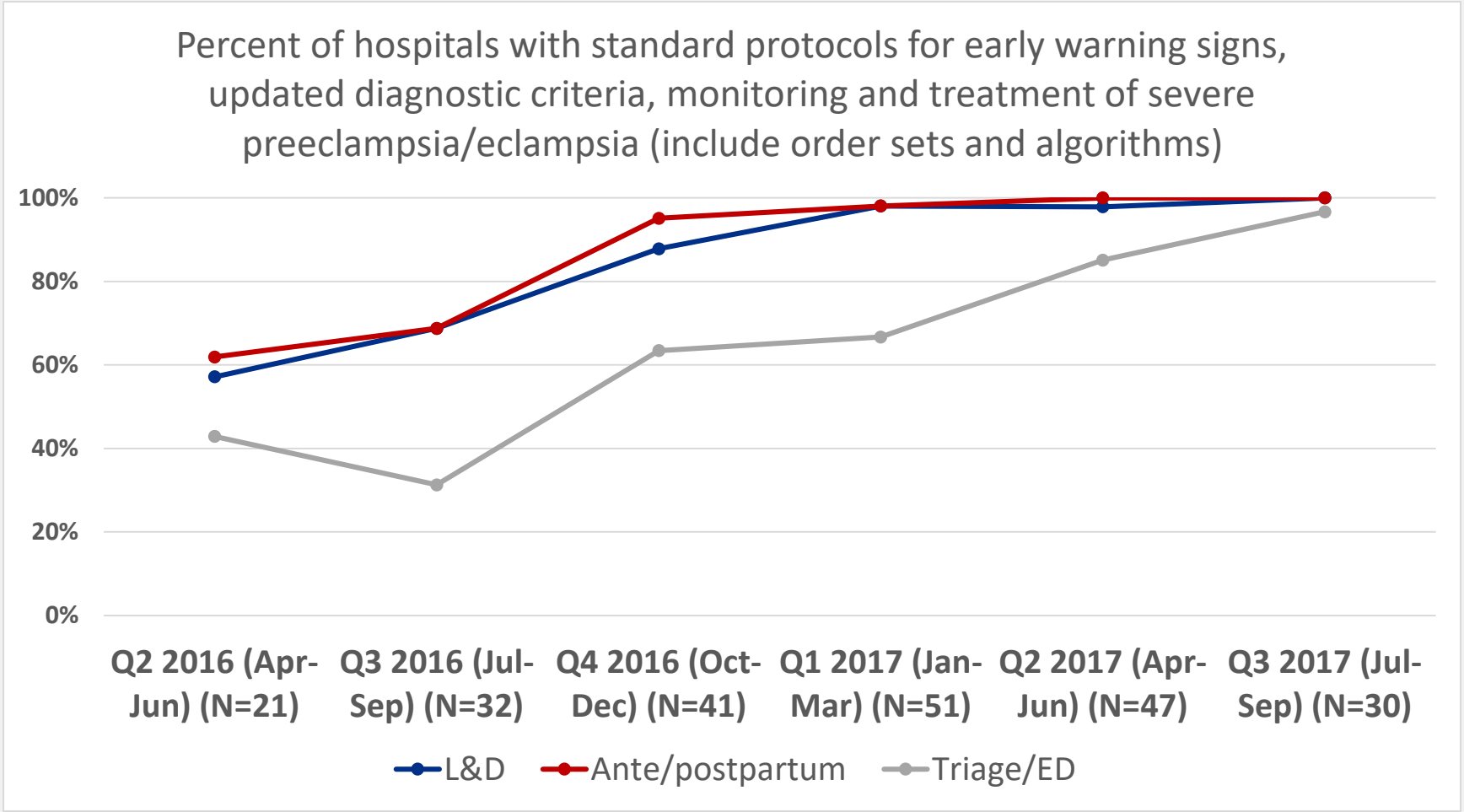


ILPQC Team Survey, 2017

Strategies to Reduce Time to Treatment

- Partner with pharmacy for quicker access to IV HTN meds in all units using: standing orders, availability in PYXIS & override of antihypertensives
- Changing policies on telemetry with IV meds, labetalol
- Facilitate consistent and timely interdepartmental communication using: nurse champions to carry to all units; debriefs, huddles, daily rounds, individual feedback to discuss cases; share REDCap data with staff and providers
- Adapt and implement protocols, checklists, and standard order sets across units

Structure Measure: Standard Policies / Protocols Across Units



Strategies to Implement Protocols / Order Sets

- Develop interdisciplinary committee to review algorithms and order sets for implementation using Plan/Do / Study / Act = small test of change = test 1 provider, 1 patient, 1 day or test 1 unit for 1 week
- Integrate into EMR
- Develop easily accessible printed algorithms & order sets (e.g. bedside clipboard, pocket card order sets)
- Use key words in nurse provider communications: "*your patient has severe range hypertension", report BPs, "I would like to activate severe HTN protocol*"
- Post severe HTN time to treatment sign across units

Effective Steps to Implement Standard Protocols

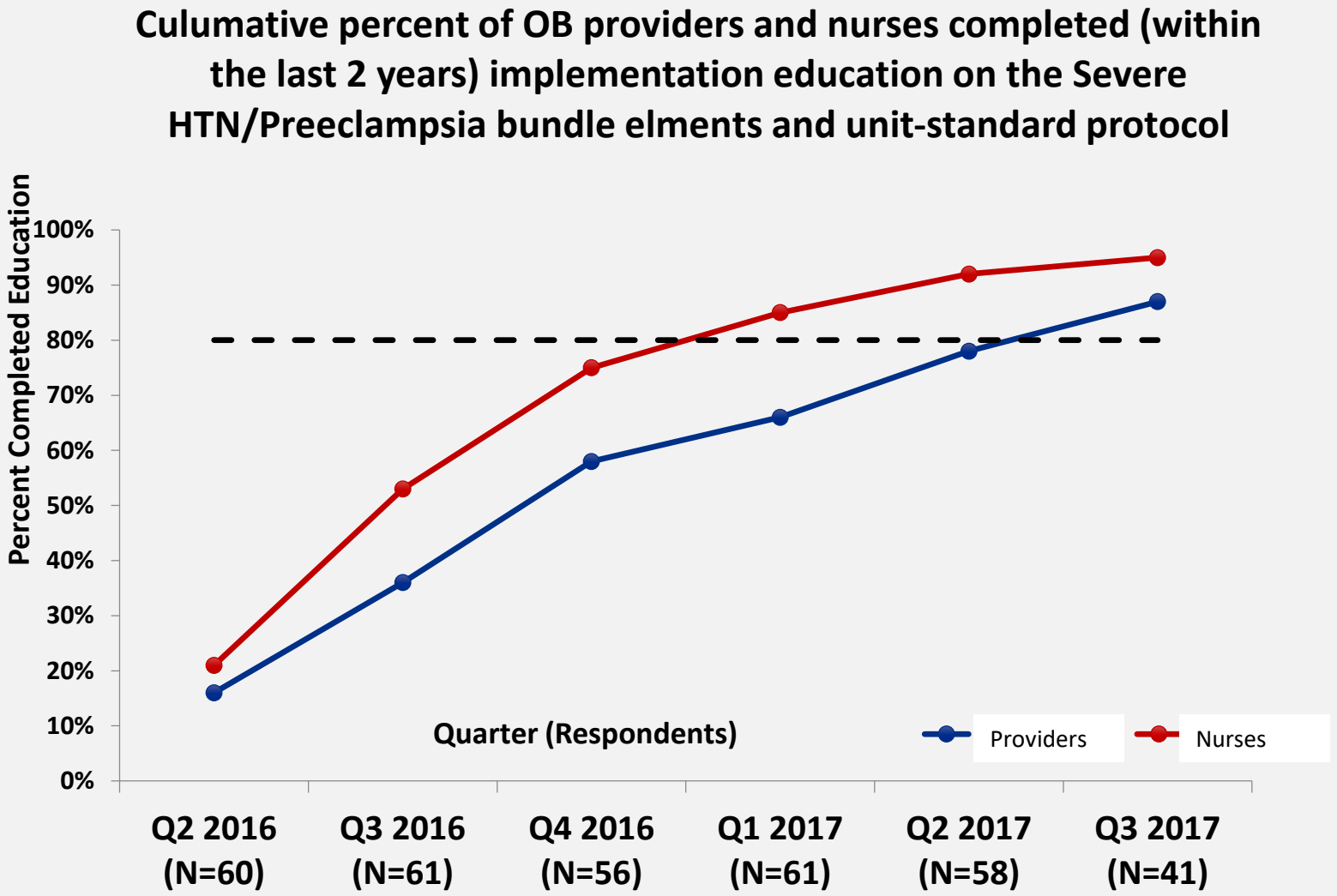
ILPQC Team Survey, 2017

We reiterate what the goal is at physician OB department meetings and work closely with OB chair to promote an overall culture of safety where the chain of command is used and event reporting is done to determine trends.

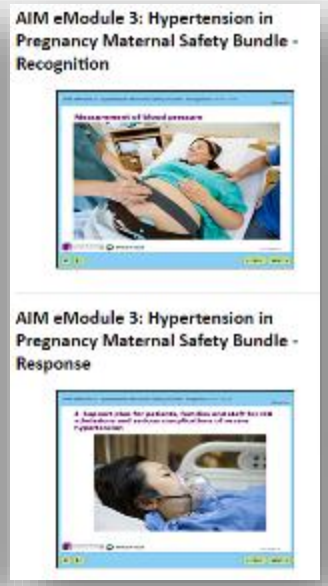
We have updated policies and created a protocol for management of severe HTN that is posted in all rooms with other visual aides.

We use common order set for all units. ED knows that they have the full support of the OB unit and can call at anytime for us to facilitate the treatment of possible patient

Structure Measure: Provider & Nurse Education



Education Tools for Physician/Nurse Buy In



AIM eModules	Severe Maternal HTN Grand Rounds
Available on AIM website. Quiz at end with certificate - can ask providers/staff to submit certificate. View eModules here.	Available to download from ILPQC website (or click here). Speakers group available to provide Grand Rounds across the state. Email info@ilpqc.org for more information.

Effective Steps to Implement Education Program

ILPQC Team Survey, 2017

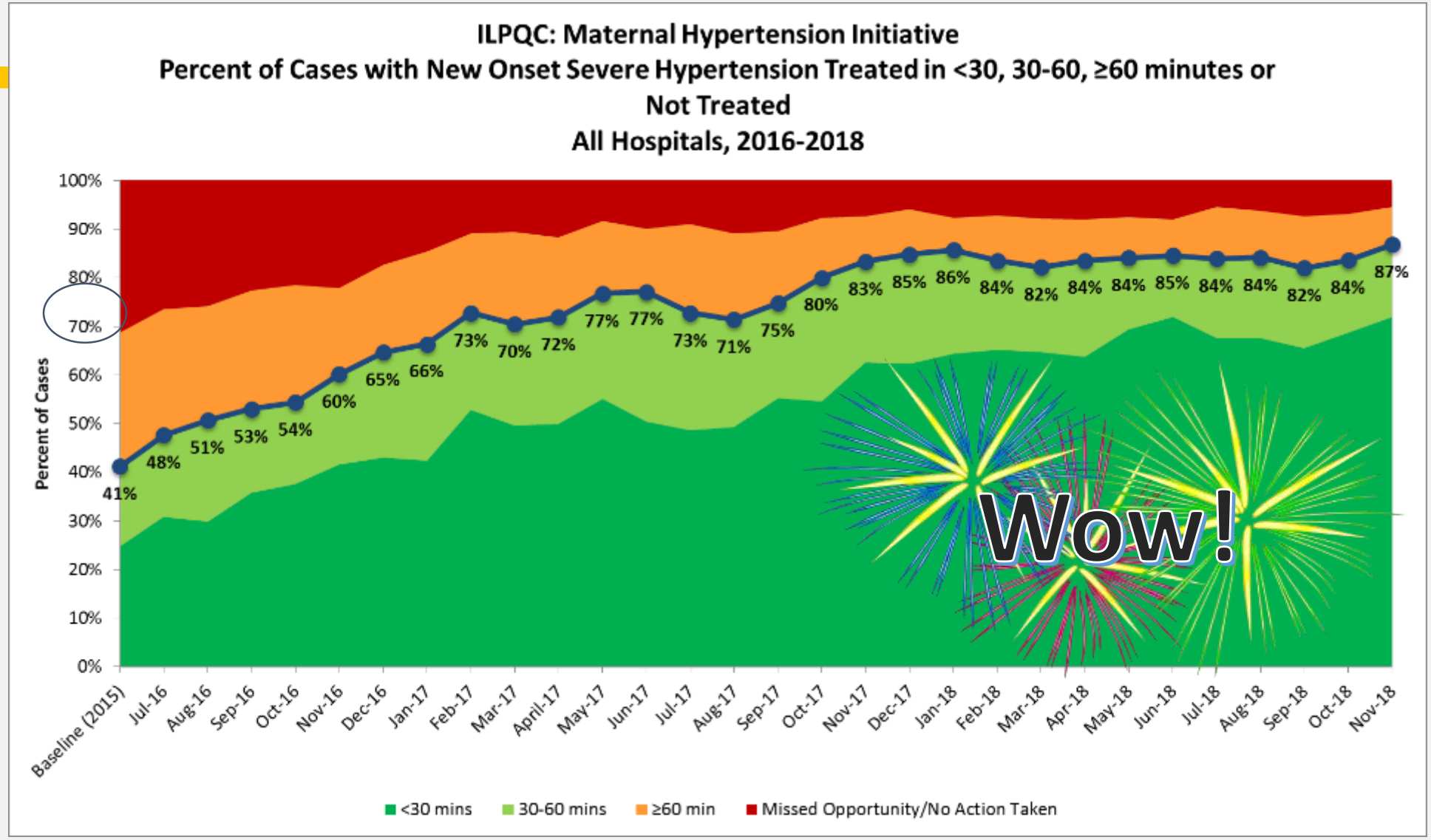
We used consistent reminders after education in huddles and unit meetings and audited charts.

We have included the education into our computer modules and have made it an annual requirement. We have also included maternal hypertension simulations

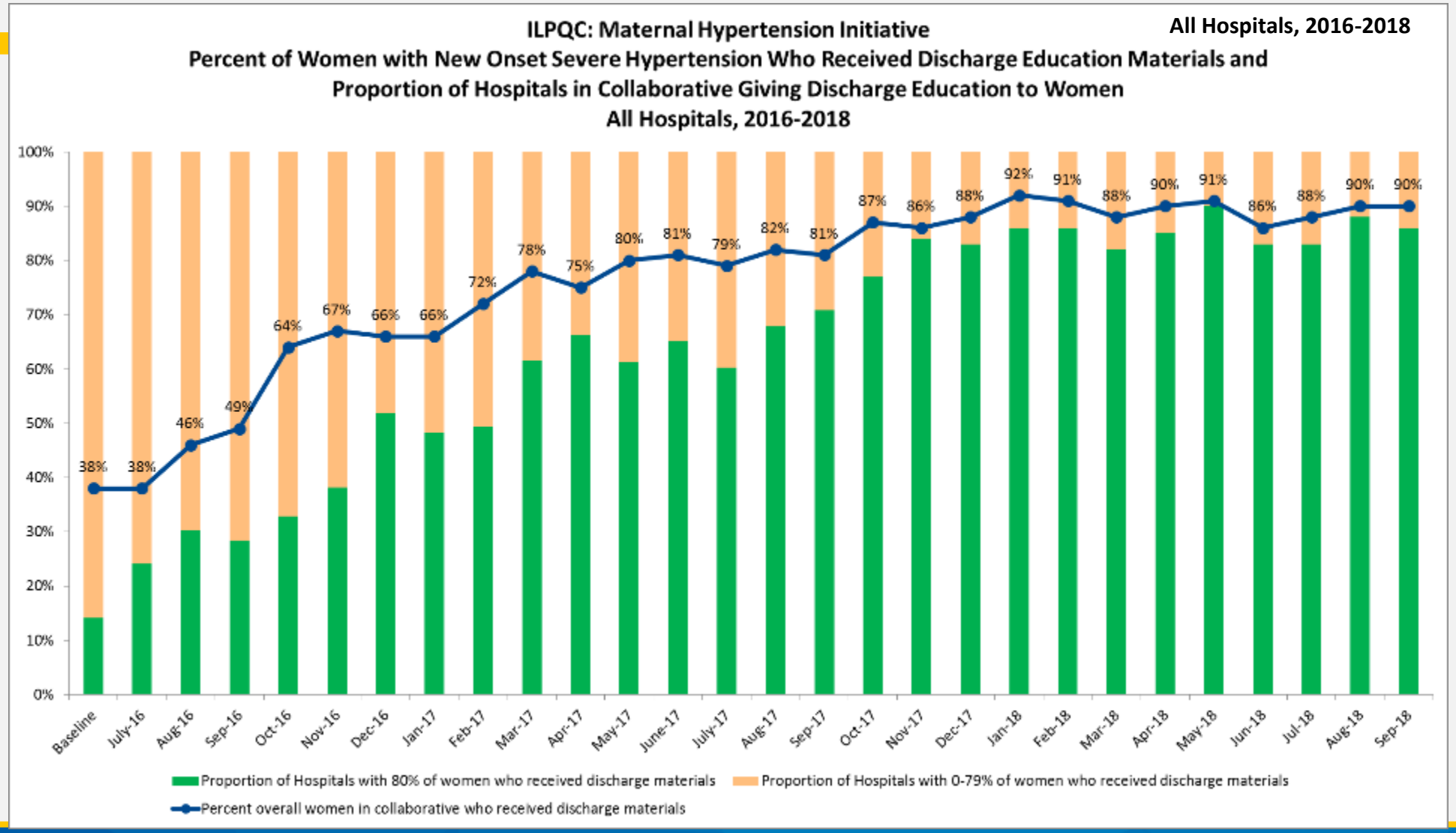
We identified RN and MD champions for the whole hospital along with unit champions and have the support of nursing administration

We incorporated HTN education as part of nursing skills day yearly. All new staff and physicians will be educated using the comprehensive slide set.

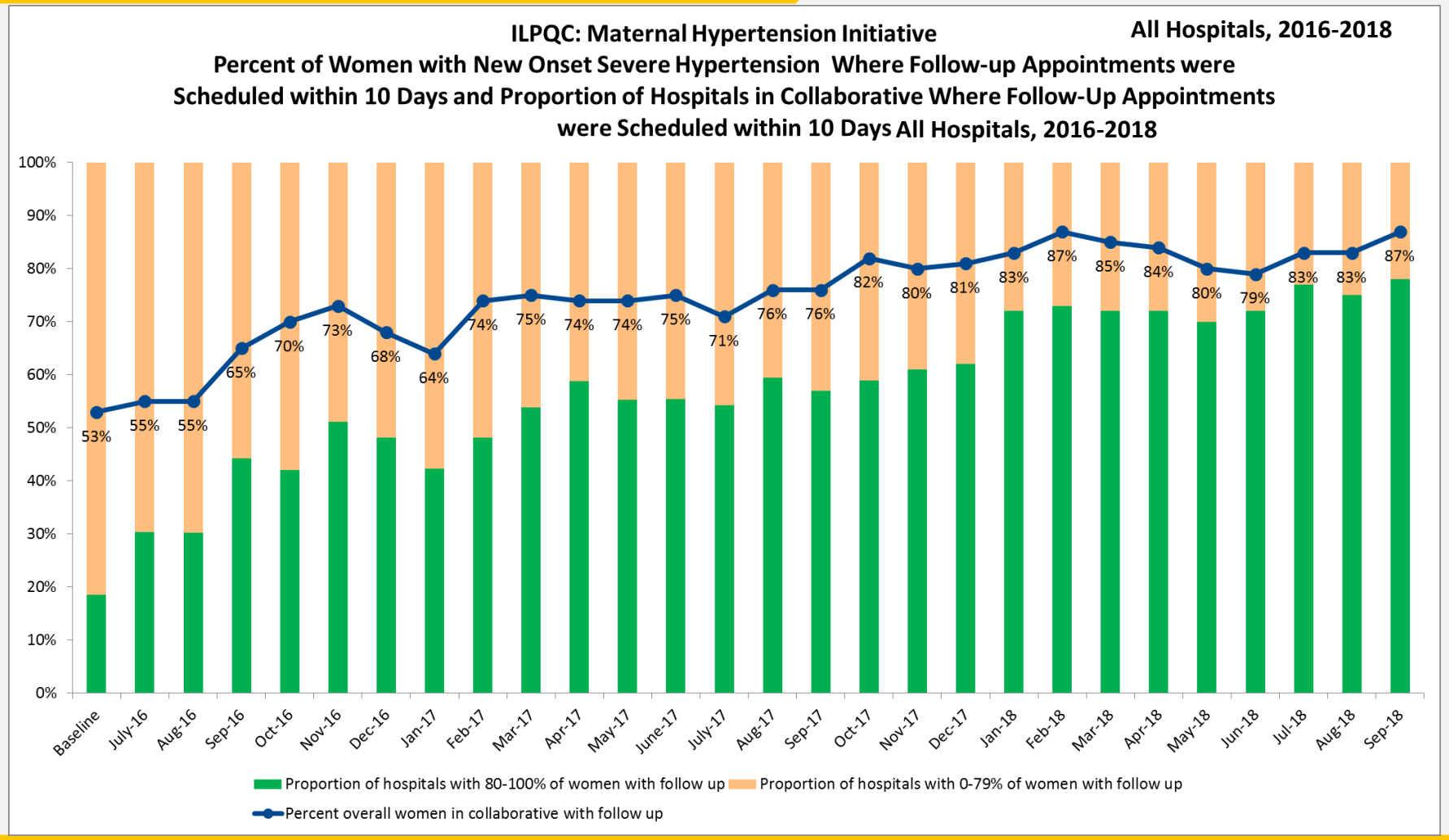
Maternal Hypertension Data: Time to Treatment



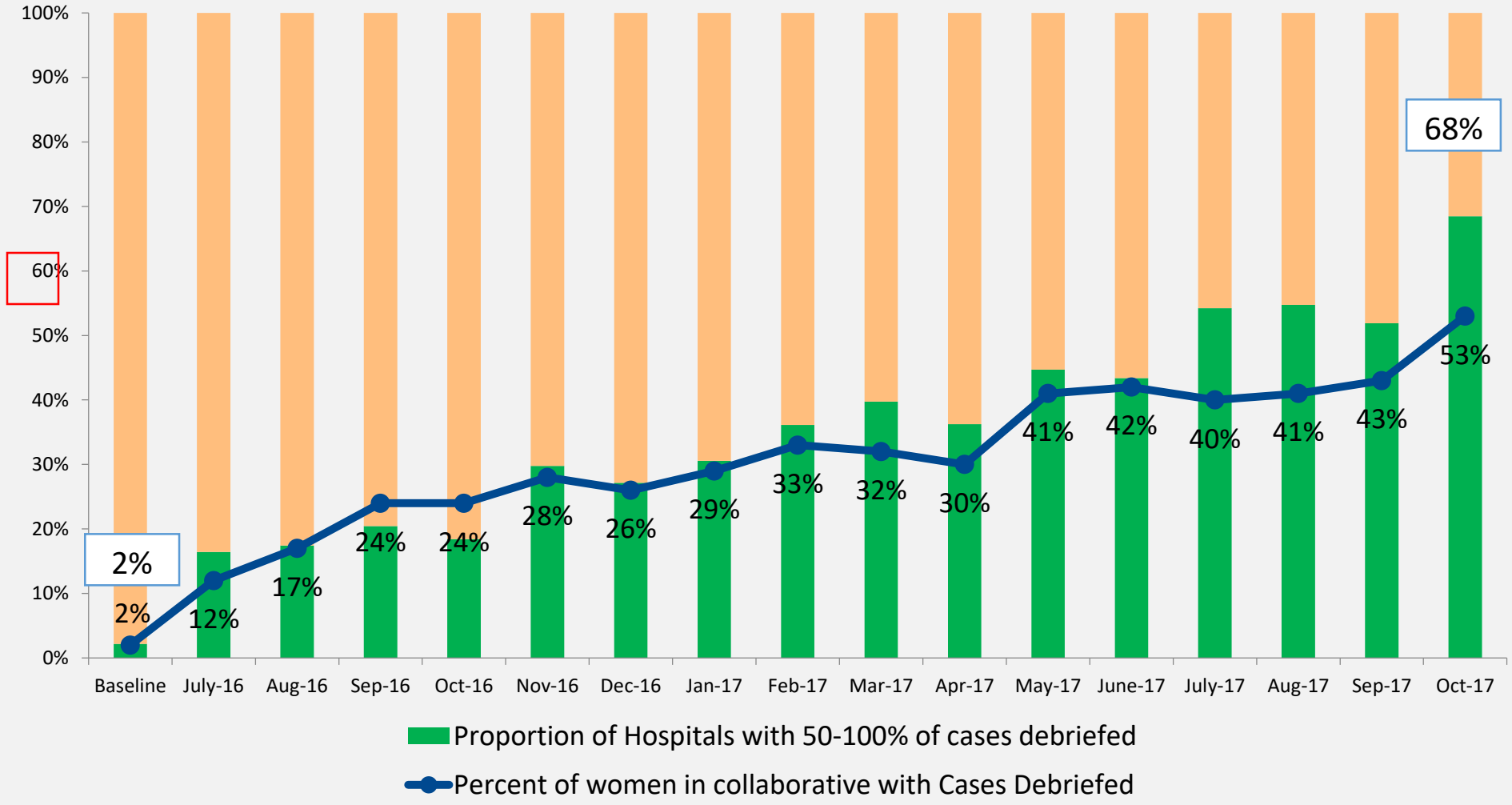
Maternal Hypertension Data: Patient Education



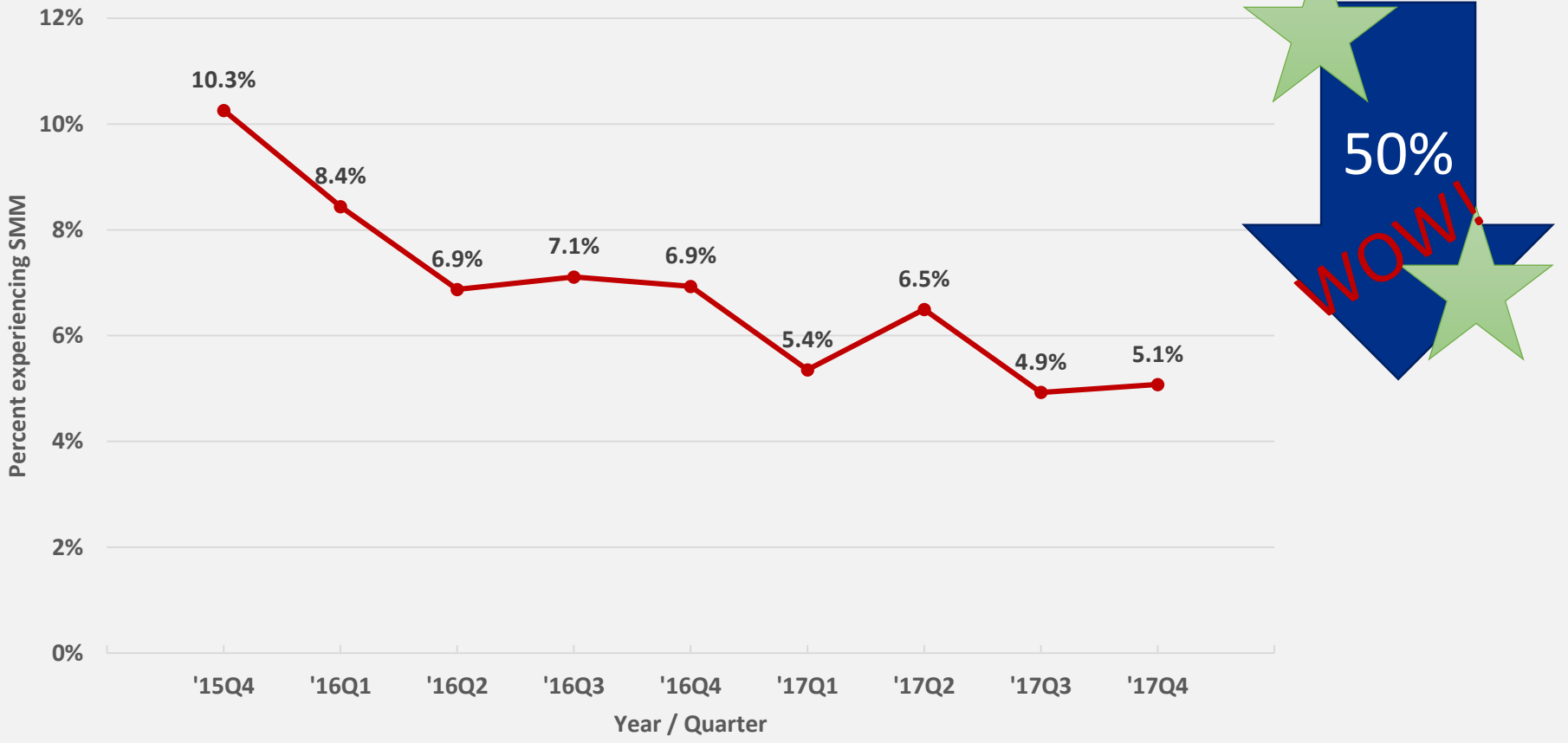
Maternal Hypertension Data: Patient Follow-up



Severe Maternal Hypertension Time To Treatment Debriefed



Severe Maternal Morbidity Rate Deliveries with Hypertension,
Hospital Discharge Data, All Illinois Hospitals



Between 2015-Q4 and 2017-Q4, the SMM rate among women experiencing hypertension at delivery was <u>cut in half.</u>

Hypertension Sustainability

- Compliance Monitoring
- New Hire Education
- Ongoing Staff/Provider Education

PQC
nois Perinatal
ality Collaborative

THANKS TO OUR

FUNDERS

IDPH
Illinois Department of Public Health

CDC
Centers for Disease Control and Prevention

DHS
Illinois Department of Human Services

JB & MK PRITZKER
Family Foundation

Email info@ilpqc.org
Visit us at www.ilpqc.org

Thank you!

IL Perinatal Quality Collaborative: Holding & Building on the Gains

Ann Borders

info@ilpqc.org

The Hypertension Project
We did it and so can you!

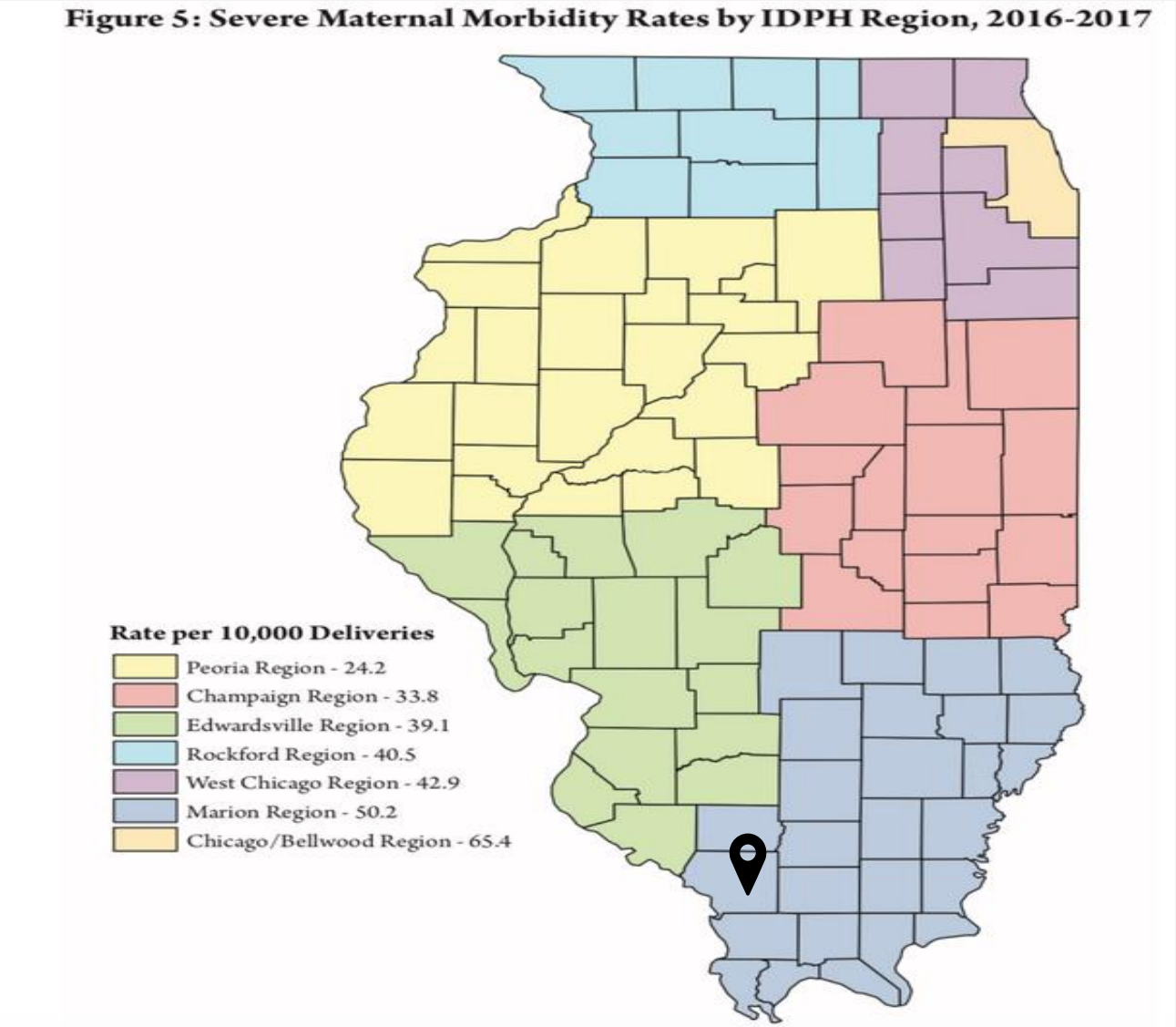
Memorial Hospital of Carbondale

Southern Illinois Healthcare

Memorial Hospital of Carbondale

- Providers: 19 physicians + 7 CNM
- 2400+ deliveries/year
- LDR beds 7
- Triage beds 6
- Antenatal beds 10

Maternal Morbidity



Hypertension Initiative Team

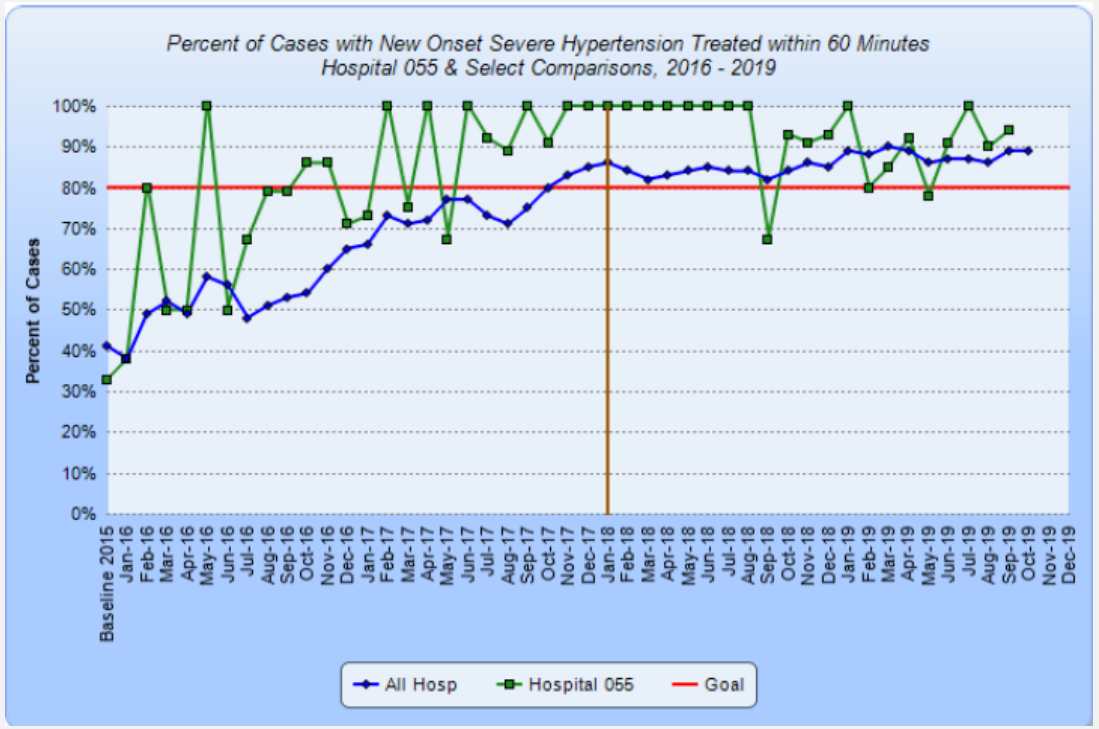
- Team Composition:
  - Physicians
  - Nursing
    - Management level nurse
    - Staff nurse
  - Education staff
  - Pharmacy (ad hoc)
  - IT (ad hoc)
  - ER staff (ad hoc)
  - Anesthesia (ad hoc)

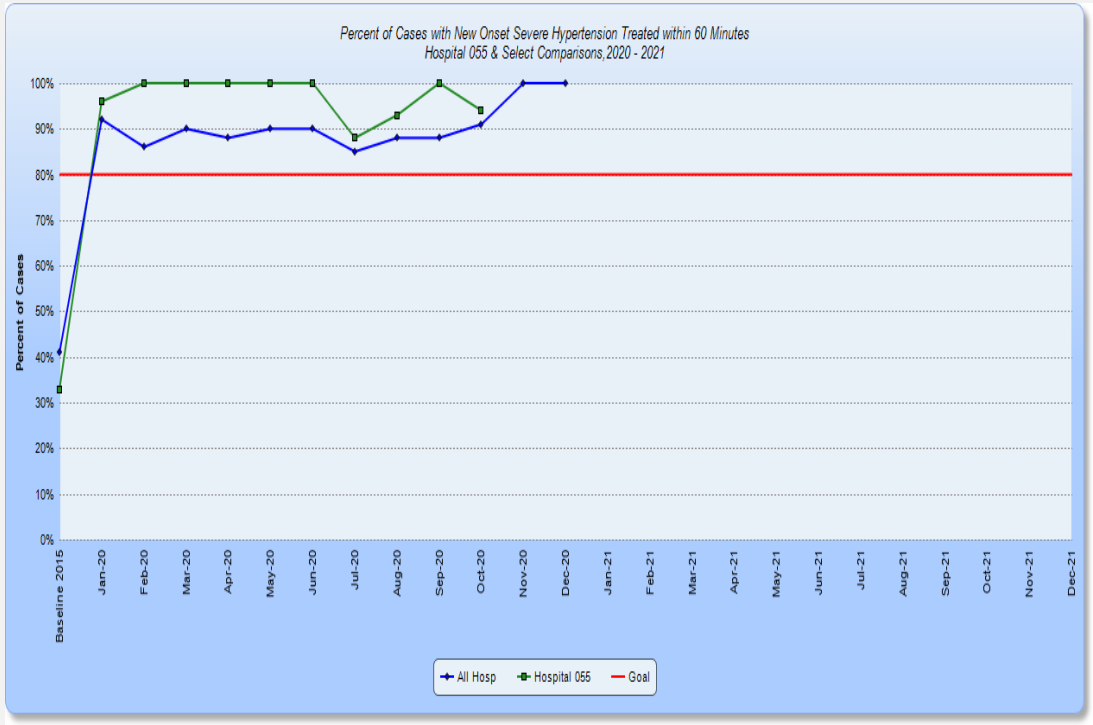
- Sherry Jones, MD,MPH
  - Medical Director, Labor and Delivery
  - Provider Champion , Hypertension Project

- Terri Purcell, MSN, RN
  - Manager-Women and Children's Services

- Christy Greer, RN
  - Clinical Support Nurse
  - Lead Hypertension Project

How did we do?


Percent of Cases with New Onset Severe Hypertension Treated within 60 Minutes
Hospital 055 & Select Comparisons, 2016 - 2019
Percent of Cases
All Hosp
Hospital 055
Goal


Percent of Cases with New Onset Severe Hypertension Treated within 60 Minutes
Hospital 055 & Select Comparisons, 2020 - 2021
Percent of Cases
All Hosp
Hospital 055
Goal

Where to begin??

- Everyone is already treating hypertension already
  - Break down your current process into steps
    - How do you identify patients who need treatment?
    - What parameters do you use for blood pressure notification and treatment?
    - What happens when patients are found to have severe hypertension?
    - How do you get the meds and where do they come from?
    - Do you have order sets to standardize process?
  - Compare your process with evidence based guidelines
  - Assemble your resources: Who do you need, What do you need?

Where to begin??

- What are your barriers? (There are always barriers)
  - Providers: Win them over with the evidence.
    - ACOG Practice Bulletins, Consensus statements from major journals
    - Grand Rounds, Speakers from referral centers
    - Find your influencers and convince them first
  - Nurses
    - Push back against change, fear of conflict with providers
    - Focus on patient safety, make it easy
    - Have nurse leaders know the protocol inside and out and be willing to teach continuously
  - Pharmacy
    - Work to create hypertensive medicine box/drawer/cart

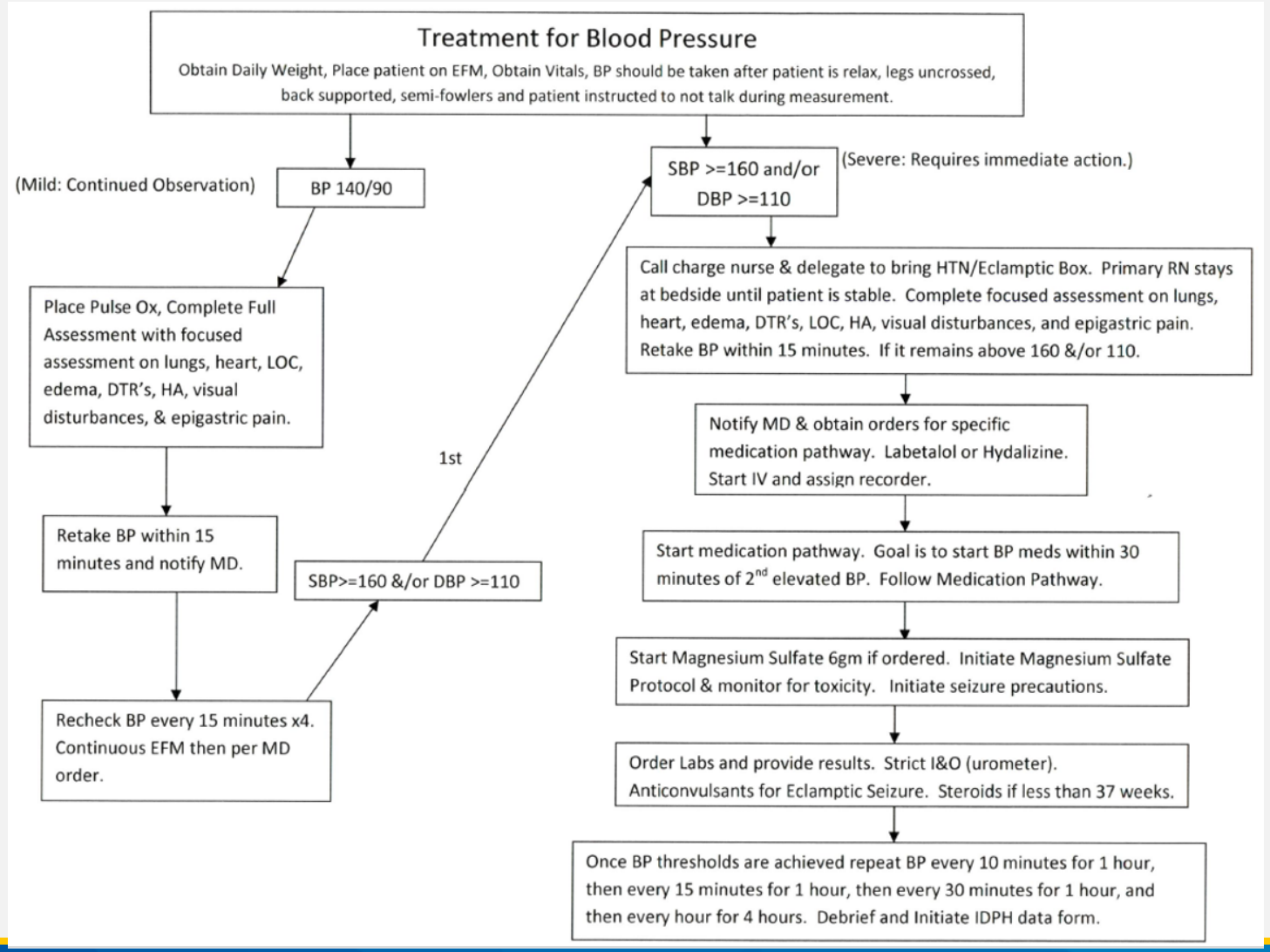
Where to begin??

- Barriers
  - ER: Pregnant and Postpartum women are different
    - Can not use the same parameters and treatment as with other patients
    - Need to be able to identify pregnant and postpartum patients
    - Need to know who to call, where to call, and how to begin treatment before they get to OB floor.
    - Labor and Delivery could fax/send copy of pathway to follow
    - Develop ER order sets which mirror OB's order set

Mythbusters

- Patients do not develop severe range hypertension from being in pain
- Magnesium sulfate and epidurals are not treatments for hypertension
- There doesn’t need to be confirmed preeclampsia to treat
- PO maintenance meds can not be used as first line treatment
- Providers to not need to wait until they have obtained higher level consultation to treat.
- Systolic blood pressures do matter
- Once patients are delivered, the risk of severe hypertension is not done.

SIH Maternal Hypertensive Emergency Response



Hypertensive Emergency Medications

Eclamptic Box/Kit

****In Pyxis in L&D & MB****

Location:
L&D Omnicell (1)
Antepartum Omnicell (2)
Mother Baby Omnicell (1)

Medications

Hydralazine 20 mg/ml - 3 vials

Labetalol 100mg/20ml – 2 vials

Nifedipine 10mg tabs – 5 tablets

Supplies

3cc syringes - 3

5cc syringes - 3

19g needles - 5

Needless needles - 5

Call for Help!

- Notify Charge Nurse/Shift Supervisor
- Notify Physician/Provider

Critical Assessment Team (CAT), Adult & Pediatric/Neonatal, SY-NG-009

  - Activate Critical Assessment Team if indicated
    - See Section V, Item 4
  - Activate the OB Emergency Team if indicated
    - See Section V, Item 6

Team Events

Utilize Team Events for **EVERY** patient

- With Maternal Hypertension
- With Maternal Hypertension that is @ Risk for Hypertensive Emergency
- With every Maternal Hypertensive Emergency

When in doubt, make it easy

- Laminated Algorithms- posted on units, on clipboards, and hanging by Omnicell
- Order set with medication dose and frequency as well as nursing notification parameters
- All essential elements pre-checked on order set
- Medications in Omnicell with ability to override to pull in emergency

How to identify patients in ER?

Are you pregnant or have been pregnant within the last 6 weeks?

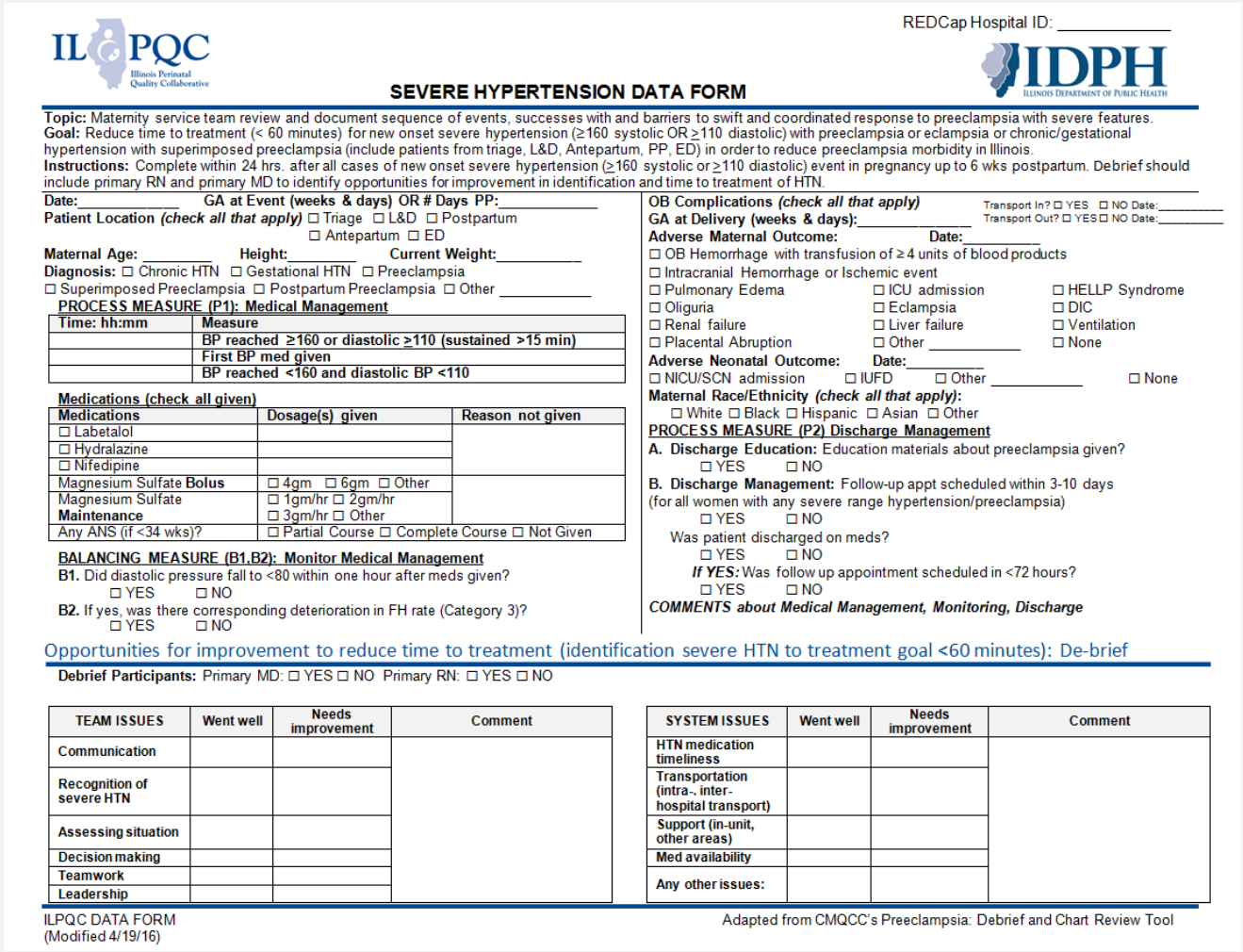
Please alert the staff for prompt evaluation!

Monthly Data

XI. Severe Hypertension

Name of woman /RedCap #	Date of admission	Medical Record Number	Time BP 160/110 x 2	Time Treated	Reason if >60 min
Patient A	12/11/2019	1	515	523	
Patient B	12/4/2019	2	1237	1254	
Patient C	12/12/2019	3	2148	2200	
Patient D	12/14/2019	4	2032	2049	no f/u apt for 6 weeks
Patient E	12/16/2019	5	2300	2408	coached MB nurse on protocol
Patient F	12/18/2019	6	1336	1407	
Patient G	12/19/2019	7	905	917	
Patient H	12/20/2019	8	240	311	
Patient I	12/26/2019	9	1045	1054	
Patient J	12/17/2019	10	1615	n/a	3rd bp 157/95
Patient K	12/2/2019	11	1300	1340	
Patient L	12/3/2019	12	2040	2104	
Patient M	12/8/2019	13	104	110	
Patient N	12/2/2019	14	1022	n/a	3rd bp 152/85
Patient O	12/21/2019	15	2015	n/a	3rd bp 132/71

IL Maternal Hypertension: Data Form



REDCap Hospital ID: _____

ILPQC Illinois Perinatal Quality Collaborative

IDPH Illinois Department of Public Health

SEVERE HYPERTENSION DATA FORM

Topic: Maternity service team review and document sequence of events, successes with and barriers to swift and coordinated response to preeclampsia with severe features.
Goal: Reduce time to treatment (< 60 minutes) for new onset severe hypertension (≥160 systolic OR ≥110 diastolic) with preeclampsia or eclampsia or chronic/gestational hypertension with superimposed preeclampsia (include patients from triage, L&D, Antepartum, PP, ED) in order to reduce preeclampsia morbidity in Illinois.
Instructions: Complete within 24 hrs. after all cases of new onset severe hypertension (≥160 systolic or ≥110 diastolic) event in pregnancy up to 6 wks postpartum. Debrief should include primary RN and primary MD to identify opportunities for improvement in identification and time to treatment of HTN.

Date:_____ **GA at Event (weeks & days) OR # Days PP:**_____
Patient Location ***(check all that apply)*** ☐ Triage ☐ L&D ☐ Postpartum ☐ Antepartum ☐ ED
Maternal Age: _____ **Height:**_____ **Current Weight:**_____
Diagnosis: ☐ Chronic HTN ☐ Gestational HTN ☐ Preeclampsia ☐ Superimposed Preeclampsia ☐ Postpartum Preeclampsia ☐ Other _____

PROCESS MEASURE (P1): Medical Management

Time: hh:mm	Measure
	BP reached ≥160 or diastolic ≥110 (sustained >15 min)
	First BP med given
	BP reached <160 and diastolic BP <110

Medications (check all given)

Medications	Dosage(s) given	Reason not given
☐ Labetalol		
☐ Hydralazine		
☐ Nifedipine		
Magnesium Sulfate **Bolus**	☐ 4gm ☐ 6gm ☐ Other	
Magnesium Sulfate **Maintenance**	☐ 1gm/hr ☐ 2gm/hr ☐ 3gm/hr ☐ Other	
Any ANS (if <34 wks)?	☐ Partial Course ☐ Complete Course ☐ Not Given	

BALANCING MEASURE (B1,B2): Monitor Medical Management
B1. Did diastolic pressure fall to <80 within one hour after meds given? ☐ YES ☐ NO
B2. If yes, was there corresponding deterioration in FH rate (Category 3)? ☐ YES ☐ NO

OB Complications ***(check all that apply)*** Transport In? ☐ YES ☐ NO Date:_____
GA at Delivery (weeks & days):_____ Transport Out? ☐ YES ☐ NO Date:_____
Adverse Maternal Outcome: **Date:**_____
☐ OB Hemorrhage with transfusion of ≥ 4 units of blood products
☐ Intracranial Hemorrhage or Ischemic event
☐ Pulmonary Edema ☐ ICU admission ☐ HELLP Syndrome
☐ Oliguria ☐ Eclampsia ☐ DIC
☐ Renal failure ☐ Liver failure ☐ Ventilation
☐ Placental Abruption ☐ Other _____ ☐ None
Adverse Neonatal Outcome: **Date:**_____
☐ NICU/SCN admission ☐ IUFD ☐ Other _____ ☐ None
Maternal Race/Ethnicity ***(check all that apply)*****:**
☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other

PROCESS MEASURE (P2) Discharge Management
A. Discharge Education: Education materials about preeclampsia given? ☐ YES ☐ NO
B. Discharge Management: Follow-up appt scheduled within 3-10 days (for all women with any severe range hypertension/preeclampsia) ☐ YES ☐ NO
Was patient discharged on meds? ☐ YES ☐ NO
If YES: Was follow up appointment scheduled in <72 hours? ☐ YES ☐ NO
COMMENTS about Medical Management, Monitoring, Discharge

Opportunities for improvement to reduce time to treatment (identification severe HTN to treatment goal <60 minutes): De-brief

Debrief Participants: Primary MD: ☐ YES ☐ NO Primary RN: ☐ YES ☐ NO

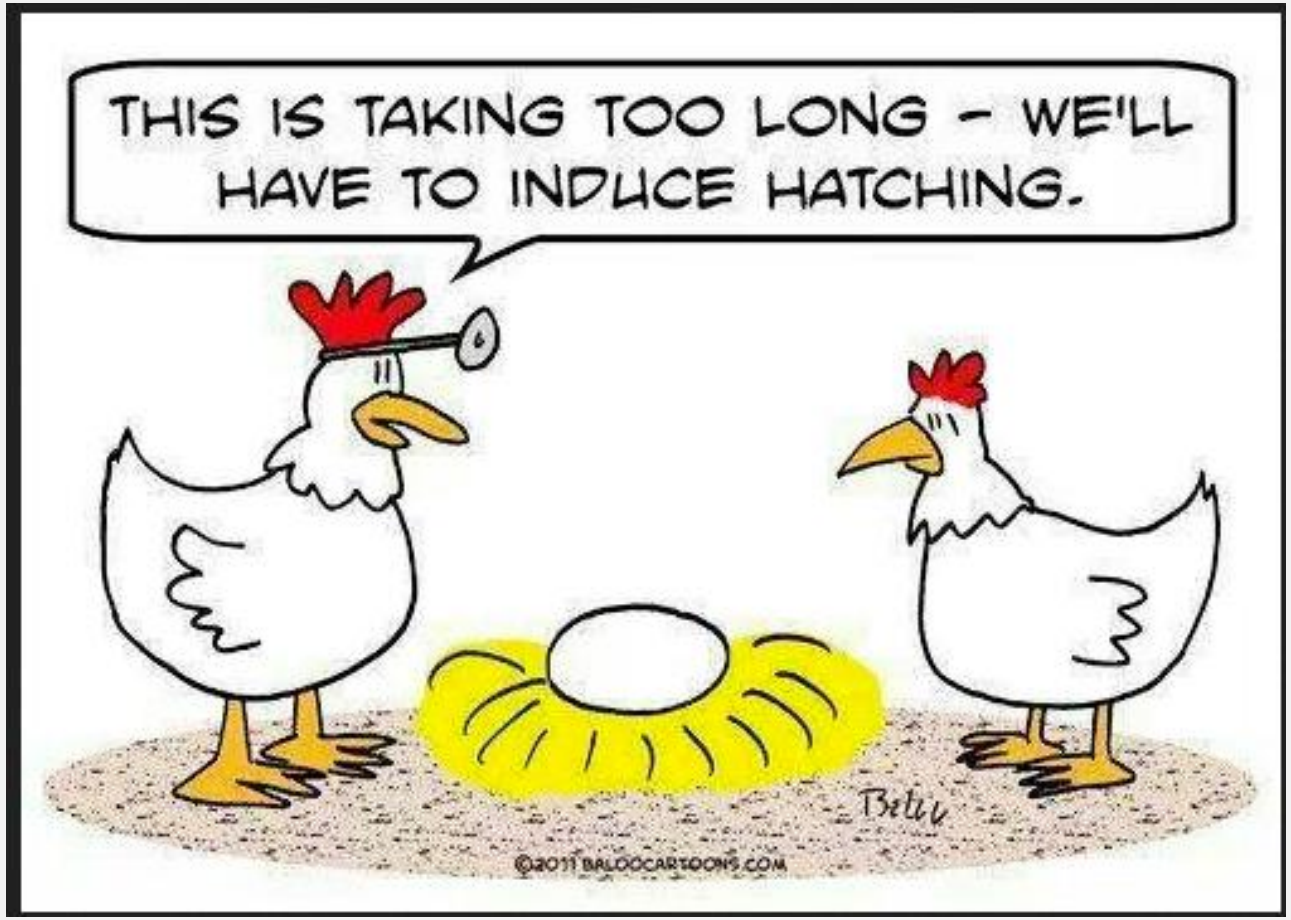
TEAM ISSUES	Went well	Needs improvement	Comment
Communication			
Recognition of severe HTN			
Assessing situation			
Decision making			
Teamwork			
Leadership			

SYSTEM ISSUES	Went well	Needs improvement	Comment
HTN medication timeliness			
Transportation (intra-, inter-hospital transport)			
Support (in-unit, other areas)			
Med availability			
Any other issues:			

ILPQC DATA FORM (Modified 4/19/16)

Adapted from CMQCC's Preeclampsia: Debrief and Chart Review Tool

Thank you


THIS IS TAKING TOO LONG - WE'LL HAVE TO INDUCE HATCHING.
©2011 BALOOCARTOONS.COM

Setting the Stage for Severe Hypertension in Pregnancy: The Oklahoma Experience

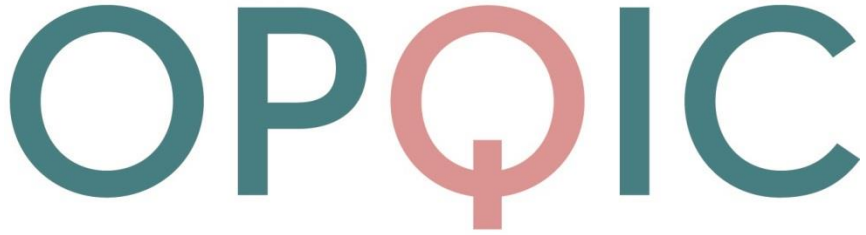
April Adams, RNC-OB

Stacie Elfrink, MD

Barbara O'Brien, MS, RN

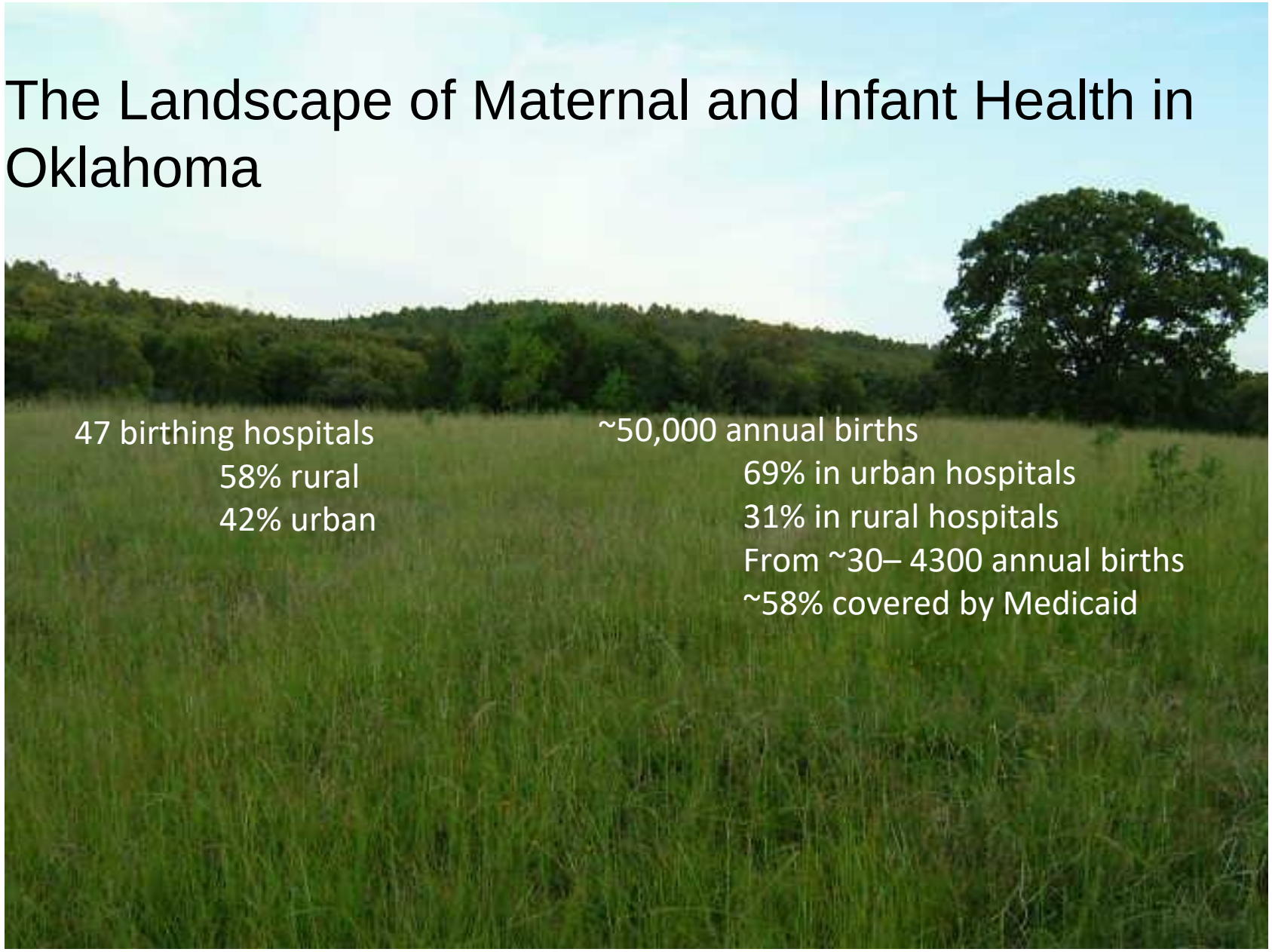
OKLAHOMA PERINATAL QUALITY

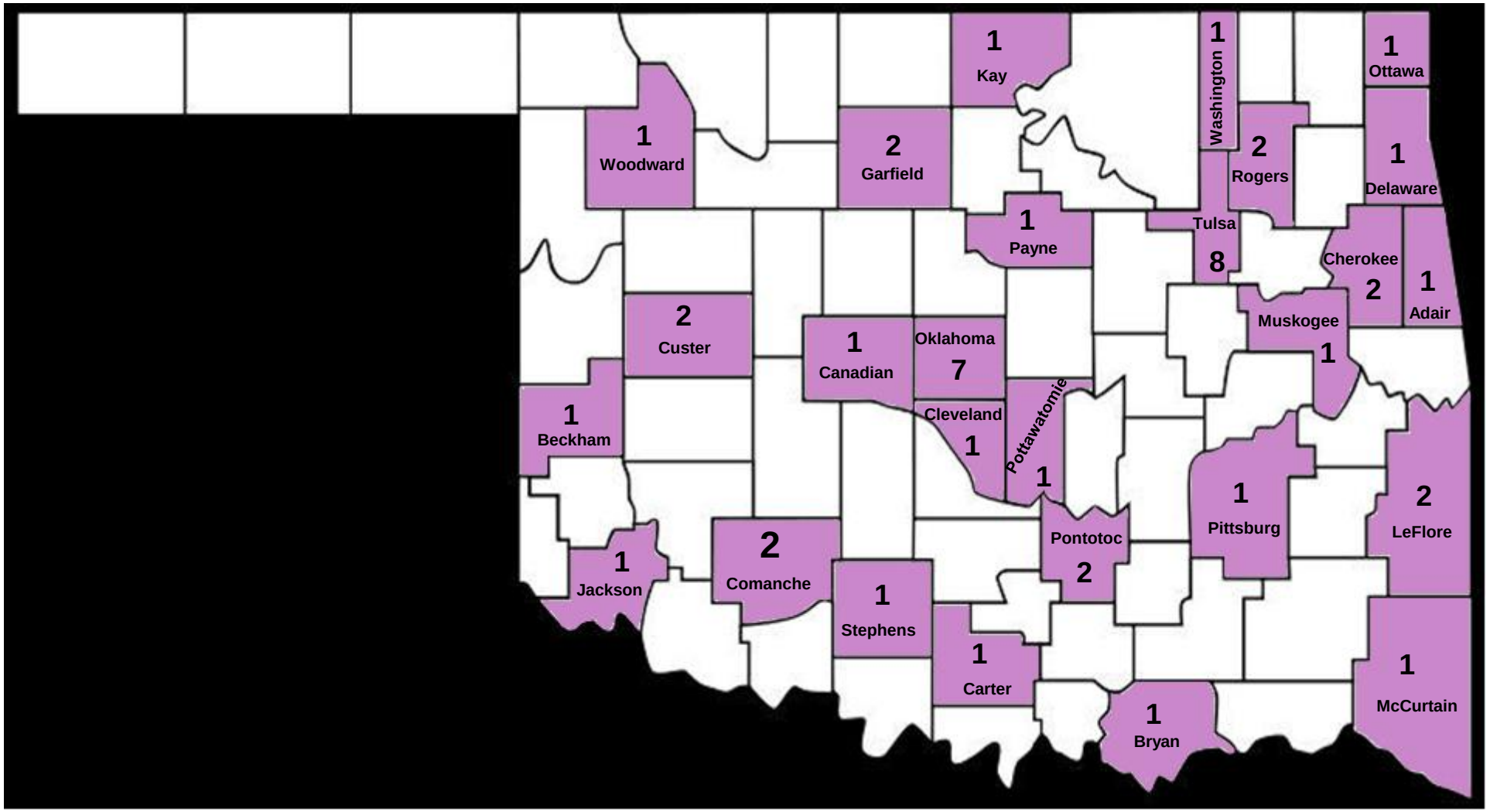
IMPROVEMENT COLLABORATIVE



Creating a culture of excellence, safety and equity in perinatal care

The Landscape of Maternal and Infant Health in Oklahoma





Oklahoma Birthing Hospitals November 2020

Duncan Regional Hospital
Duncan, Oklahoma

Duncan Regional Hospital
2018, 2019, 2020

Tips for Success

Duncan Regional Hospital

Duncan, OK

Setting the Stage

- Formulated our Team
- Kick-Off April, 2016
- Came up with a Plan
- Held Regular Meetings
- Reported to Executive Leadership

Protocol

- Finalized Protocol
  - Developed and added order set

Order Sets - Same Language

For patients without history of hypertension, Notify physician if B/P 140/90 or greater and obtain CBC, CMP, LDH, Uric Acid, Total protein urine random, and Creatinine urine random.
For patients with a diagnosis or history of any type of hypertension, chronic hypertension, pre-eclampsia, gestational hypertension, or pregnancy induced hypertension then notify physician of B/P in severe range 160/110 or greater, change in neuro status or any lab value changes.

Med orders

Severe Hypertension:

Recommended for severe hypertension SBP ≥ 160 or DBP ≥ 110 for TWO measurements within 15 minutes (the readings do not have to be consecutive readings)

Labetalol 20 mg IV once given over 2 minutes

Hydralazine 5 mg IV once given over 2 minutes

Hydralazine 10 mg IV once given over 2 minutes

Severe Hypertension, if no IV access:

Labetalol 200 mg PO once

Nifedipine 10 mg PO once

Education

- **Nurses**
  - Education on accurate BP measurement
  - Requirement to view AIM eModules annually
  - Nurses conduct educational in-services on unit regularly
- **Physicians**
  - Required to read publications and sign-off on them

Taking a Blood Pressure

Correct Position!

- Sitting or Semi Fowlers
- Feet flat, not dangling
- If BP ≥ 160 systolic **and/or** ≥ 110 diastolic, take steps to initiate treatment for severe hypertension—notifying provider, procuring medication

DO NOT REPOSITION PATIENT (yet)

- **Retake BP after 15 minutes**. If BP remains severe, obtain order for medication.
- Administer medication as ordered

***Treat ASAP*—at least within 1 hour of 1st severe reading**

Correct Cuff Size!

Data – Capturing Patients

- First used paper report
- Now use flag for medication use
  - Nurses alert Nurse Manager if patient not treated
    - Rarely happens
- Working on EHR alert for EDs

Accountability

- Real-time team approach if protocol not followed
- Outliers go through peer review

Patient Education

- Implemented AWHONN Post-Birth Warning Signs (2018)
  - Including on-line nurse education
- Discharged with appointment for postpartum check-up with physician within 3-5 days
- Prenatal education by physicians

Integration with Emergency Department

- Education on preeclampsia/HTN bundle, emphasis on post-partum preeclampsia
  - Currently working with IT to flag pregnant and postpartum patients with hypertension

Culture of Safety

- A culture of safety is important
- Trusting and open relationship between nurses, physicians, executive leadership
- Collaboration with OPQIC and with other hospitals
- Culture of safety in state

www.opqic.org

Tips from OPQIC

- Coding education
- The Joint Commission New Standards for Perinatal Safety - January 2021
  - PC.06.03.01
    - Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia

AIM

The Alliance for Innovation on Maternal Health (AIM) is a national partnership of organizations poised to reduce severe maternal morbidity by 100,000 events and maternal mortality by 1,000 deaths by 2018. The AIM program is funded through a cooperative agreement with the Maternal and Child Health Bureau/Health Resource Services Administration.

Oklahoma is the first state to join the AIM initiative in conjunction with the OPQIC Every Mother Counts collaborative.

NEW AIM RESOURCES!

- *NEW!* AWHONN Maternal Mortality Resources
- Hemorrhage Bundle Implementation Research and Resources
- Hypertension Bundle Implementation Research and Resources

(Please note: To watch the videos below, please use Windows 10 Internet Explorer, Microsoft Edge or another web browser like Mozilla FireFox or Google Chrome.)

AIM Webcast: Treating Maternal Hypertension

https://opqic.org/aim/

HYPERTENSION IN PREGNANCY

Every Mother Counts aims to improve each hospital's readiness for, recognition of, response to and reporting of severe hypertension. This will be accomplished through the implementation of the Severe Hypertension Patient Safety Bundle. Registration is required to access the bundle for tracking purposes.

There are many links to resources that can be accessed through the bundle. Please use the resources that are listed in the bundle.

READINESS:

NEW! Hypertension Bundle Implementation Research and Resources
Severe Hypertension Patient Safety Bundle (Council on Patient Safety in Women's Healthcare)
Hypertension in Pregnancy ACOG Task Force Report
Patient Education Resource from the Preeclampsia Foundation
7 Symptoms Every Pregnant Woman Should Know Video
Hypertension Driver Diagram Appendix B
Hypertension in Pregnancy-Readiness Assessment

RECOGNITION:

Preeclampsia Early Recognition Tool (PERT)
Accurate Blood Pressure Measurement
Accurate BP Flyer
Hypertension in Pregnancy-Recognition Assessment

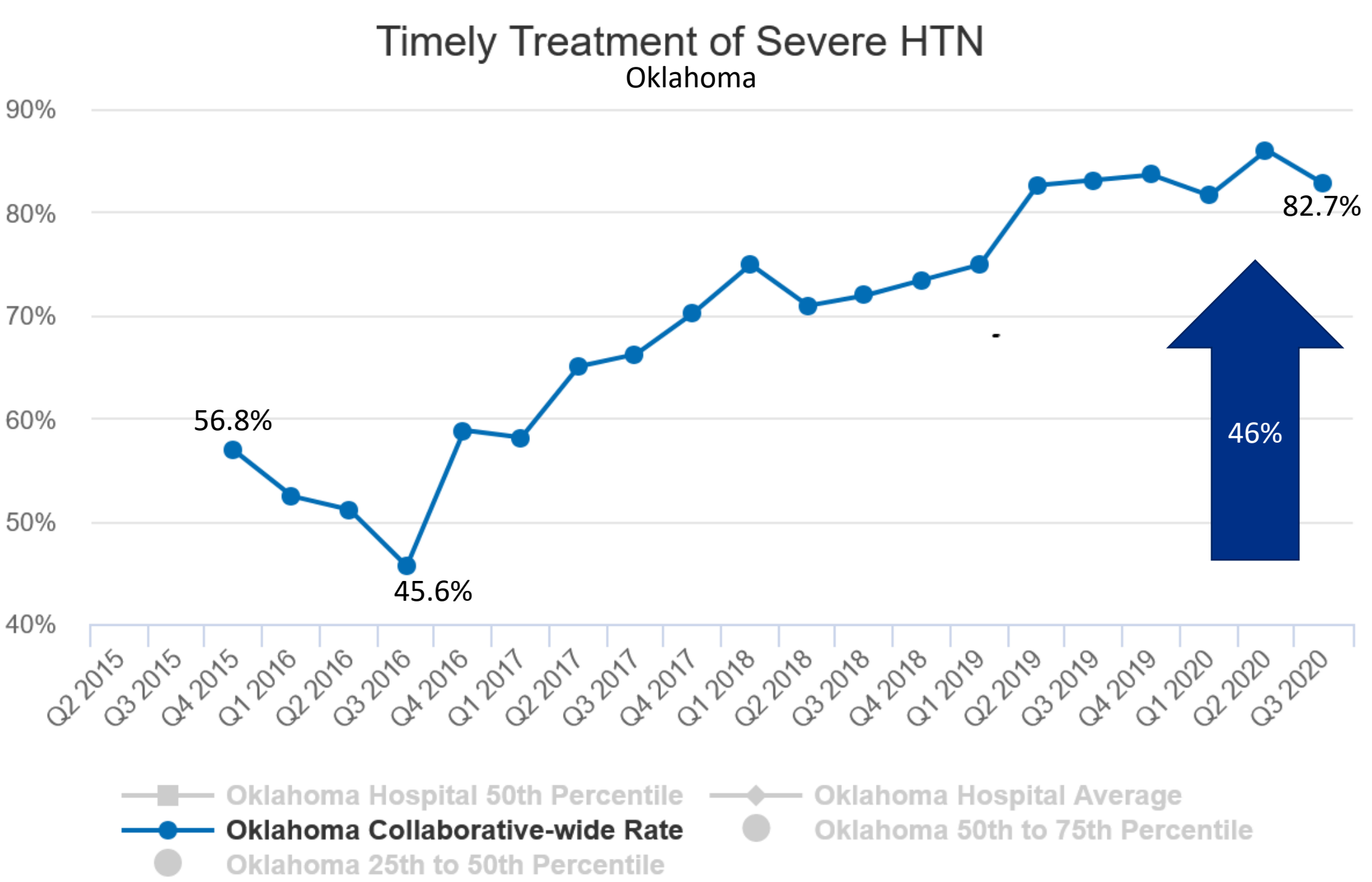
https://opqic.org/initiatives/emc/hypertension/

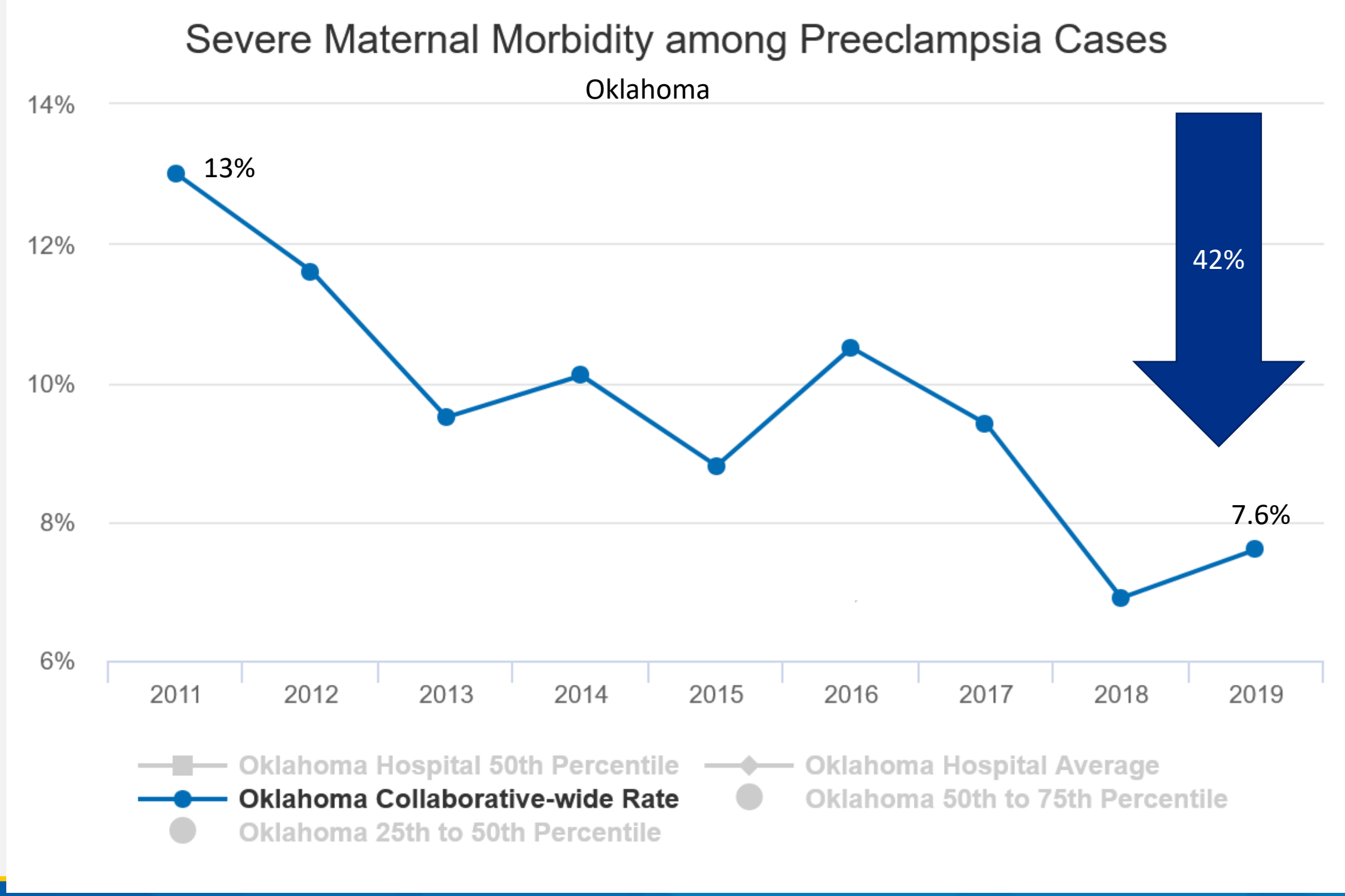
RESPONSE:

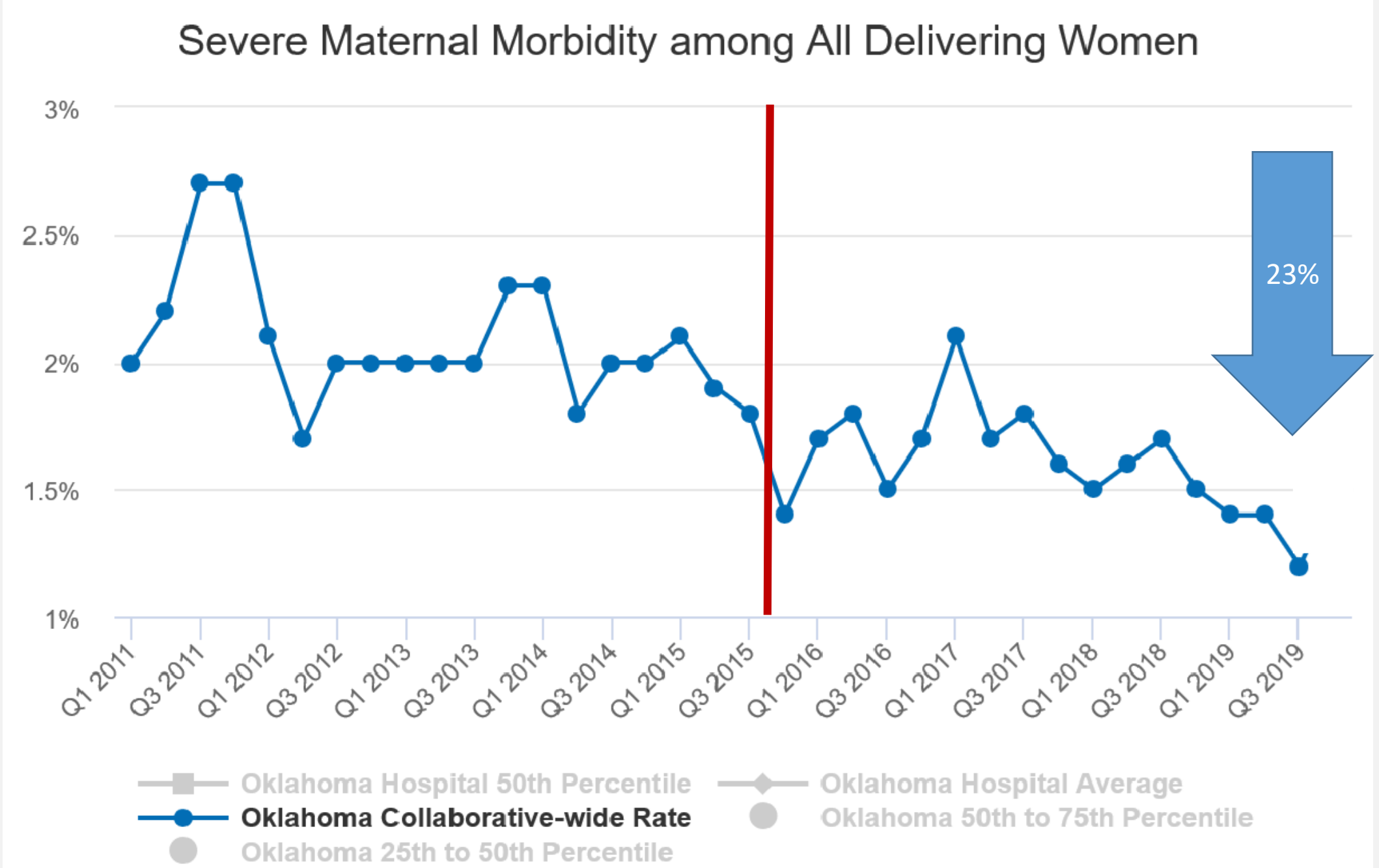
ACOG Committee Opinion 692: Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period
Maternal Mental Health Resources
AIM FAQ Topic: Treatment for Acute Onset Severe HTN (by Elliot Main)
Preeclampsia Toolkit (CMQCC)
Hypertension in Pregnancy-Response Assessment
Patient, Family, and Staff Support (Council on Patient Safety in Women's Healthcare)

REPORTING:

Severe Maternal Morbidity Facility Review Forms (Council on Patient Safety in Women's Healthcare)


Timely Treatment of Severe HTN
Oklahoma
90%
80%
70%
60%
50%
40%
56.8%
45.6%
82.7%
46%
Q2 2015
Q3 2015
Q4 2015
Q1 2016
Q2 2016
Q3 2016
Q4 2016
Q1 2017
Q2 2017
Q3 2017
Q4 2017
Q1 2018
Q2 2018
Q3 2018
Q4 2018
Q1 2019
Q2 2019
Q3 2019
Q4 2019
Q1 2020
Q2 2020
Q3 2020
Oklahoma Hospital 50th Percentile
Oklahoma Hospital Average
Oklahoma Collaborative-wide Rate
Oklahoma 50th to 75th Percentile
Oklahoma 25th to 50th Percentile


Severe Maternal Morbidity among Preeclampsia Cases
Oklahoma
14%
12%
10%
8%
6%
13%
42%
7.6%
2011
2012
2013
2014
2015
2016
2017
2018
2019
Oklahoma Hospital 50th Percentile
Oklahoma Hospital Average
Oklahoma Collaborative-wide Rate
Oklahoma 50th to 75th Percentile
Oklahoma 25th to 50th Percentile



AIM Data Portal – Oklahoma hospital discharge data

Thank you!

Setting the Stage for Severe Hypertension in Pregnancy: The Oklahoma Experience

April Adams april.adams@drhhealth.org

Barbara O’Brien barbara-obrien@ouhsc.edu

Session 1: Panel Discussion

Patrick Ramsey, MD, MPH

Facilitator

End of Session 1- STREEEEETCH

Ice Breaker

Share one recent accomplishment or lesson learned in maternal health safety

TEXAS
Health and Human Services

Texas Department of State Health Services

Integrating Health Equity in Maternal Safety Improvement

Rakhi Dimino
MD, MMM

Kristina Wint
MPH

Carla Ortique
MD

Nakeenya Wilson
MA

Christina Davidson
MD

Welcome and Introductions

Answering the Call to Accountability:

Racial equity as a national public health imperative

Kristina Wint, MPH

Program Manager, Women's Health

Association of Maternal & Child Health Programs

Disclosures

- None to disclose

Who is AMCHP?

The Association of Maternal & Child Health Programs is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.

We lead and support programs nationally to protect and promote the optimal health of women, children, youth, families, and communities.

We envision a nation that values and invests in the health and wellbeing of all women, children, youth, families, and communities so that they may thrive.

A Call to Accountability

- May 2020 commenced a season of protest – a demand for police accountability

- #WhiteCoatsForBlackLives
  - But what does that mean?
  - What does accountability look like in medicine? In public health?

Foundation for Our Work

Racism is the root cause and engine of the racial disparities in maternal health in the U.S.

Inequitable practices are ‘baked into’ institutional histories, policies and systems

“*We have no answer that Black women do not already possess*”

There’s no health equity without community engagement

“Evidence” should be led by lived experience and cultural rigor

We’re all in

What does “All In” Mean?

- Dismantling racism and committing to anti-racism
- Holding racial equity at the center
- Acknowledging racism as a public health crisis

AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

June 23, 2020

We’re all in.

AMCHP’s mission is to lead and support programs nationally to protect and promote the optimal health of women, children, youth, families, and communities. We cannot fully achieve this goal unless we acknowledge that racism is a public health crisis and directly impacts the health outcomes of our communities and those we serve. The physical and mental health of the Black community and other communities of color related to intergenerational and chronic stress caused by individual and systemic racism is well documented. Given the recent events and collective outrage around the murder of George Floyd and others, we are reminded of how urgent this issue is for us as a country. AMCHP is committed to rolling up our sleeves with you to ensure that we are actively working to dismantle racism and bring about real change; change that we can be proud of when our work is referenced in history.

We, in AMCHP, are focused on health equity and must infuse this in all that we do. Although we’ve made progress, there is much more to be done. We will continue to:

- Value lived experience by engaging with, listening to, and partnering with impacted communities
- Be truthful about our history and acknowledge the role that we have played in directly or unintentionally enabling and/or supporting systems of inequity
- Be comfortable with the “un-comfortability” of having difficult conversations that challenge our thinking and stretch us in our approach to dismantling inequitable systems
- Be bold, brave, and courageous as we lead in this work
- Hold ourselves and those around us accountable as we work, and sometimes stumble, toward progress

We believe that an important part of the process of reconciliation and improvement requires a close examination of self, an admission of ignorance or error and acknowledging past actions so that we are not destined to repeat them. In that spirit, we acknowledge and regret that we have not achieved our own standards and have not always been an ally to people of color. For example, we recognize that we have used language that characterizes a racial group as “at-risk”, and “vulnerable”, as if the race of a person is the pre-determining factor, as opposed to racism. We have contributed to the invisibility of Indigenous populations of women, their children and youth, their tribes, their birth caregivers, and their histories by existing as an organization for decades and having few longstanding, historical relationships with Indigenous people or organizations. Our membership structure and events, including our annual conference, are not easily accessible for all community-based organizations and has not

1825 K Street, NW, Suite 250, Washington, DC 20006 **MAIN** 202 775 0436 **FAX** 202 478 5120 WWW.AMCHP.ORG

Value lived experience by engaging with, listening to, and partnering with impacted communities

Valuing lived experience

READINESS

Every health system

- Establish systems to accurately document self-identified race, ethnicity, and primary language.
  - Provide system-wide staff education and training on how to ask demographic intake questions.
  - Ensure that patients understand why race, ethnicity, and language data are being collected.
  - Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
  - Evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English.
  - Educate all staff (e.g., inpatient, outpatient, community-based) on interpreter services available within the healthcare system.
- Provide staff-wide education on:
  - Peripartum racial and ethnic disparities and their root causes.
  - Best practices for shared decision making.
- Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

PATIENT SAFETY BUNDLE

Reduction of Peripartum Racial/Ethnic Disparities

Valuing lived experience

Centering Women's Voices in Maternity Care Quality Improvement
AKA "You Can't Bundle This"

Chanel Porchia-Albert

Poulette Brewster

Kaitlin Doyle

ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH AIM

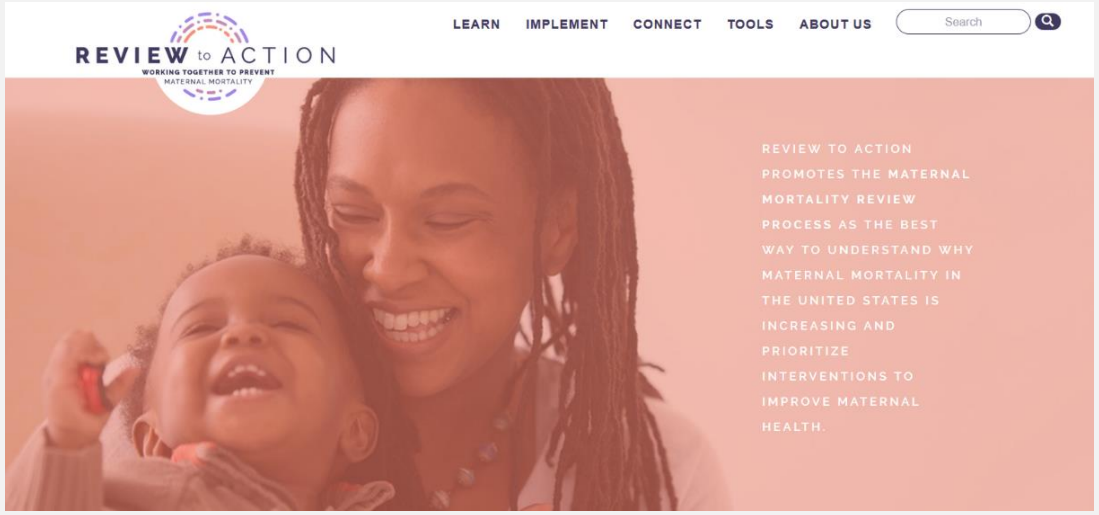
Be truthful about our history and acknowledge the role that we have played in directly or unintentionally enabling and/or supporting systems of inequity

Being truthful about our history

- We are late in our acknowledgement
- We have used callous language
  - Examples: “At-risk” and “vulnerable population”
- Not prioritized Indigenous populations
- Our membership structure and events
  - Who are they accessible to?
- Our internal processes
  - Who do we partner with and why?
- What are the truths in your field’s history? Your personal history?

Be comfortable with the “un-comfortability” of having difficult conversations that challenge our thinking and stretch us in our approach to dismantling inequitable systems

Be comfortable with the uncomfortable



ERASE MM

Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

- In the spaces we hold:
  - Who is missing? Why?
  - What type of space are we creating? Who feels comfortable here?
  - What is preventing transparent data sharing?
  - Lean into the “Why?”
  - How did my bias show up in this interaction?

Be comfortable with the uncomfortable

AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

November 8, 2020

Dear Commissioners, thank you for the opportunity to participate in this hearing on the very important topic of maternal health disparities. My name is Jonathan Webb and I am the CEO of the Association of Maternal & Child Health Programs (AMCHP). AMCHP is a national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth, and families, including those with special health care needs.

AMCHP's members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, and other public health leaders who work with and support state maternal and child health programs. Our members directly serve all women and children nationwide, and strive to improve the health of all women, infants, children, and adolescents, including those with special health care needs, by administering critical public health education and screening services, and coordinating preventive, primary and specialty care. Our membership also includes academic, advocacy and community-based family health professionals, as well as families themselves.

AMCHP builds successful programs by disseminating best practices; advocating on our member's behalf in Washington; providing technical assistance; convening leaders to share experiences and ideas; and advising states about involving partners to reach our common goal of healthy children, healthy families, and healthy communities.

AMCHP has been
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1825 K Street, NW, Suite 250, Was

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HEALTH EQUITY

AMA: Racism is a threat to public health

NOV 16, 2020

NICHQ National Institute for Children's Health Quality

Insights

Racism and Public Health: Seeking an Improved Approach for the New Decade

onal Goals for 2020

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

From the American Academy of Pediatrics Policy Statement

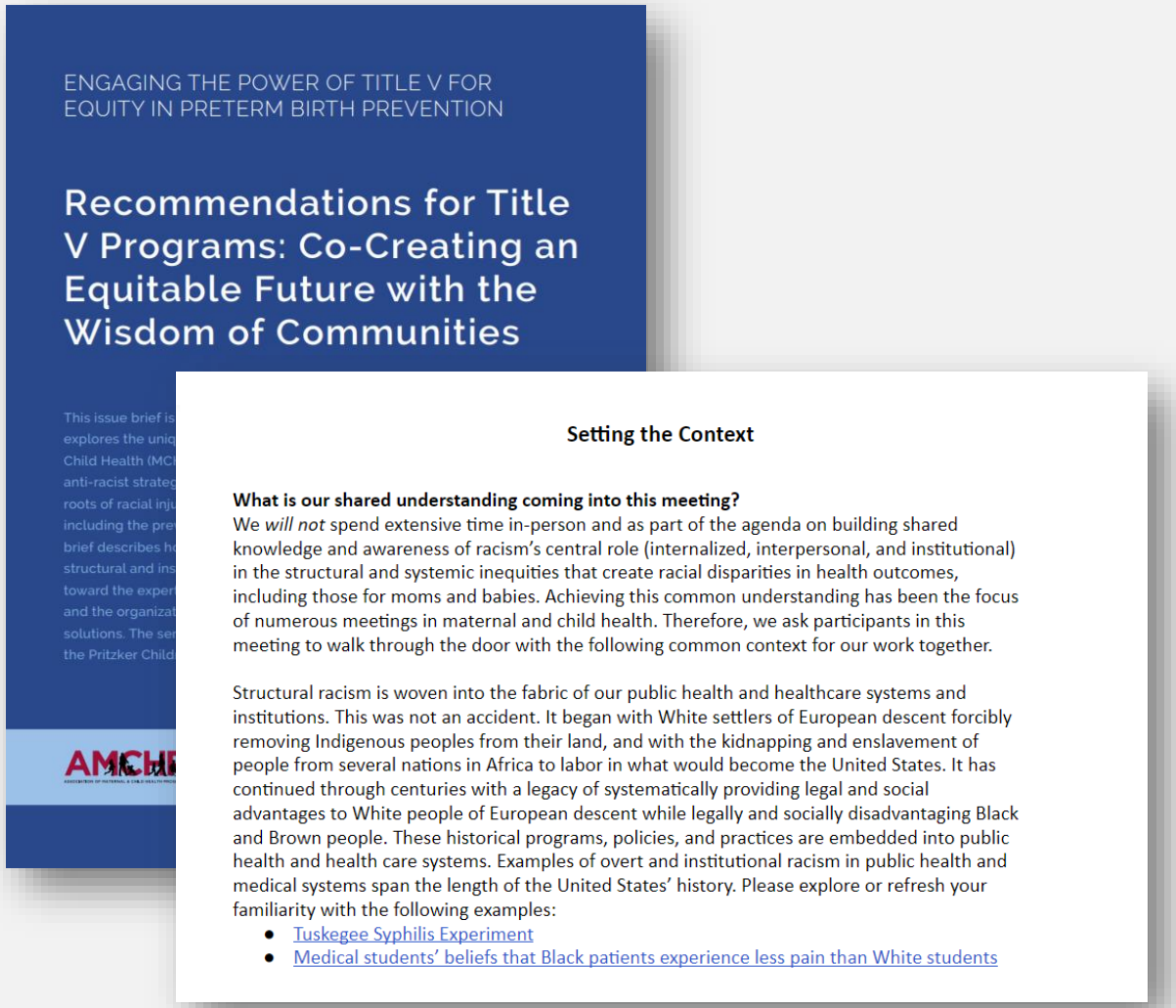
The Impact of Racism on Child and Adolescent Health

Maria Trent, Danielle G. Dooley, Jacqueline Dougé, SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS and COMMITTEE ON ADOLESCENCE

Pediatrics August 2019, 144 (2) e20191765; DOI: https://doi.org/10.1542/peds.2019-1765

Be bold, brave, and courageous as we lead in this work

Be bold, brave, & courageous



- Making intentional choices and standing in their consequences
- Set an expectation, and ask partners to reach it
- Co-create spaces with those who have the knowledge
  - Context statement, co-written with community partners Jennie Joseph, Aza Nedhari, Alexis Cobbins, and Jere McKinley
- Who is uncomfortable? Are we "softening the blow"?
- Move past the individual level, and confront systems and policies

A Call to Action & Accountability

- Holding ourselves and partners accountable also means inviting them with us on this journey, so we invite you to join us

- We extend this invitation from a place of imperfection; we have stumbled and know we will continue to do so

A Call to Action & Accountability

Establish honest conversations on racism in your spheres of influence

Educate yourselves, your staff and organization members on the history of racism in our communities and country

Examine current and new policies to determine their impact on equity and recognize your power in changing those that have unjust impact

Promote life course theory to understand accumulated disadvantage and advantage and encourage efforts that support resilience and restore power to communities of color

Engage and partner, with humility and truth, with impacted communities and local organizations

A Call to Action & Accountability

Suggested reading:

- Perritt J. (2020). #WhiteCoatsForBlackLives - Addressing Physicians' Complicity in Criminalizing Communities. *The New England journal of medicine*, *383*(19), 1804–1806. https://doi.org/10.1056/NEJMp2023305
- Hardeman, R. R., Medina, E. M., & Boyd, R. W. (2020). Stolen Breaths. *The New England Journal of Medicine*, *383*(3), 197–199. https://doi.org/10.1056/NEJMp2021072
- “How the Bad Blood Started” episode of the 1619 Project podcast
- “Roots of the Black Birthing Crisis” episode of NATAL podcast

Thank you!

Answering the Call to Accountability: Racial equity as a national public health imperative

Kristina Wint, MPH

Program Manager, Women's Health

kwint@amchp.org

Integrating Health Equity In Maternal Safety Improvement Perspectives From State Maternal Mortality Review TexasAIM Summit 12-09-2020

Carla Ortique, MD Chair Texas MMMRC Subcommittee on Maternal Health Disparities

Background

- The Texas Maternal Mortality and Morbidity Task Force (now Review Committee) was legislatively established in 2013 and began its work in late 2014.

- The multidisciplinary **Texas Maternal Mortality and Morbidity Review Committee** is an advisory committee within the Texas Department of State Health Services and is supported by DSHS.

Duties of the Review Committee

Studies and reviews:

- Cases of potentially pregnancy related deaths;
- trends, rates, or disparities in pregnancy-related deaths and severe maternal morbidity;
- health conditions and factors that disproportionately affect the most at-risk population
- best practices and programs operating in other states
- **Compares rates of pregnancy-related deaths based on mothers' socioeconomic status**
- **Determines feasibility of studying cases of severe maternal morbidity**; and
- In consultation with the state Perinatal Advisory Council, **makes recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity** in Texas.

MMMRC and DSHS submit biennial joint report of findings and recommendations to state lawmakers

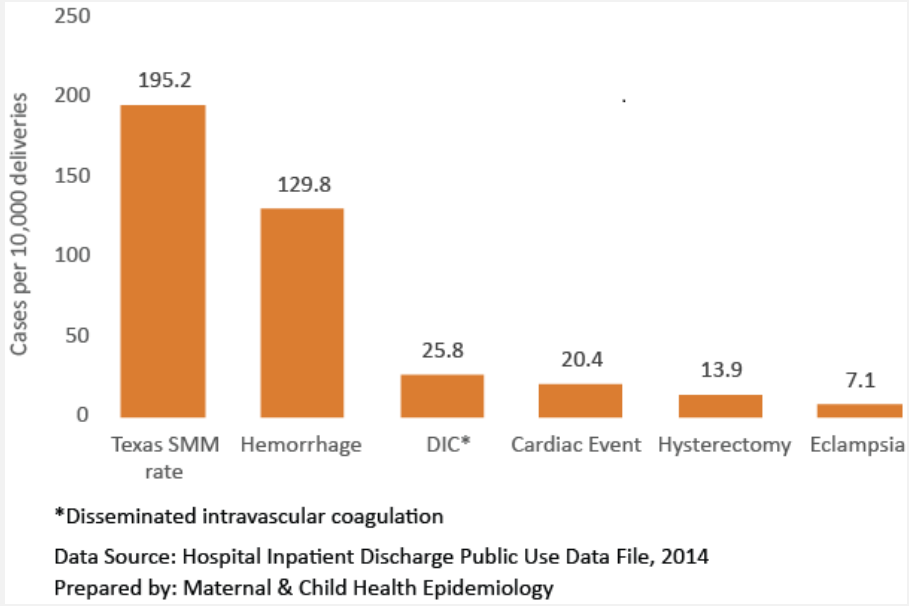
Key Questions

1. Was the death related to the pregnancy?
2. What caused and contributed to the death?
3. Was the death preventable?
4. What recommendations can be made to prevent future deaths?

Hemorrhage and cardiac event were the two most common causes of death while pregnant or within 7 days postpartum

	TIMING OF DEATH					
Cause of Death	While Pregnant	0-7 Days Postpartum	8-42 Days Postpartum	43-60 Days Postpartum	61+ Days Postpartum	TOTAL
Drug Overdose	0	3	7	5	49	64
Other Causes	5	5	6	3	44	63
Cardiac Event	2	12	9	5	27	55
Homicide	2	1	5	2	32	42
Infection/Sepsis	1	3	14	3	11	32
Suicide	0	1	2	2	28	33
Cerebrovascular Event	0	8	9	1	9	27
Hemorrhage	3	12	2	0	3	20
Hypertension/Eclampsia	0	7	4	0	7	18
Pulmonary Embolism	2	3	4	2	2	13
Amniotic Embolism	1	9	0	0	0	10
Substance Use Sequelae (e.g., liver cirrhosis)	0	0	2	0	3	5
TOTAL	16	64	64	23	215	382

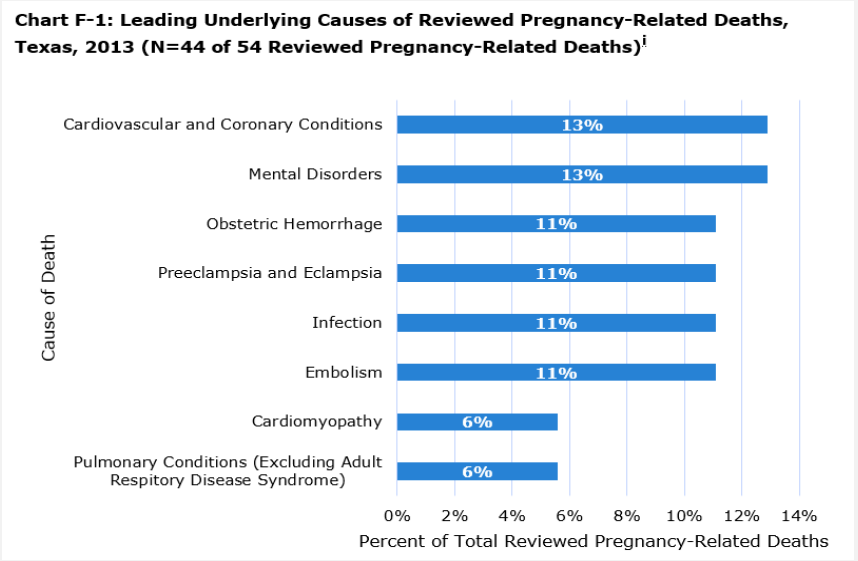
Severe Maternal Morbidity Overall and Top Causes



Finding: MMMRC And Department of State Health Services Joint Biennial Report, December, 2020

Eight underlying causes of death accounted for 82 percent of all pregnancy-related death among reviewed 2013 cases.

Chart F-1: Leading Underlying Causes of Reviewed Pregnancy-Related Deaths, Texas, 2013 (N=44 of 54 Reviewed Pregnancy-Related Deaths)[i]



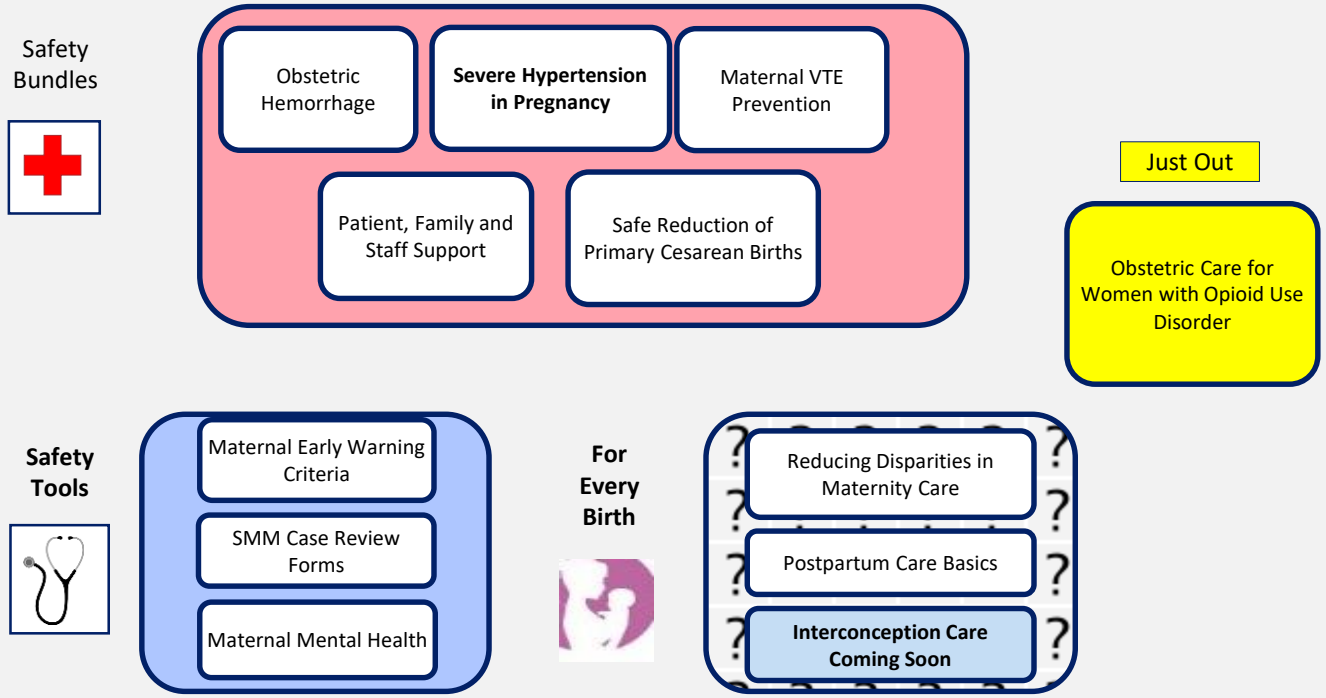
PREPARED BY: Healthy Texas Mothers and Babies Branch, Maternal & Child Health Unit, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Maternal Mortality and Morbidity Task Force And Department of State Health Services Joint Biennial Report, September 2018

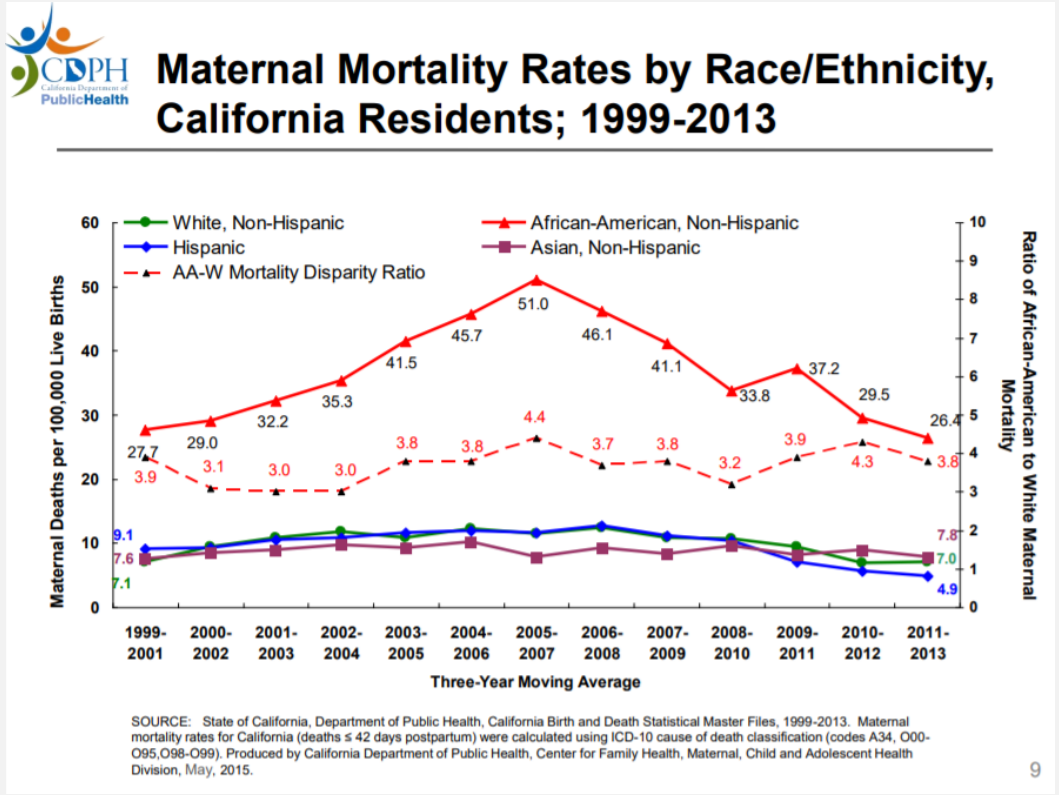
- *Increase access to health services during the year after pregnancy and throughout the inter-conception period to improve the health of women, facilitate continuity of care, enable effective care transitions, and promote safe birth spacing*
- *Enhance screening and appropriate referral for maternal risk conditions*
- ***Promote a culture of safety and high reliability through implementation of best practices in birthing facilities***
- *Identify or develop and implement programs to reduce maternal mortality from cardiovascular and coronary conditions, cardiomyopathy and infection*
- *Improve postpartum care management and discharge education for patients and families*
- *Increase maternal health programming to target high-risk populations, especially Black women*
- *Initiate public awareness campaigns to promote health enhancing behaviors*
- *Champion integrated care models combining physical and behavioral health services for women and families*
- *Support strategies to improve the maternal death review process*

AIM Quality and Safety Bundles

- 1



Maternal Mortality Disparities: Equality vs Equity



Finding: MMMRC And Department of State Health Services
Joint Biennial Report, December, 2020

Disparities persist in maternal mortality. Non-Hispanic Black women are disproportionately impacted.

Race/Ethnicity	Racial/Ethnic Distribution of Live Births in 2013	Racial/Ethnic Distribution of Reviewed Pregnancy-Related Deaths in 2013
Non-Hispanic Black Women	*11%*	*31%*
Hispanic Women	*48%*	*26%*
Other Races/Ethnicities	*6%*	*2%*
Non-Hispanic White Women	*34%*	*41%*

Statewide Trends Maternal Death

Black women bear the greatest risk for maternal death

Maternal Death Rates by Demographic Characteristics, Texas, 2012-2015

Demographic Characteristic	Number of Live Births	Number (%) of Maternal Deaths	Rate (per 100,000 live births)
RACE/ETHNICITY			
Black	180,714	77 (20%)	42.6
White	539,177	149 (39%)	27.6
Hispanic	748,644	144 (38%)	19.2
Other	103,934	12 (3%)	11.5

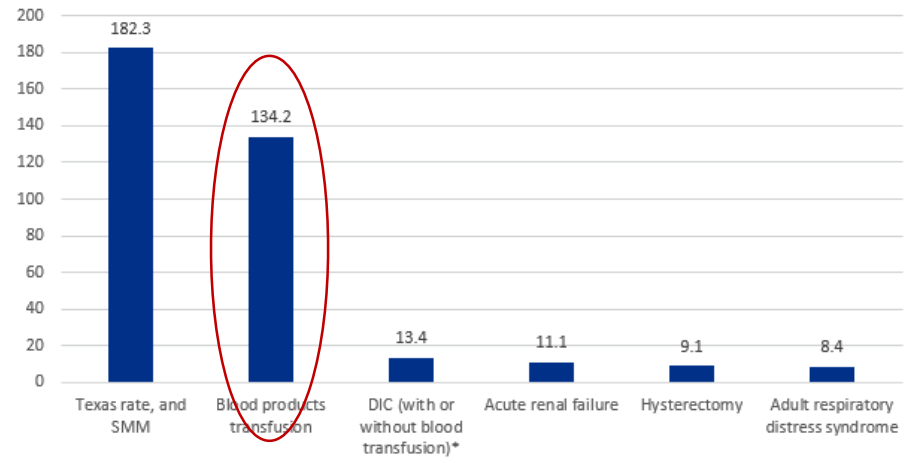
MATERNAL MORTALITY: INEQUITY MAGNIFIED

- Black - White Maternal Mortality disparity is the largest among all conventional perinatal health disparities
- Black women consistently experience 4X greater risk of pregnancy related death than white women
- This is independent of age, parity, socioeconomic status, education level or presence of co-morbidities such as obesity, hypertension and diabetes
- U.S. Maternal Mortality Review Committees findings identify that approximately 80% of pregnancy related deaths are preventable

Statewide Trends:
Severe Maternal Morbidity- Transfusion

Blood product transfusions, with or without other indicators of SMM, was the leading procedure indicating any SMM in delivery hospitalizations in 2018.

Figure H-3: Rates in Severe Maternal Morbidity Indicators per 10,000 Delivery Hospitalizations, Texas, Any Severe Maternal Morbidity Rate and Leading Indicators, 2018[i]

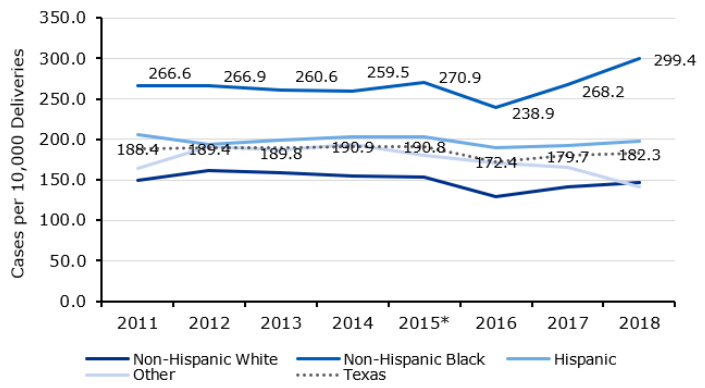


[i]PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Statewide Trends: Severe Maternal Morbidity

Severe maternal morbidity (SMM) disproportionately impacts Non-Hispanic Black and Hispanic women. Rates of delivery hospitalizations involving any SMM at delivery vary by county.

Figure H-1: Rate of Delivery Hospitalizations Involving Any Severe Maternal Morbidity in Texas per 10,000 Delivery Hospitalizations by Race and Ethnicity, 2011-2018[i]

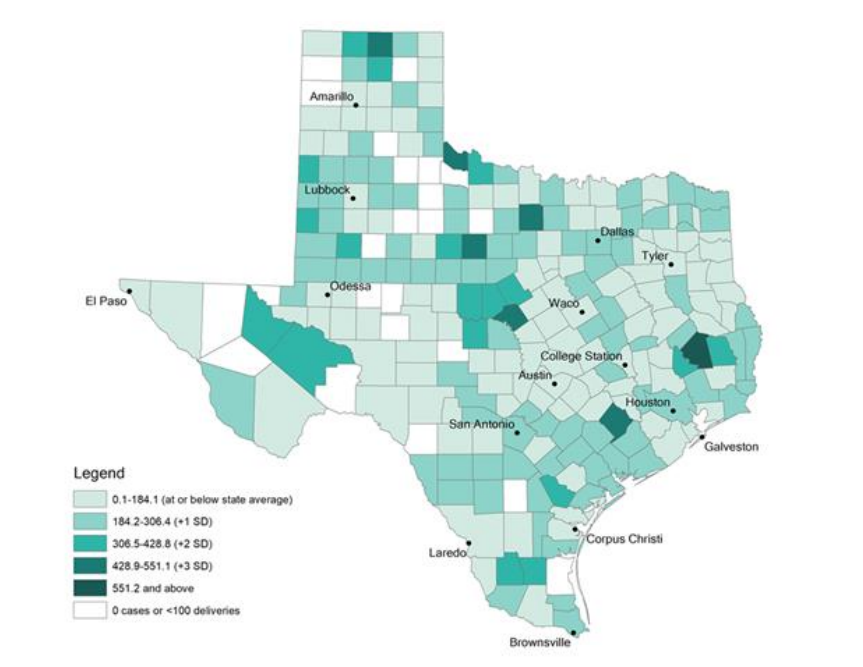


[i] PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

The rate of any SMM per 10,000 delivery hospitalizations for Non-Hispanic Black women in 2018 was 299.4 cases compared to the state rate of 182.3. Higher rates of any SMM were also observed among Hispanic mothers .

Statewide Trends: Severe Maternal Morbidity

Rates of Delivery Hospitalizations Involving Severe Maternal Morbidity per 10,000 Delivery Hospitalizations by County, 2013-2018

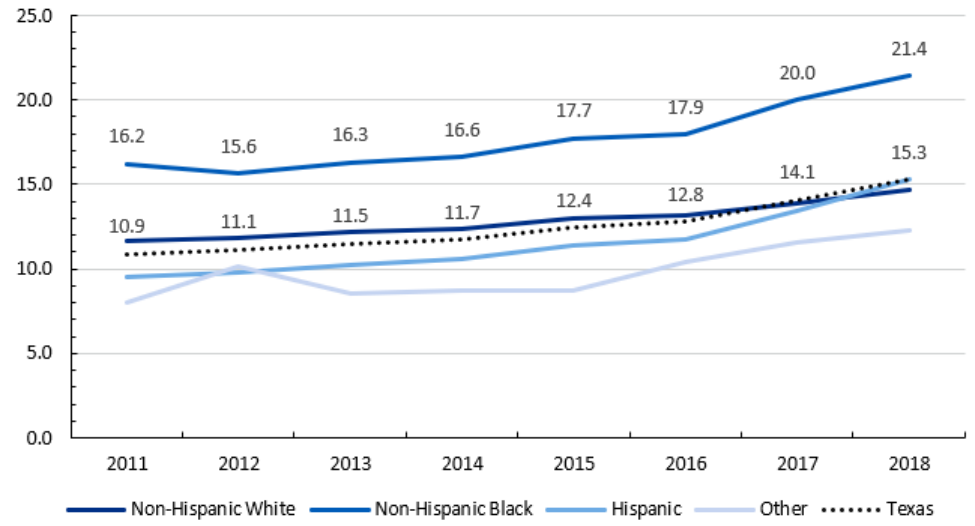


Severe maternal morbidity (SMM) disproportionately impacts Non-Hispanic Black and Hispanic women. Rates of delivery hospitalizations involving any SMM at delivery vary by county.

Statewide Trends: Severe Maternal Morbidity-Hypertension

Rates of delivery hospitalizations involving hypertensive disorder were highest among Non-Hispanic Black mothers and varied by county.

Figure H-4: Delivery Hospitalization Involving Hypertensive Disorder Rates by Race/Ethnicity, Texas, 2011-2018[i]

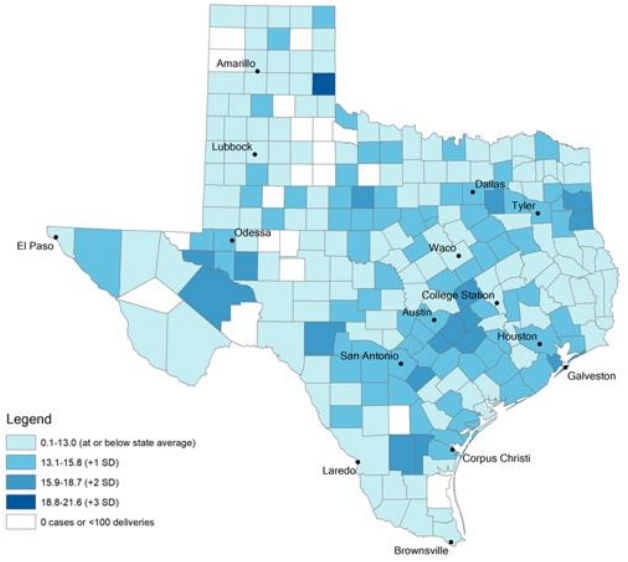


[i]PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Severe Maternal Morbidity- Hypertension

Rates of delivery hospitalizations involving hypertensive disorder were highest among Non-Hispanic Black mothers and varied by county.

Figure H-5: Rate of Delivery Hospitalization Involving Hypertensive Disorder per 10,000 Delivery Hospitalizations by County of Residence, Texas, 2013-2018[i]



[i]PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

Subcommittee on Maternal Health Disparities Addressing Gaps In Understanding

- Developed to address recommendations of the 2018 biennial report regarding at risk populations
- MMMRC members with interest and/or expertise in public health outcomes in communities of color, represent each of the four review teams and participate fully in case reviews
- Goals
  - Provide secondary review of maternal deaths involving Black and Native American women in Texas to identify key drivers of disparities in maternal health outcomes
  - Develop strategies and recommendations to eliminate racial disparities in maternal health outcomes
  - Provide guidance to the full MMMRC for applying a Health Equity lens to identifying contributing factors and avoiding bias in the maternal death review process
- Developed implicit bias tool for identifying impact of social determinants and evidence of bias as a contributing factor in maternal death review
  - The MMMRC will begin to incorporate this tool into the review process in December, 2019.
- Analysis of the contributing factors identified in previous case reviews by race and ethnicity of the decedent

Addressing Gaps In Understanding

To date, the Subcommittee has engaged in the following activities:

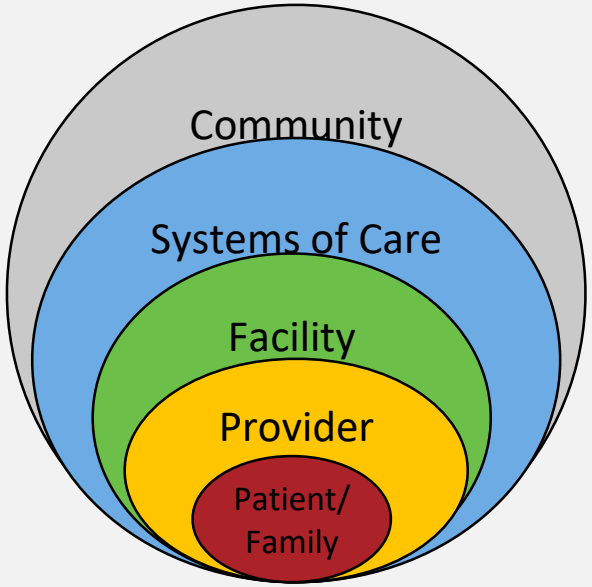
- studied pregnancy-related death cases in the 2012 case cohort and the association of women's race or ethnicity with the number and types of contributing factors that the review committee identified during their review;
- consulted with DSHS in the development of a Texas Socio-Spatial Dashboard; and
- developed and currently testing the Discrimination Assessment and Social determinants of Health
- (DASH) Facilitated Discussion Tool

Domains of Contributing Factor Themes in a Social-Ecological Model

A complex interaction of factors contributed to pregnancy-related death.

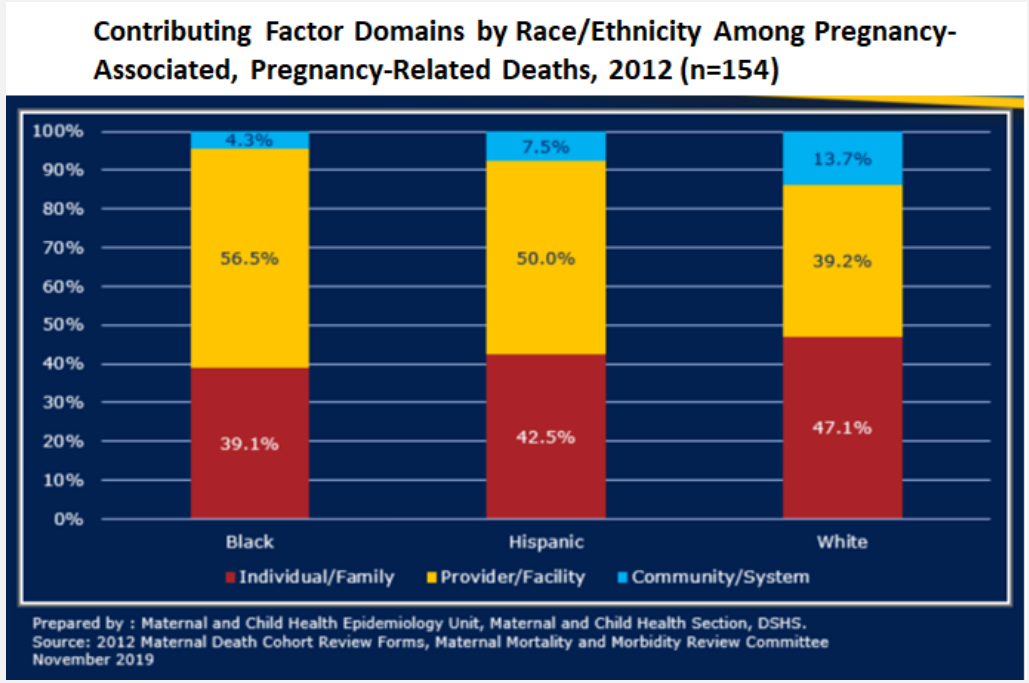
Contributing Factors: factors identified by the review committee that contributed to the death. Identification of contributing factors to death allows the review committee to identify prevention and quality improvement opportunities that may have prevented the woman's death and make recommendations to reduce maternal mortality.

367 factors contributed to the 54 pregnancy-related cases reviewed from the 2013 cohort, an average of 6.8 contributing factors per case were identified.



Maternal Mortality Disparities: Addressing Gaps in Understanding

Findings from the Subcommittee on Maternal Health Disparities



Maternal Mortality Disparities: Addressing Gaps in Understanding

COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH

DID **DISCRIMINATION** CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

DISCRIMINATION
Treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making. (Smedley et al, 2003 and Dr. Rachel Hardeman)

STRUCTURAL RACISM
The systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc. – (Adapted from Bailey ZD. Lancet. 2017 and Dr. Carla Ortique)

INTERPERSONAL RACISM
Discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization. (Jones, CP, 2000 and Dr. Cornelia Graves).

From: Maternal Mortality Review Information Application (MMRIA) Committee Decisions Form , version 20

Recommendation MMMRC And Department of State Health Services Joint Biennial Report, December, 2020

Engage Black communities and apply health equity principles in the development of maternal and women's health programs.


be the
CHANGE
you want to see
in the
WORLD

Thank you!

cxortiqu@texaschildrens.org

Beyond the Chart:

Advocating for Equity in Maternal Healthcare

Nakeenya Wilson, MA

Executive Director

Black Mamas ATX

Black Mamas ATX

MISSION
Ensure that Black women survive and thrive before, during, and after childbirth

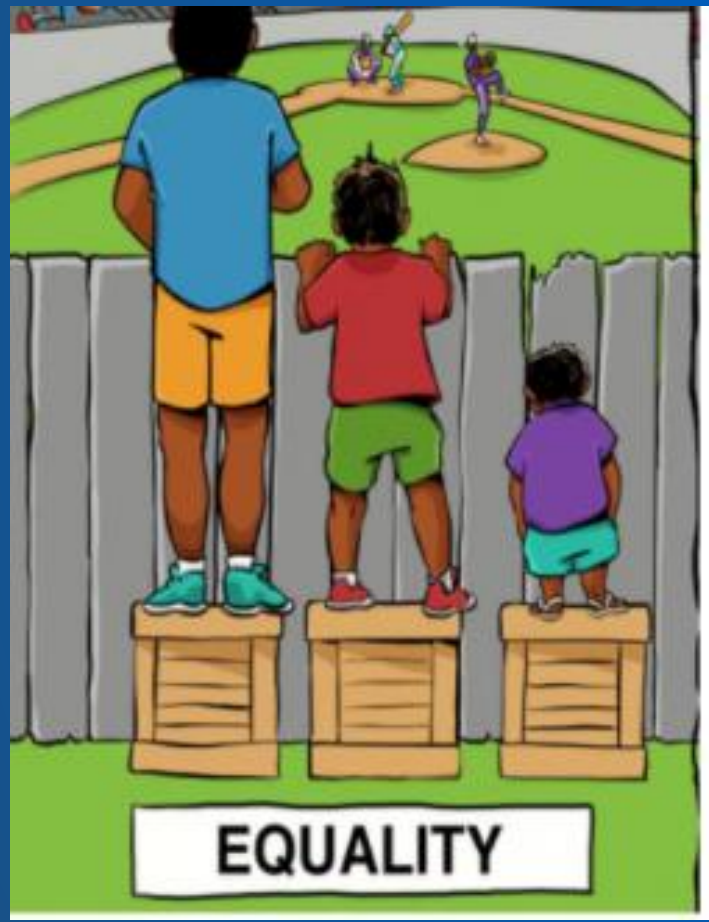
VISION
A world without maternal health disparities

Black Mamas Community Collective: A Social Movement

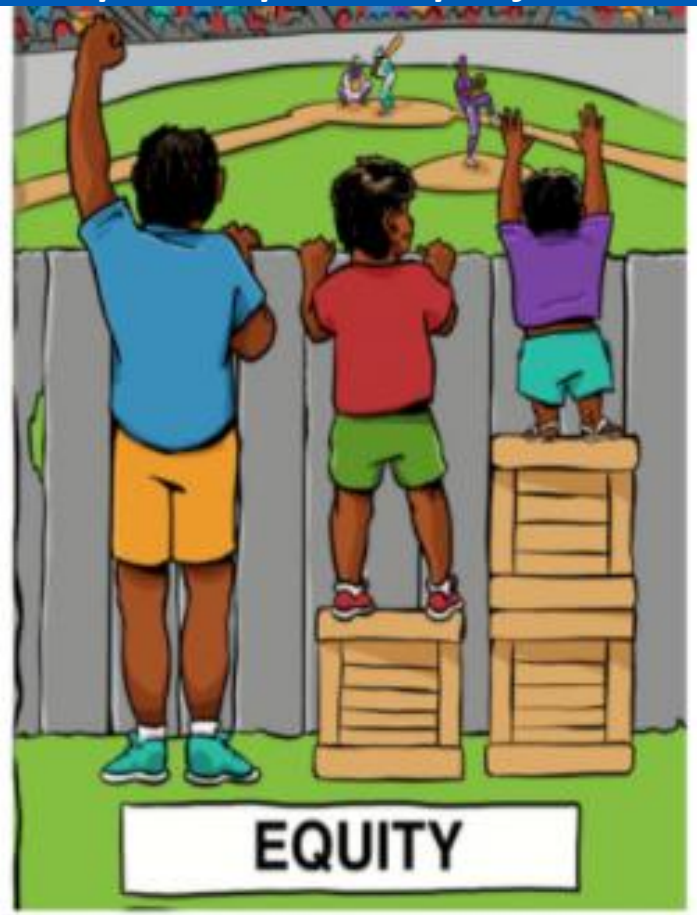
- Sister Circles & Anxiety Support Groups
- Full Spectrum Doulas
- Public Awareness
- Policy Advocacy
- Groundwater Analysis Training
- Psychotherapy/Case Management

Recognizing Inequity

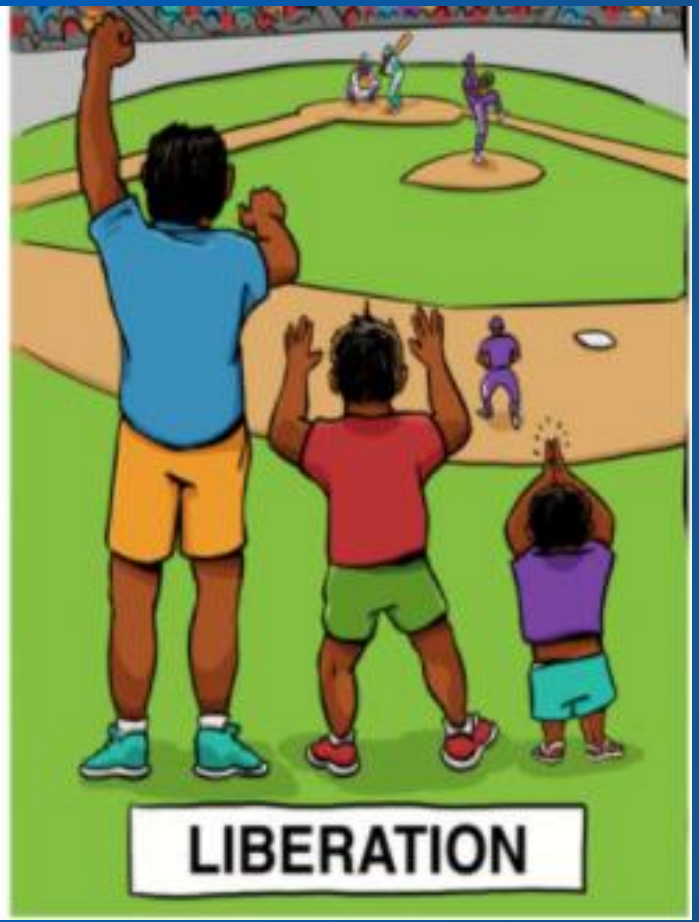
We treat all patients the same based policy and best practice



We meet people where they are and provide patient specific care



We center patients VOICE and CHOICE in their care and remove all barriers



Shifting Perspective & Practice

What are the assumptions that inform patient care?

- All women have the same resources
- Evidence-based practice is inclusive
- Doctor knows best
- Medical mistrust is baseless

Weathering

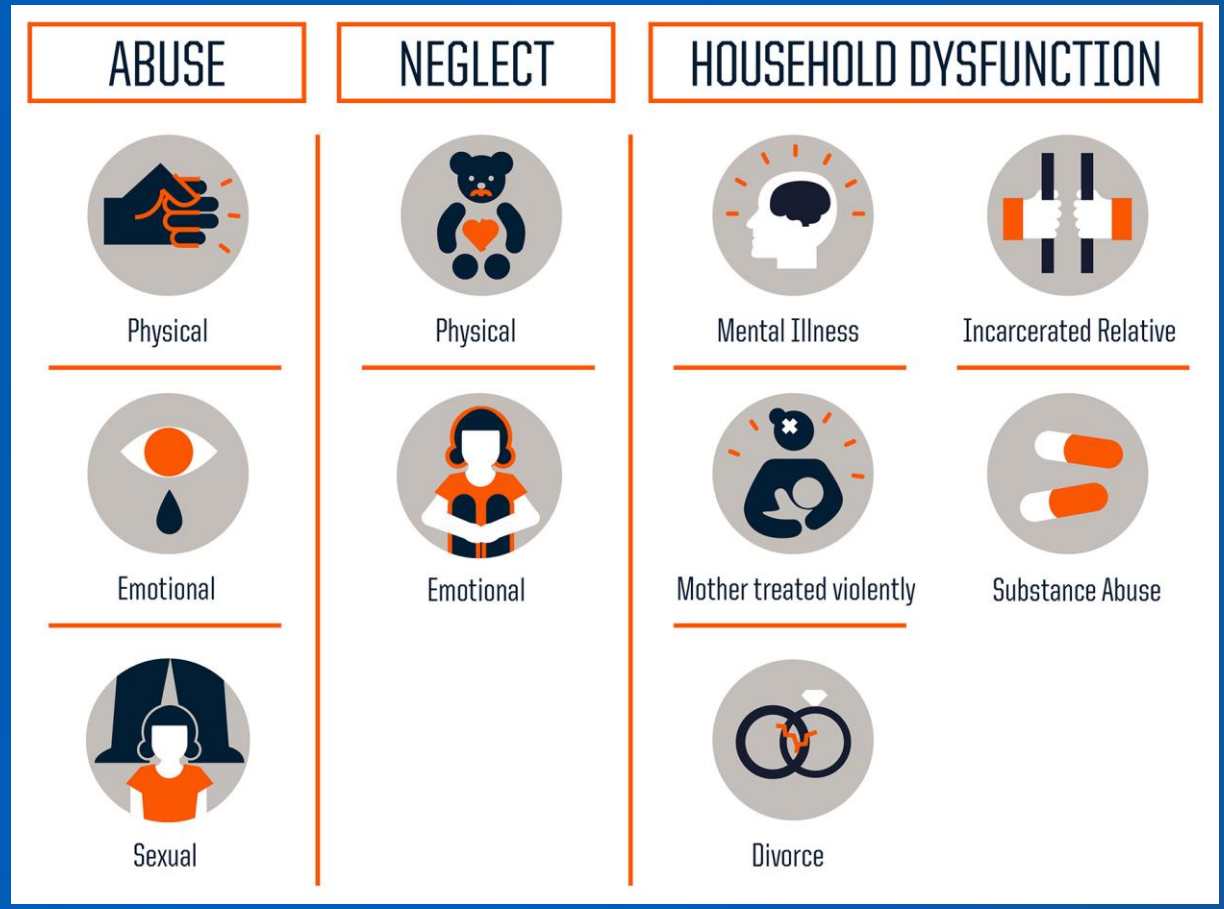
African-American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage, erosion of health due to chronic stress.

Social Determinants of Health

Adverse Childhood Experiences (ACES)

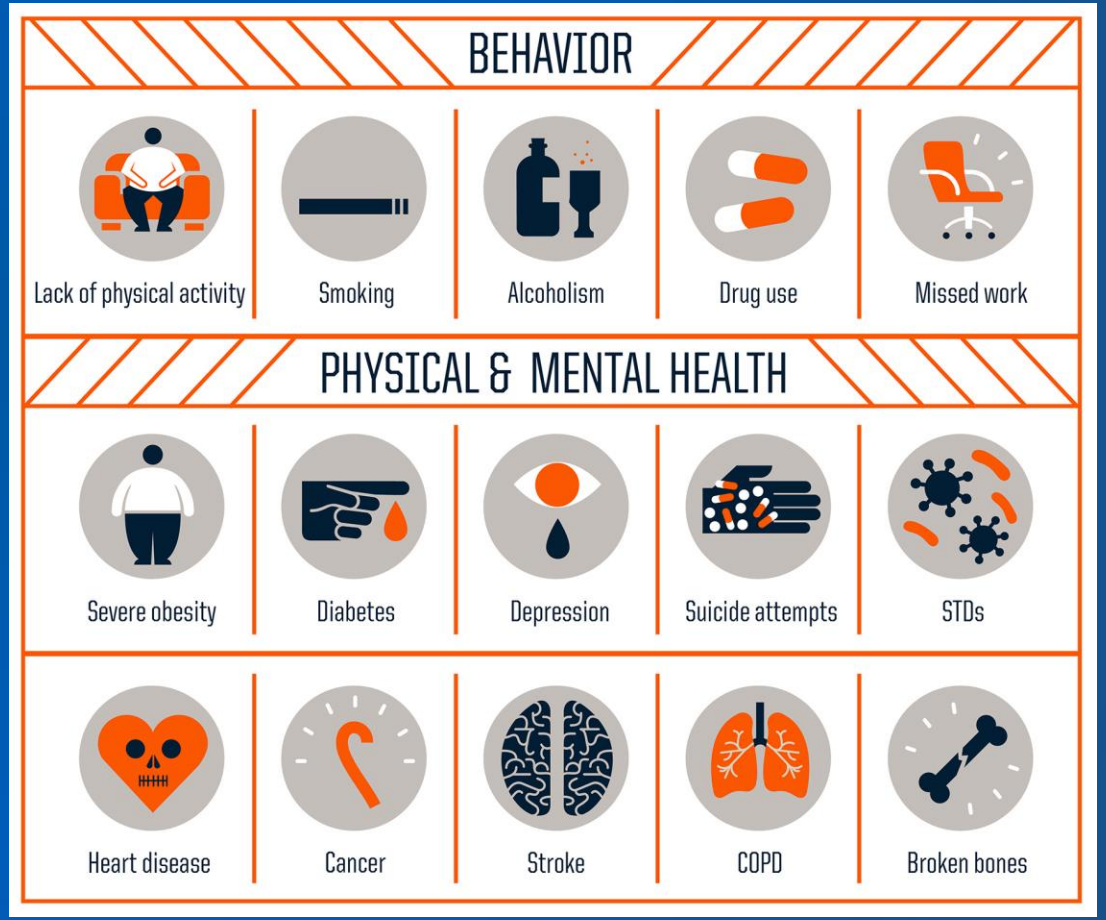
Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years)

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood.



Adverse Childhood Experiences (ACES)

How can ACES impact certain women being categorized as “high risk” ?



Racial Trauma is a Health Concern

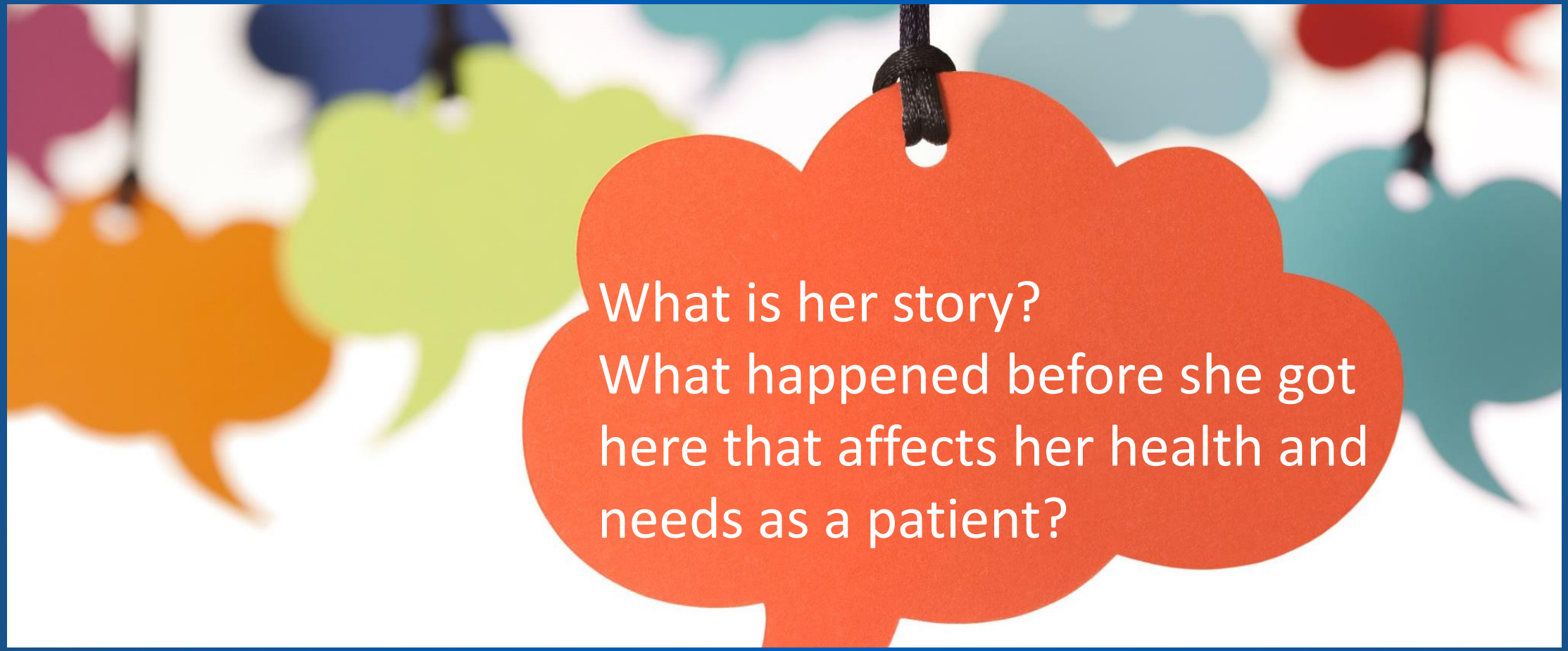
What is Racial Trauma?

Racial trauma is the result of experiencing and witnessing racial stressors including racism, discrimination and violence against people of color. These acts of racism and discrimination create an environment in which a person of color feels unsafe and vulnerable in their community simply for existing in their own skin.

Effects of Racial Trauma

- Re-experiencing distressing events
- Chronic stress
- Hypervigilance
- Depression
- Anxiety
- Physical pain
- Cardiovascular disease
- Hypertension
- Respiratory complications

Debunking Flawed Thinking



What is Her Story?

- Advanced Degree
- Middle Class
- Married
- Homeowner
- Non-Smoker
- No Alcohol
- Gestational Diabetes
- 3 Preeclampsia Births
- Perinatal Anxiety & Depression
- Traumatic Birth Experience
- 2 deliveries AMA
- Pregnancy Induced Hypertensive
- BMI 30.2
- A1C of 6.1
- Cholesterol 206

Beyond Her Chart

- Product of generational poverty
- Family history of substance use & mental illness
- Domestic Violence Survivor
- ACE Score of 7

Conscious Curiosity

Who is the patient, holistically?

Who am I in relation to the patient?

Who all should be involved in the patient care team?

Why is the patient presenting this way?

What are the barriers to care?

What does the patient want?

When am I responsible for addressing patient experience?

How can I be an advocate?

Shifting Perspective & Practice

- Institutions and systems have conducted diverse research to inform best practice
- Access to resources and social support is not equal to all women
- Doctors know medical practice; women know their bodies
- The history of harm to BIPOC by the medical community is real

References

- Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. Ethn Dis. 1992 Summer;2(3):207-21. PMID: 1467758.
- Preventing Adverse Childhood Experiences |Violence Prevention|Injury Center|CDC. (2020). Retrieved 4 December 2020, from https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Ffastfact.html
- “Social Determinants of Health .” World Health Organization, n.d. https://www.who.int/social_determinants/en/
- (2020). Retrieved 4 December 2020, from https://www.psychology.uga.edu/sites/default/files/Slide1_4.png

Thank you!

Beyond The Chart

Nakeenya Wilson

nakeenya@blackmamasatx.com

(512) 660-1981

Addressing Racial and Ethnic Disparities through Data Disaggregation

Christina Davidson, MD

Associate Professor | Division of Maternal Fetal Medicine

Vice Chair of Quality, Patient Safety & Equity | Department of Obstetrics & Gynecology | Baylor College of Medicine

Chief Quality Officer, Obstetrics & Gynecology | Texas Children's Hospital

Co-Chair, Obstetrics Committee, Texas Collaborative for Healthy Mothers and Babies

Vice Chair, Society for Maternal-Fetal Medicine Patient Safety and Quality Committee

Texas Children's Pavilion for Women

- Located in Texas Medical Center
- ~6500 deliveries/year
- 24/7 coverage by Hospitalists, Critical Care Medicine, and BCM Residents
- Patient demographics:
  - 38% Hispanic
  - 34% Non-Hispanic White
  - 20% Non-Hispanic Black
  - 8% Asian/Other
  - 40% Medicaid

Texas Children's Hospital®

Texas Children's Hospital Pavillion for Women

Texas Children's Hospital®

Structure Measures Data Entry (3 of 6) | Process Measures Data Entry | **Measure Results**

No data entry required. Data sourced from Texas AIM (TexasAIM@dshs.texas.gov).

Outcome Measures	2011	2012	2013	2014	2015	2016	2017
Severe Maternal Morbidity among All Delivering Women	No Data	No Data	No Data	No Data	No Data	3.3%	3.5%
Severe Maternal Morbidity (excluding transfusion codes) among All Delivering Women	No Data	No Data	No Data	No Data	No Data	1.3%	1.4%
Severe Maternal Morbidity among Hemorrhage Cases	No Data	No Data	No Data	No Data	No Data	25.5%	27.2%
Severe Maternal Morbidity (excluding transfusion codes) among Hemorrhage Cases	No Data	No Data	No Data	No Data	No Data	7.9%	8.4%

Texas baseline (2011-2015): 30.9% SMM among hemorrhages

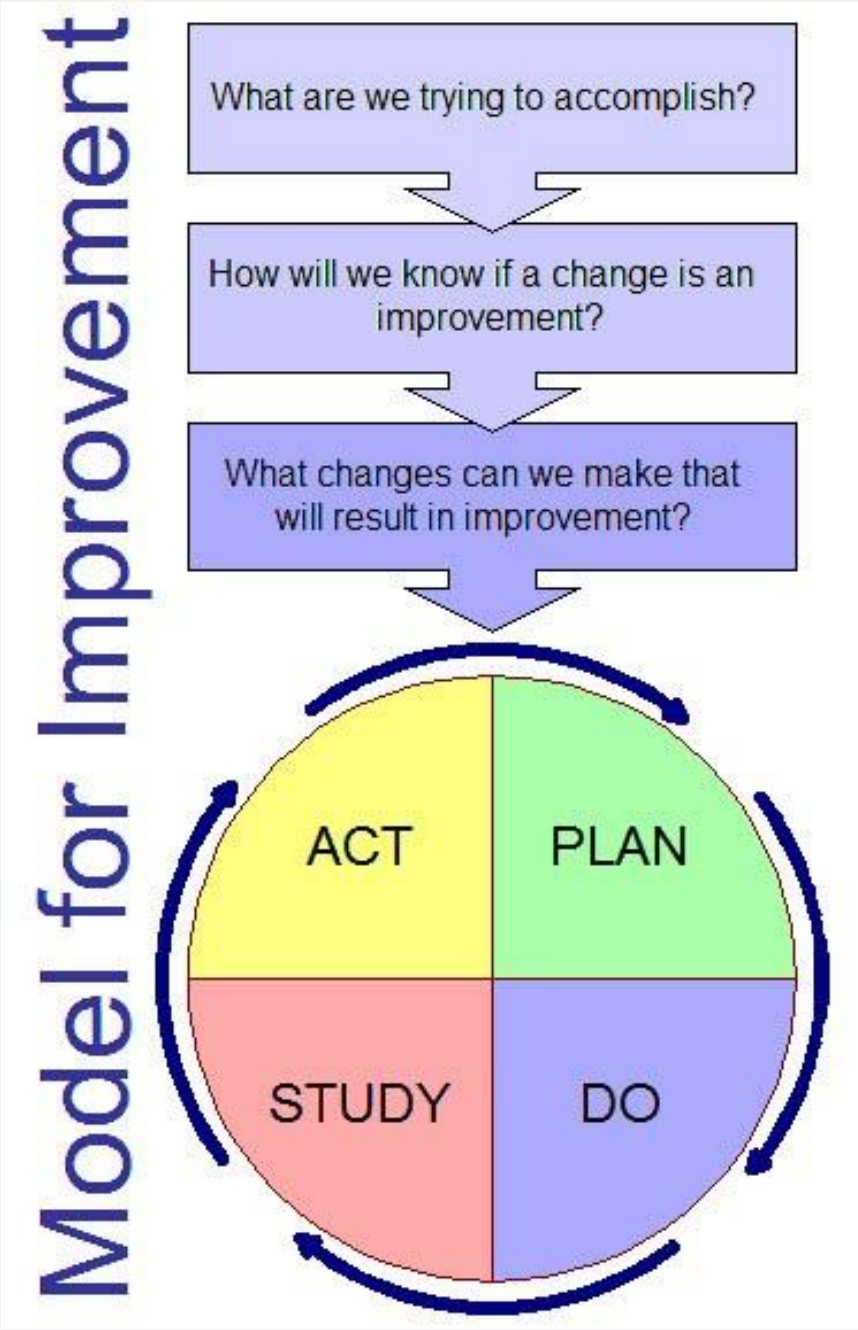
TexasAIM Goal: reduce hemorrhage SMM by 25%

PDSA: Using Data Stratification to Improve Health Equity

- What are we trying to accomplish?
  - Provide organizational leaders with strategic measures stratified by race, ethnicity, language to reveal disparities that can be reduced/eliminated to improve care

- How will we know that a change is an improvement?
  - Stratified data helps organizations identify inequities, inform action, improve overall performance

- What change can we make that will result in improvement?
  - Identify one strategic measure the organization wants to improve and provide stratified data for that measure to identify opportunities for improvement



COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Reduction of Peripartum Racial/Ethnic Disparities

READINESS

Every health system

- Establish systems to accurately document self-identified race, ethnicity, and primary language.
  - Provide system-wide staff education and training on how to ask demographic intake questions.
  - Ensure that patients understand why race, ethnicity, and language data are being collected.
  - Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
  - Evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English.
  - Educate all staff (e.g. inpatient, outpatient, community-based) on interpreter services available within the healthcare system.
- Provide staff-wide education on:
  - Peripartum racial and ethnic disparities and their root causes.
  - Best practices for shared decision making.
- Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

RECOGNITION

Every patient, family, and staff member

- Provide staff-wide education on implicit bias.
- Provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the maternal patient, in a clear and simple format that summarizes information most pertinent to perinatal care and wellness.
- Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Reduction of Peripartum Racial/Ethnic Disparities

RESPONSE

Every clinical encounter

- Engage in best practices for shared decision making.
- Ensure a timely and tailored response to each report of inequity or disrespect.
- Address reproductive life plan and contraceptive options not only during or immediately after pregnancy, but at regular intervals throughout a woman's reproductive life.
- Establish discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.
  - Provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.
  - Design discharge materials that meet patients' health literacy, language, and cultural needs.

REPORTING & SYSTEMS LEARNING

Every clinical unit

- Build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture.
- Develop a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity, with regular dissemination of the stratified performance data to staff and leadership.
- Implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes.
- Consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics.
  - Add as a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?

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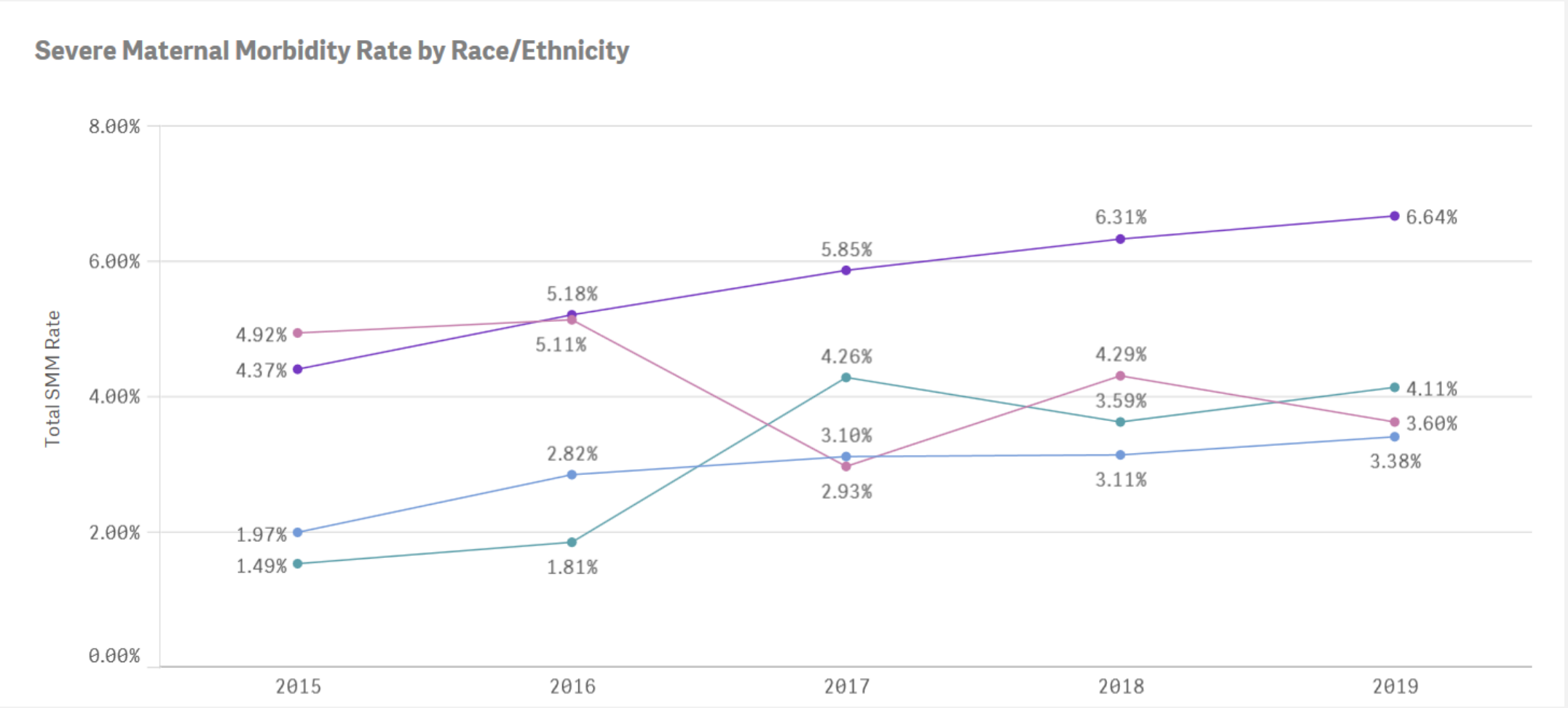
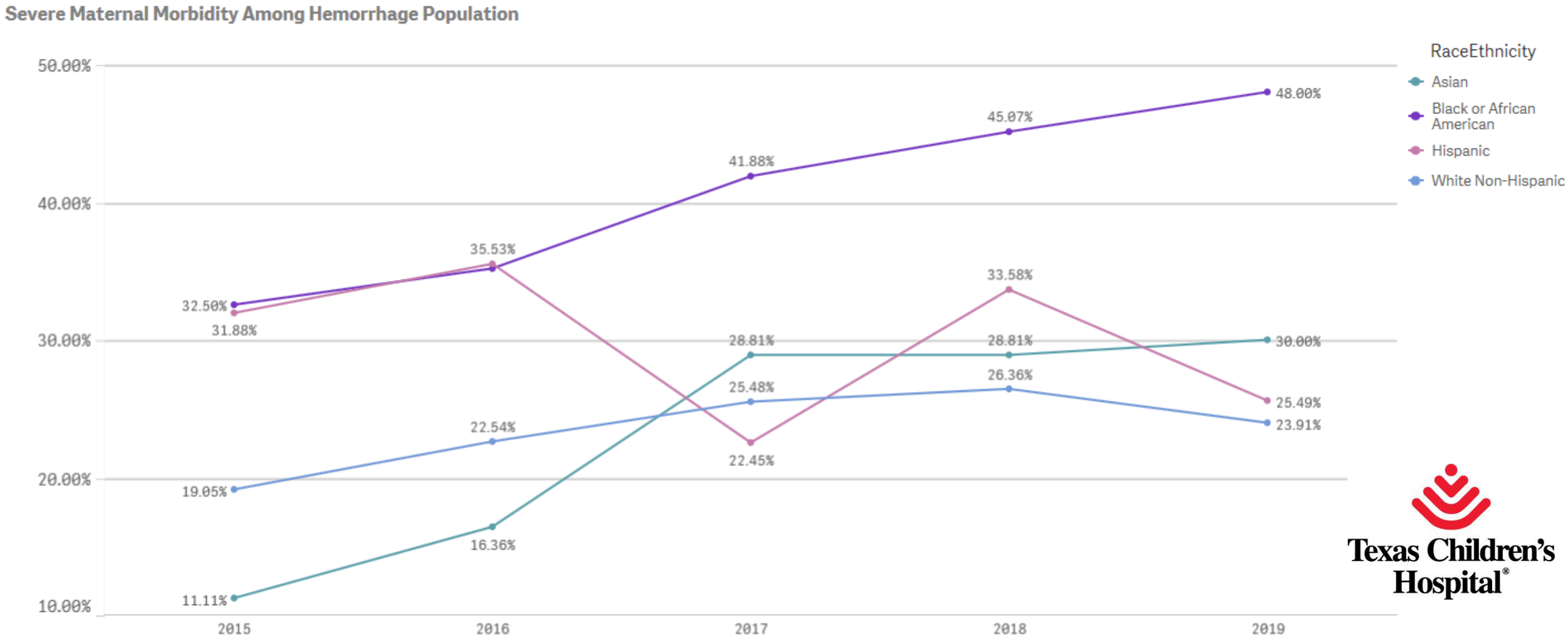


Calendar Year View

Data Presented at Texas Children's Pavilion for Women Department Meeting: March 2019



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Calendar Year View

Data Presented at Texas Children's Pavilion for Women Department Meeting: March 2019

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

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

PPH Risk Assessment & Stratification

(Patient label)

	Risk Factor	*Interventions*
Low Risk	☐ Singleton ☐ ≤4 prior vaginal births ☐ 0-1 prior cesareans ☐ No known bleeding disorder ☐ No history of PPH	✓ T&S if indirect coombs (IDC) negative ✓ T&C if IDC positive ✓ Postpartum oxytocin for 4 hours
Medium Risk	☐ BMI ≥ 40 kg/m^2 ☐ 2 or more prior cesareans OR 1 uterine incision (myomectomy) ☐ History of PPH ☐ EFW > 4,000 g ☐ Multiple gestation ☐ >4 prior vaginal deliveries ☐ Intrapartum magnesium sulfate administration ☐ Black/African American ☐ Jehovah's Witness or any woman who refuses blood products ☐ Chorioamnionitis ☐ Hgb < 9.0 g/dl ☐ Hct < 30% ☐ Platelets < 100,000 ☐ Large uterine fibroids >5cm	<u>One Medium Risk Factor:</u> ✓ T&S if IDC negative ✓ T&C if IDC positive ✓ Discuss potential PPH interventions with patient and RN ✓ Postpartum oxytocin for 8 hours <u>Two Medium Risk Factors:</u> ✓ T&C 2 Units PRBCs
High Risk	☐ Known coagulopathy ☐ Active bleeding at admission ☐ Placental abruption ☐ Placenta previa or low-lying placenta ☐ Suspected placenta accreta spectrum disease	✓ T&C 4 units PRBCs ✓ Discuss potential PPH interventions with patient and RN ✓ Extended recovery for 4 hours ✓ Postpartum oxytocin for 12 hours

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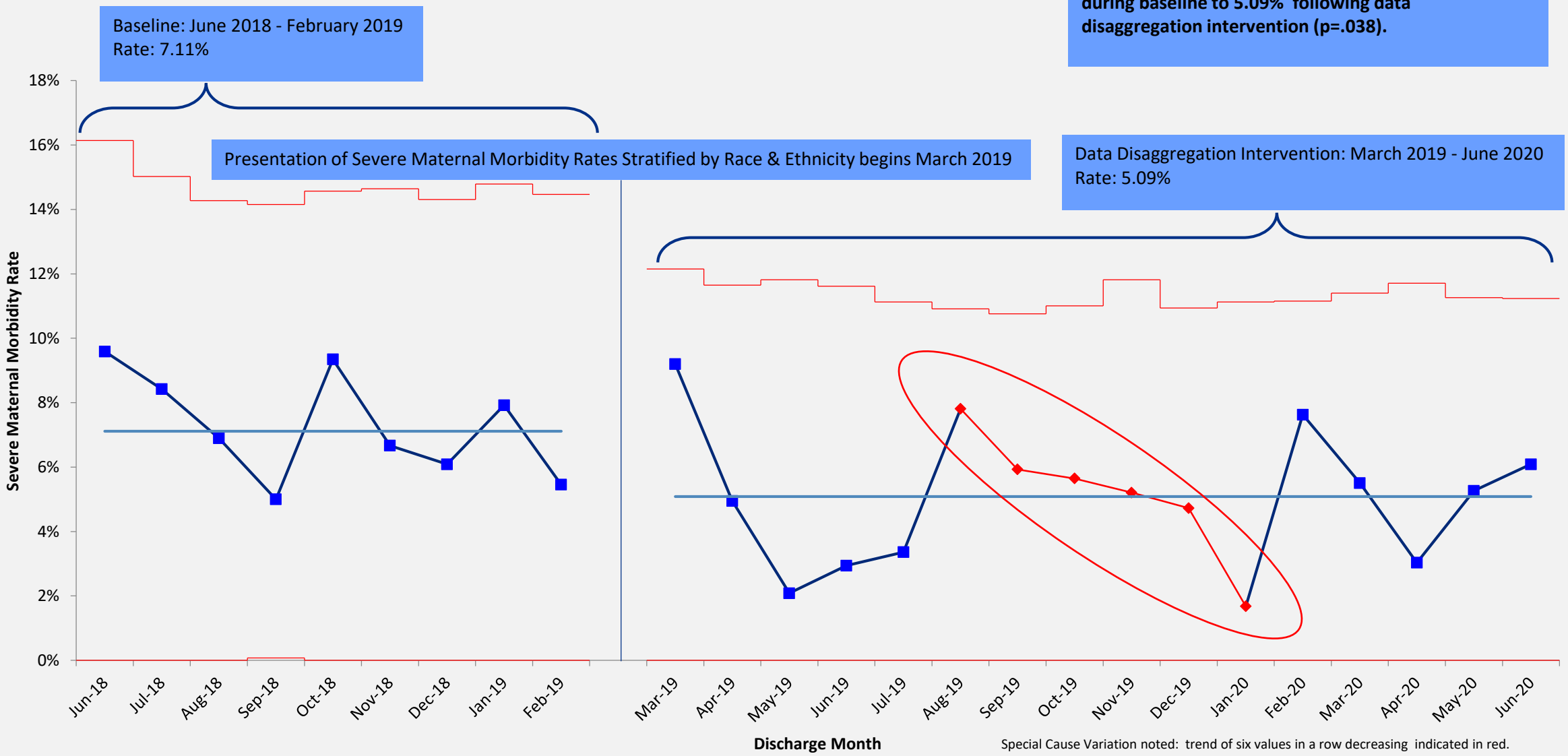
Severe Maternal Morbidity Rate among Black Non-Hispanic Mothers June 2018 - June 2020

Severe Maternal Morbidity Rate decreased from 7.11% during baseline to 5.09% following data disaggregation intervention (p=.038).



Special Cause Variation noted: trend of six values in a row decreasing indicated in red.

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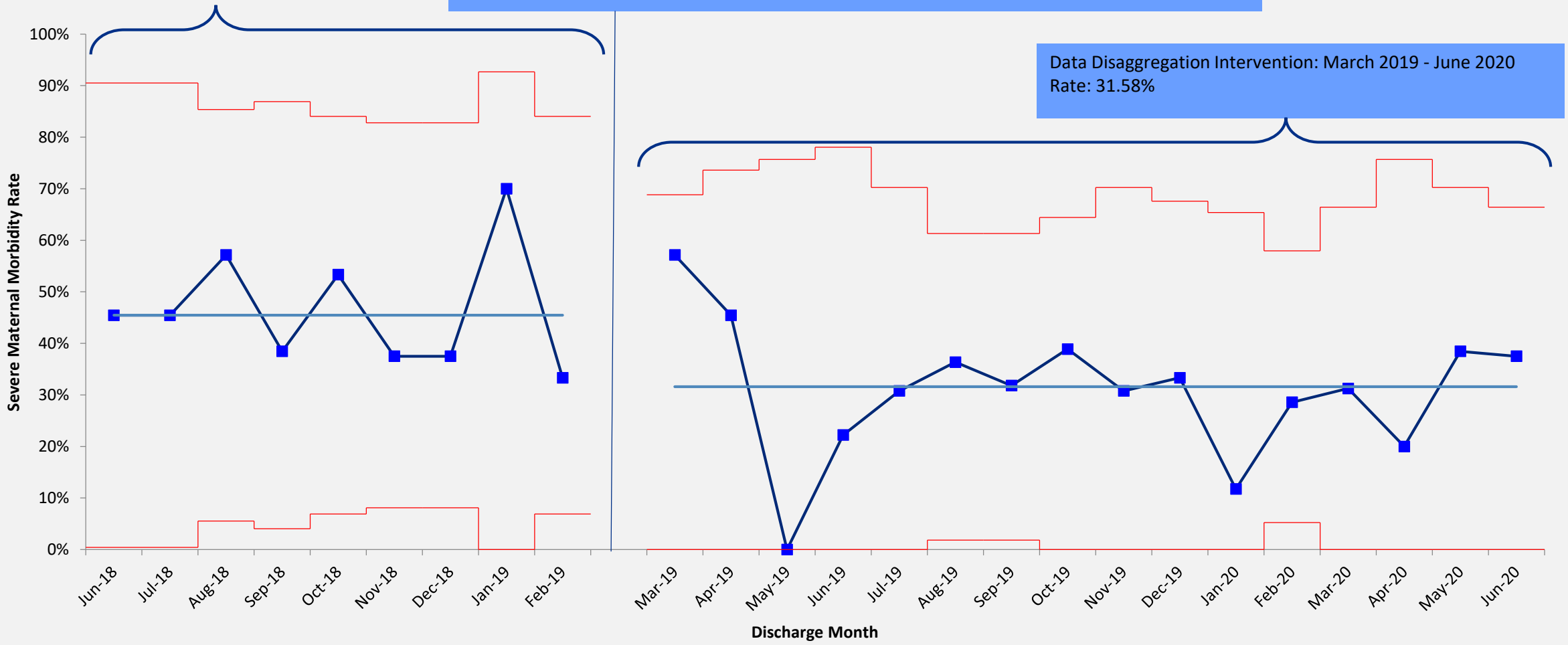
Severe Maternal Morbidity Rates among Hemorrhage Population Black Non-Hispanic Mothers June 2018 - June 2020

Severe Maternal Morbidity among Hemorrhage Population Rate decreased from 45.45% during baseline to 31.58% during intervention (p=.011).

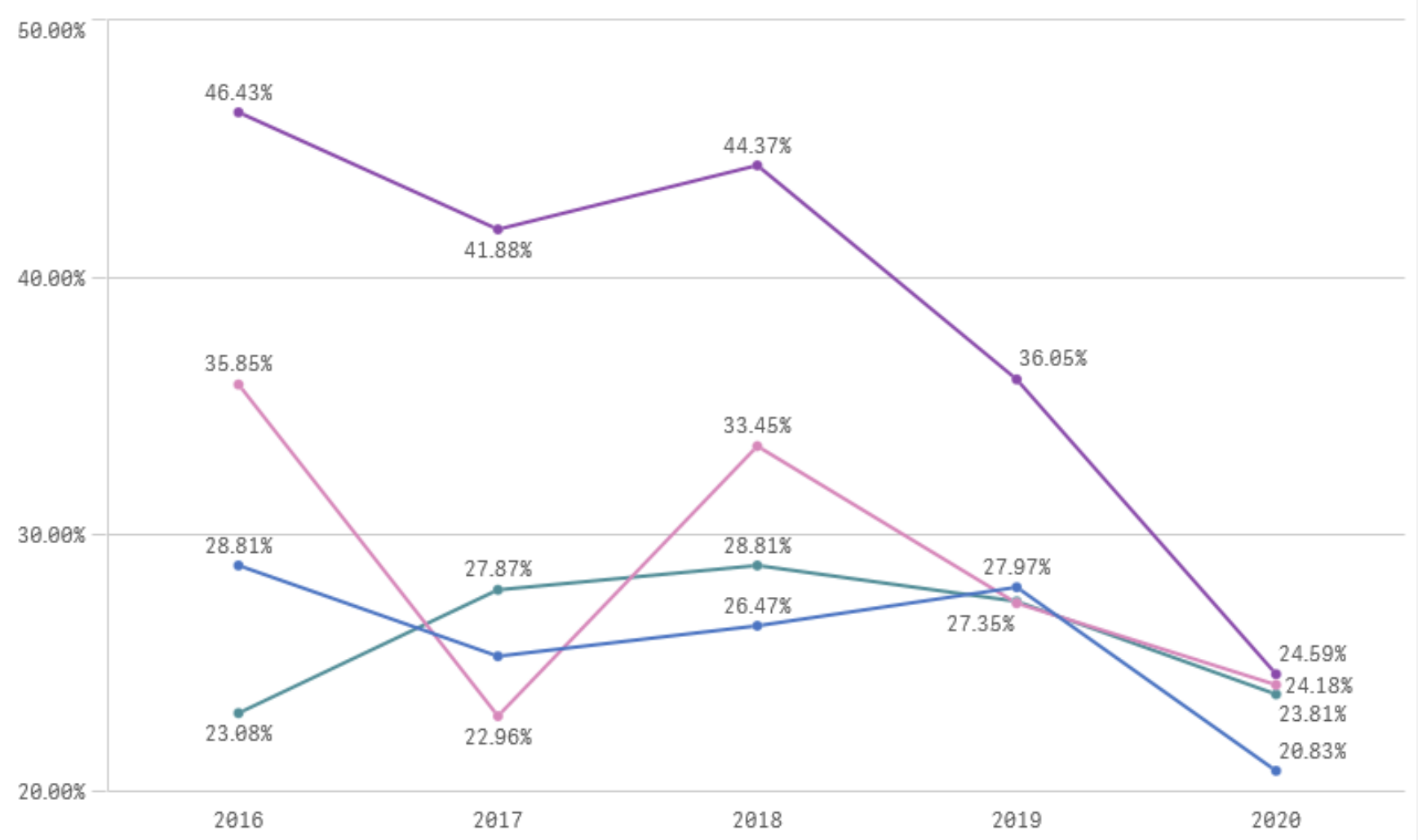
Baseline: June 2018 - February 2019
Rate: 45.45%

Presentation of Severe Maternal Morbidity Rates Stratified by Race & Ethnicity begins March 2019

Data Disaggregation Intervention: March 2019 - June 2020
Rate: 31.58%



Severe Maternal Morbidity among Hemorrhage Population by Race/Ethnicity
October 2016 – March 2020



Severe Maternal Morbidity and Preferred Language

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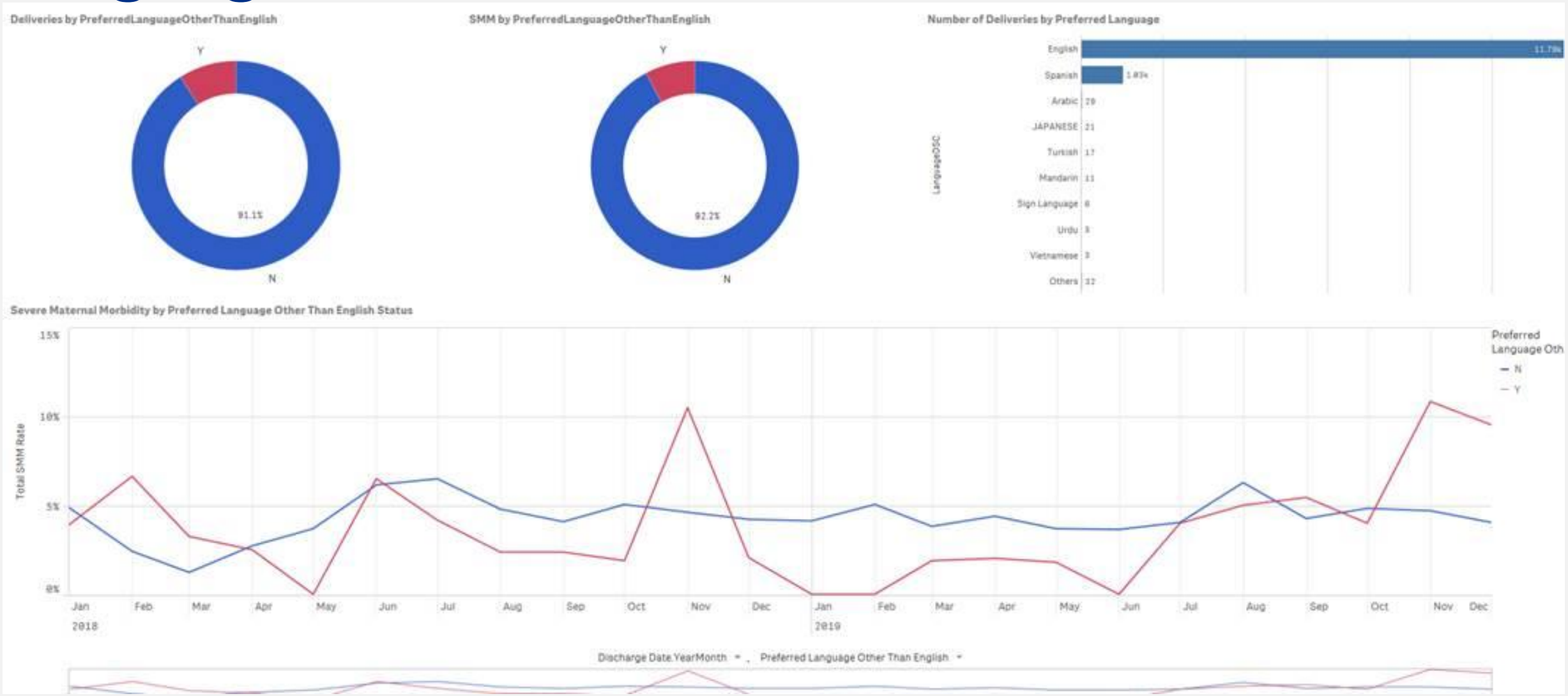


Achieving Health Equity through Data Disaggregation: Key Points

Stratify data, implement disparities dashboard

Standardize clinical management

Ensure optimal use of translation services, including printed material

Thank you!

Addressing Racial and Ethnic Disparities through Data Disaggregation

cmdavids@bcm.edu

Session 2: Panel Discussion

Rakhi Dimino, MD, MMM

Facilitator

End of Session 2

tchmb
Texas Collaborative for
Healthy Mothers & Babies

2021 TCHMB
Virtual Summit

February 11-12, 2021

REGISTER NOW

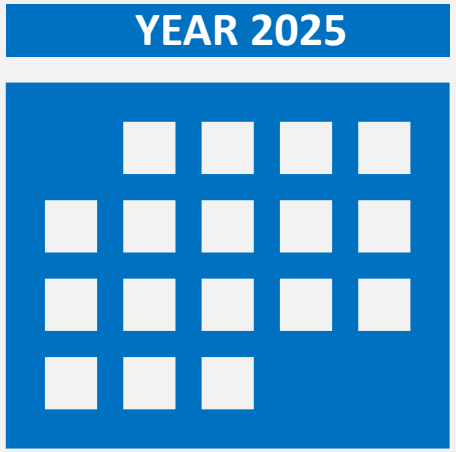
tchmb.org/2021-summit

TAKE A BREAK

10 Minutes

Ice Breaker

If you could travel forward in time five years into the future, what you would like to read in a headline for maternal health news in your city?



TEXAS
Health and Human Services

Texas Department of State Health Services

Centering Survivor Voices for Patient and Family Support

Carroll Deighton
MSN, RN
Medical City Lewisville

Nicole Purnell
MoMMA's Voices

Dee Brown
Patient Partner

Kristin Rainbow Poitier
RN, BSN, MBA, MHSM
Patient Partner

Suzanne Lundeen
PhD, RN
Harris Health Ben Taub

Welcome and Introductions

Centering Patient Voice

Survivors of Hypertensive Disorders of Pregnancy

Presented by

Nicole Purnell, Coalition Manager MoMMA's Voices

Objectives

- Learn about the Preeclampsia Foundation and MoMMA's Voices
- Provide basic examples of patient engagement
- Hear from survivors of Hypertensive Disorders of Pregnancy

Preeclampsia Foundation

Our Purpose is to improve the outcomes of hypertensive disorders of pregnancy by educating, supporting and engaging the community, improving healthcare practices, and finding a cure.

We envision a world where hypertensive disorders of pregnancy no longer threaten the lives of mothers and their babies.

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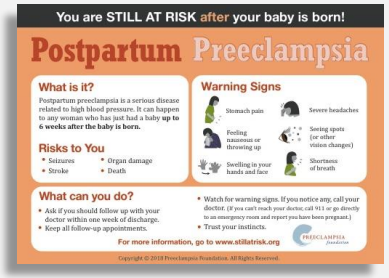
PREECLAMPSIA™ FOUNDATION

Patient Education Materials

www.preeclampsia.org/blood-pressure

Tearpads



Poster

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MoMMA's Voices

A national coalition of patient organizations and individuals with lived experiences or those who represent them, using their voice to reduce maternal complications in pregnancy and the postpartum period.

MoMMA's Voices

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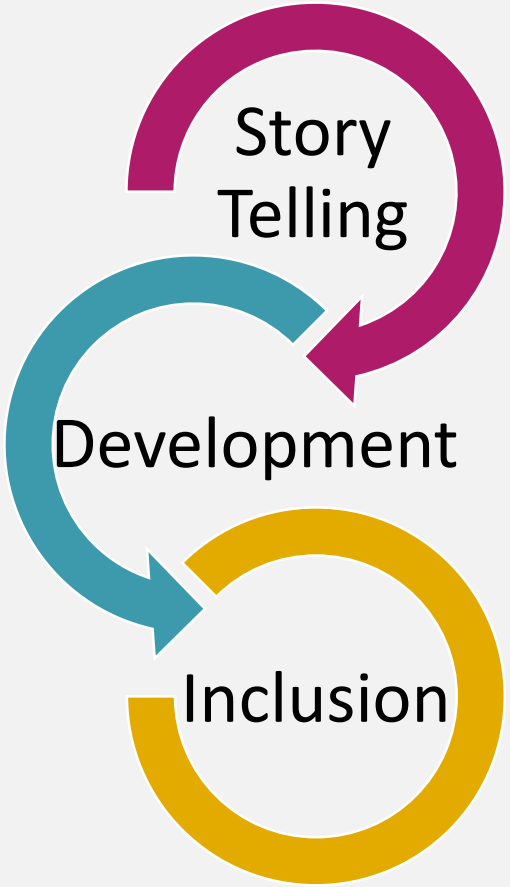
What we do

- Provide technical assistance on patient engagement
- Provide recruitment and matchmaking services
- Support a community of maternal health advocates
- Train patient advocates to be effective partners

(*HINT*: great resource to provide for your patient partners)

Visit www.mommasvoices.org for more information

Pathway to Engagement



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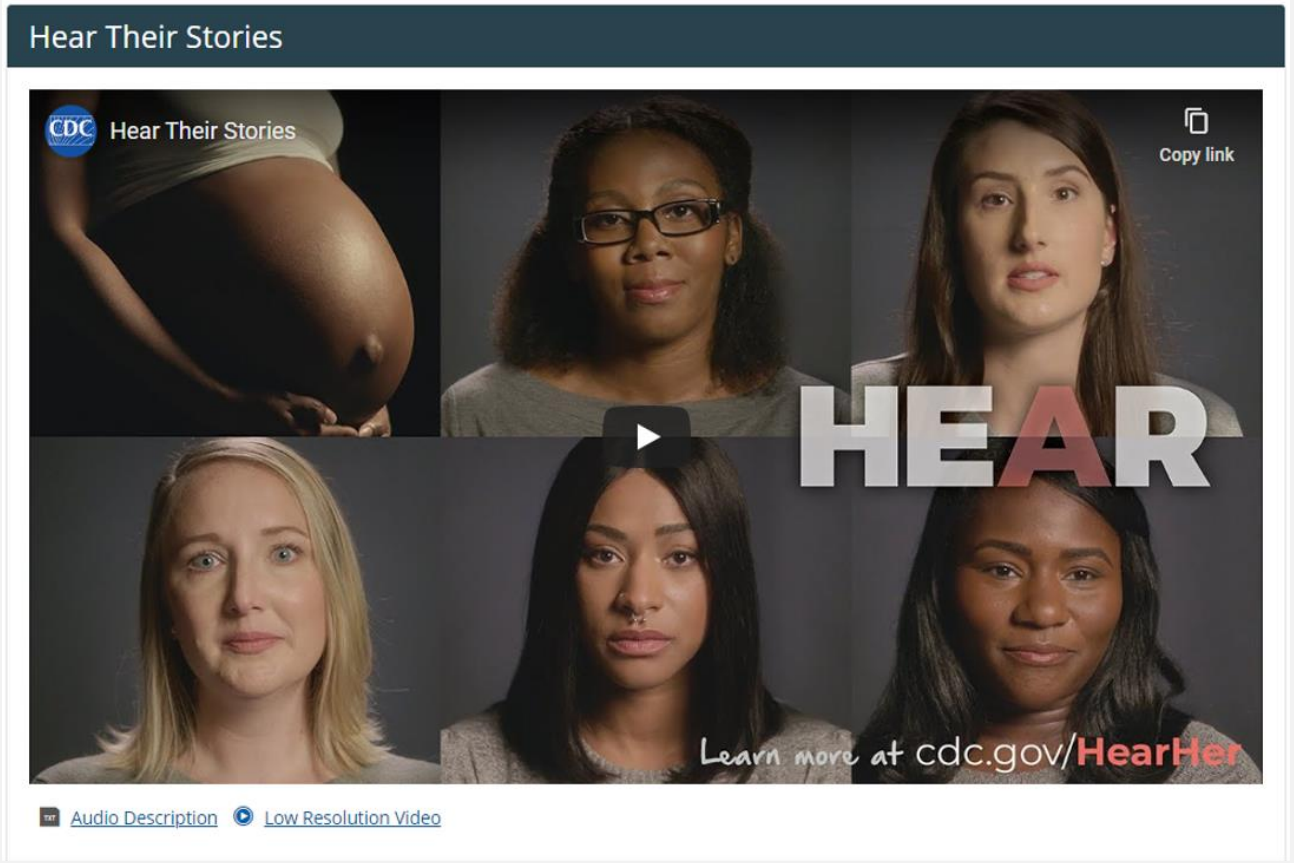
Where can patients help?

- Speaking
- Committee participation
- Family Advisory Councils
- Recruiting other Patient Family Partners
- Simulation drills
- Supporting other patients
- Aiding in development of discharge instructions
- Grand rounds

Resource to Share



View “Hear their Stories” at the bottom of this page: https://www.cdc.gov/hearher/personal-stories/index.html.

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Texas Department of State Health Services

Today's Panelist

Nicole Purnell
North Texas

Dee Brown
Houston

Kristian Poitier
North Texas

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Health and Human Services

Texas Department of State Health Services

Thank you!

Centering Patient Voices

Nicole Purnell

www.mommasvoices.org

Nicole.Purnell@preeclampsia.org

Ben Taub Harris Health Patient and Family Support

Grassroots Effort


COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

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

- 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

2018

Harris Health System Process Investigated

February 2019

Departmental Request

April 2019

Taskforce developed & first meeting

January 2020

Team HOPES go-live

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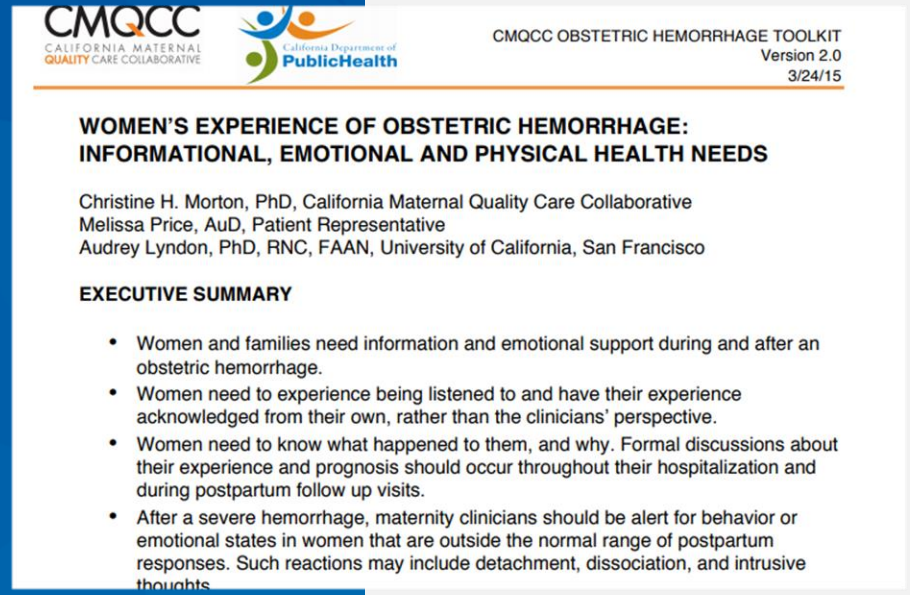
Patient and Family Support Resources & Literature



CMQCC CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE

California Department of PublicHealth

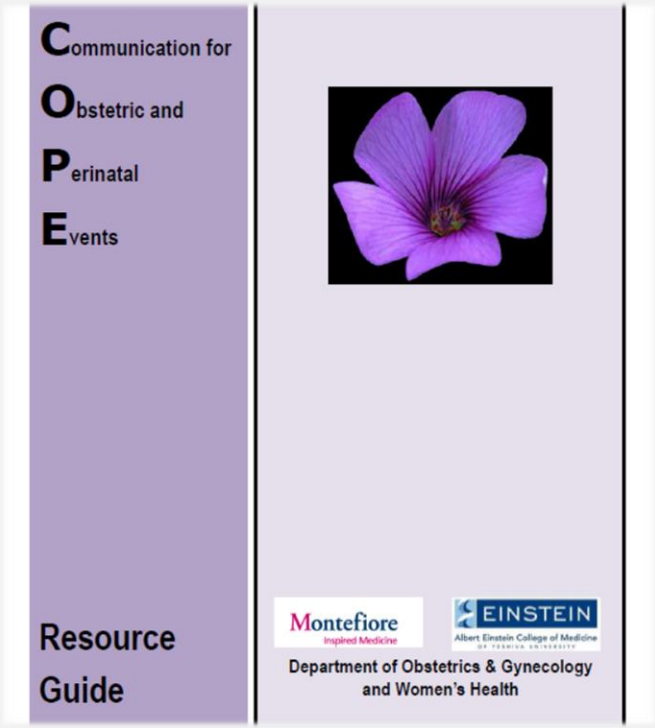
CMQCC OBSTETRIC HEMORRHAGE TOOLKIT
Version 2.0
3/24/15

WOMEN'S EXPERIENCE OF OBSTETRIC HEMORRHAGE: INFORMATIONAL, EMOTIONAL AND PHYSICAL HEALTH NEEDS

Christine H. Morton, PhD, California Maternal Quality Care Collaborative
Melissa Price, AuD, Patient Representative
Audrey Lyndon, PhD, RNC, FAAN, University of California, San Francisco

EXECUTIVE SUMMARY

- Women and families need information and emotional support during and after an obstetric hemorrhage.
- Women need to experience being listened to and have their experience acknowledged from their own, rather than the clinicians' perspective.
- Women need to know what happened to them, and why. Formal discussions about their experience and prognosis should occur throughout their hospitalization and during postpartum follow up visits.
- After a severe hemorrhage, maternity clinicians should be alert for behavior or emotional states in women that are outside the normal range of postpartum responses. Such reactions may include detachment, dissociation, and intrusive thoughts



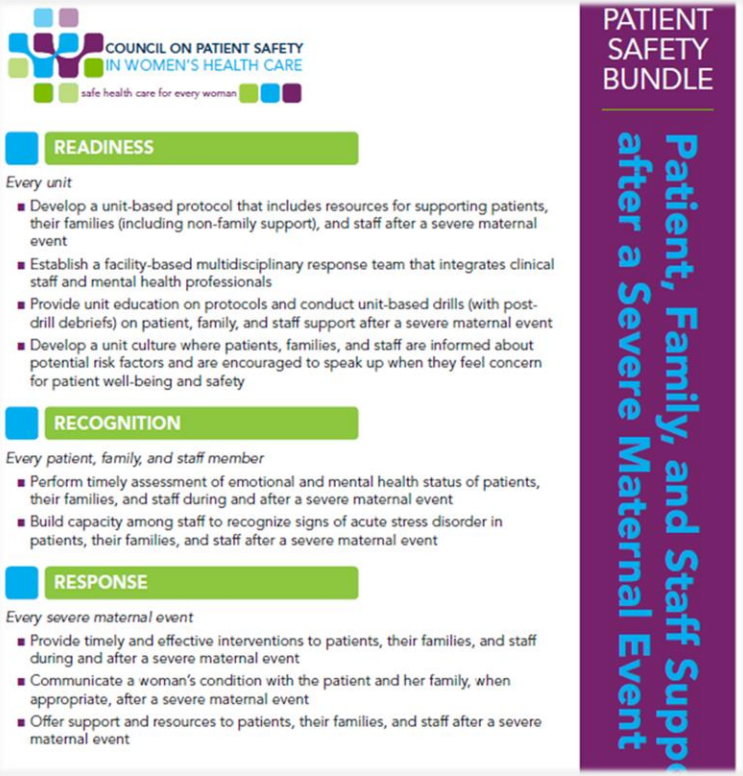
Communication for
Obstetric and
Perinatal
Events

Resource Guide

Montefiore Inspired Medicine

EINSTEIN Albert Einstein College of Medicine

Department of Obstetrics & Gynecology and Women's Health



COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

READINESS

Every unit

- Develop a unit-based protocol that includes resources for supporting patients, their families (including non-family support), and staff after a severe maternal event
- Establish a facility-based multidisciplinary response team that integrates clinical staff and mental health professionals
- Provide unit education on protocols and conduct unit-based drills (with post-drill debriefs) on patient, family, and staff support after a severe maternal event
- Develop a unit culture where patients, families, and staff are informed about potential risk factors and are encouraged to speak up when they feel concern for patient well-being and safety

RECOGNITION

Every patient, family, and staff member

- Perform timely assessment of emotional and mental health status of patients, their families, and staff during and after a severe maternal event
- Build capacity among staff to recognize signs of acute stress disorder in patients, their families, and staff after a severe maternal event

RESPONSE

Every severe maternal event

- Provide timely and effective interventions to patients, their families, and staff during and after a severe maternal event
- Communicate a woman's condition with the patient and her family, when appropriate, after a severe maternal event
- Offer support and resources to patients, their families, and staff after a severe maternal event

PATIENT SAFETY BUNDLE

Patient, Family, and Staff Supp
after a Severe Maternal Event

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Team HOPES

- HOPES: Holistic Obstetric Patient Emotional Support
- GOAL: To provide a continuum of **emotional, physical and informational support** to patients and families that experience an adverse obstetric event

Indicators for Team HOPES trigger

Maternal Indicators	Infant Indicators
ICU Admission	Stillbirth: >23 weeks, IUFD
Removal of an organ	Neonatal Code
PPH greater than 3L	Hypoxic Ischemic Encephalopathy: Infant is actively cooled
Unanticipated return to the OR	Infant Injury Brachial plexus, Long Bone FX & as needed
Readmission after Delivery Wound Infection and/or as needed	Other, as needed For maternal & neonatal indications

Checklist

Ben Taub: Team HOPES

"Holistic Obstetric Patient Emotional Support"

Provides a continuum of emotional, physical and informational support to patients and families that experience an adverse obstetric event

Maternal Indicators	Infant Indicators
ICU Admission	Stillbirth: >23 weeks, IUFD
Removal of an organ	Neonatal Code
PPH greater than 3L	Hypoxic Ischemic Encephalopathy Infant is actively cooled
Unanticipated return to the OR	Infant Injury Brachial plexus, Long Bone FX & as needed
Readmission after Delivery Wound Infection and/or as needed	Other, as needed For maternal & neonatal indications

Intrapartum	Date/Time	Initials
1. A member of the OB Team provides patient and family updates/support throughout the event, using translation services		
2. Support services provided via Chaplain Services (page Chaplain Services or Chaplain responds to OB Emergency)		
3. Ensure Infant is cared for by TCN and stays with patient/family, if possible		
4. Place family in a private room, if available (avoid waiting room)		
5. If patient is in the OR, family is provided opportunity to accompany her, if possible		
6. L & D charge nurse activates Team Hopes and completes the following: a. Place Team Hopes Card on patient door b. Place Team Hopes Sticker on front of chart c. Log patient in Team HOPES binder at L&D desk d. Track Team Hopes patient on L&D whiteboard using magnet		
7. If able, ask the L&D charge nurse or nurse manager if a team debrief was conducted immediately after the event		
8. Add Treatment Team Sticky Note: Team HOPES activation (include trigger event)		
9. Add progress note: using Team HOPES smart phrase (.hopes)		
10. Provide patient/family with a Team Hopes comfort gift from customer relations **(not currently available)**		

Document is not included in medical record

Team Hopes Taskforce 3.9.2020

Postpartum	Date/Time	Initials
1. Team HOPES member performs daily rounding on patient/family; collaborate with the nurse caring for patient to evaluate the patients' and family's informational, emotional, and/or physical needs surrounding the event.		
2. Provider conducts patient debrief/disclosure of the event (ideally the attending provider conducts the disclosure). Pertinent team members to include in the discussion: attending, nurse, translator (if needed), chaplain (if patient requests).		
3. Within 24 hours of admission to postpartum unit: in-patient EPDS is complete		
4. Utilize resources/consults. For example: social work, physical therapy, child life, dietician, chaplain, pharmacist, blood bank		
5. Consult Inpatient Consult Liaison Psychologist for (1) EPDS > 10 and/or (2) signs of Acute Stress Disorder and/or (3) patient request		

Discharge	Date/Time	Initials
1. High-Risk OB Postpartum follow-up to be scheduled within 7 – 14 days; align with additional appointments		
2. Ensure that the provider has completed disclosure of the event: disclosure includes information about what happened, the prognosis, and the risk in future pregnancies (flowsheet note).		
3. Provide written information/hand-outs for reference		
4. Schedule follow-up appointment with OB Psychology (Fridays: BT OB Psych template) for the following conditions:		
5. (1) EPDS > 10 *and/or* (2) signs of Acute Stress Disorder *and/or* (3) patient/family request		

* Readmission Patients Only* Wound Infection and as needed	Date/Time	Initials
1. Upon readmission, RN caring for patient notifies L&D charge nurse of readmission Team HOPES activation		
3. Follow intrapartum checklist, starting with #8		

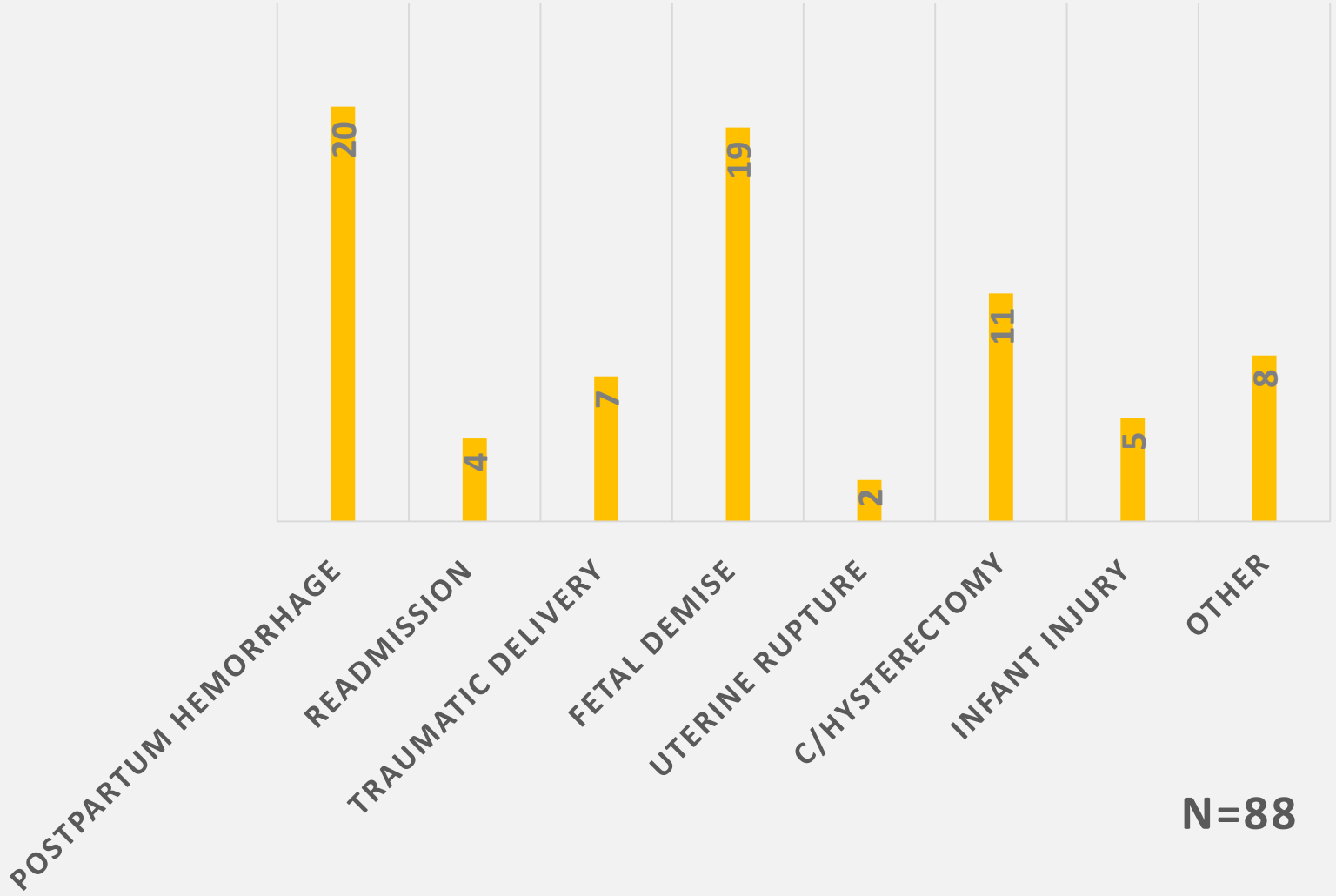
** Infant Indicators Only**	Date/Time	Initials
1. Upon identification of infant indicator, RN caring for infant notifies L&D charge nurse of Team HOPES activation		
2. Follow intrapartum checklist, starting with #8		

Notes	Date/Time	Initials

Volunteer Taskforce

1. Maria Capote- 3C
2. Jasmine Kalsi -3F
3. Maria DeJuan -3F
4. Primrose Pari An - 3F
5. Mallorie Braithwaite - 3F
6. Afoluke Kadiri -3F
7. Ria Ellen Tatlonghari - 3F
8. Nicole Mora - 3F
9. Maya Muralee - 3E
10. Treesa Varghese -3E
11. Stephanie Puckett -3F
12. Monique Rhodes -3B
13. Juliana Miranda -3B
14. Bindhu Mathew -3B
15. Gloria Ramirez-Scully -3F
16. Leticia Martinez -THS
17. Adeleenne deMesa -THS
18. Patricia Flores -THS
19. Agnes Akinfenwa -3C
20. Ma Gonzaga -3F
21. Deepa Paul -3C
22. Rowena Guisadio-3F
23. Socorro Arellano-3C
24. Janette Buenavista-3E
25. Uju Oko-3C
26. Susamma Thomas-3C
27. Suzy Lundeen-3F
28. Brittney Wade -3F
29. Carey Eppes-3F
30. Denitria Preston -3F
31. Evelyn Loyola - 3F
32. Victoria Orozco - 3B
33. Sarah Evans - 3B
34. Monica Manthey - 3B
35. Beena Mathew - 3B
36. Christina Arredondo - 3C
37. Chantell Bell - 3B
38. Aleks Bochus - 3B
39. Evan Harrison - 3F
40. Amion Bamba - 3C

Patient & Families Supported



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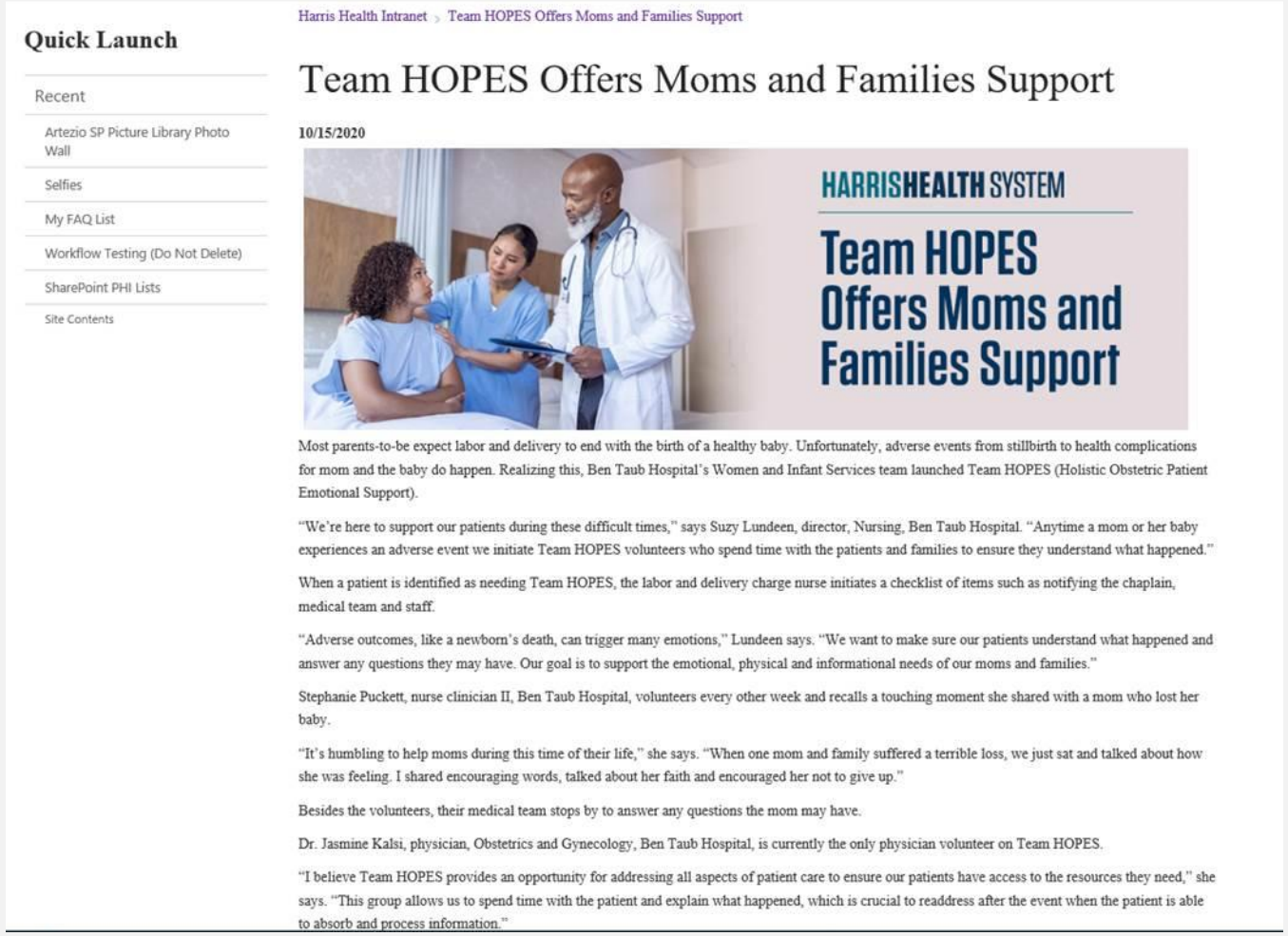
Hip, hip hooray!



Quick Launch

Recent

Artezio SP Picture Library Photo Wall

Selfies

My FAQ List

Workflow Testing (Do Not Delete)

SharePoint PHI Lists

Site Contents

Harris Health Intranet › Team HOPES Offers Moms and Families Support

Team HOPES Offers Moms and Families Support

10/15/2020

Most parents-to-be expect labor and delivery to end with the birth of a healthy baby. Unfortunately, adverse events from stillbirth to health complications for mom and the baby do happen. Realizing this, Ben Taub Hospital's Women and Infant Services team launched Team HOPES (Holistic Obstetric Patient Emotional Support).

"We're here to support our patients during these difficult times," says Suzy Lundeen, director, Nursing, Ben Taub Hospital. "Anytime a mom or her baby experiences an adverse event we initiate Team HOPES volunteers who spend time with the patients and families to ensure they understand what happened."

When a patient is identified as needing Team HOPES, the labor and delivery charge nurse initiates a checklist of items such as notifying the chaplain, medical team and staff.

"Adverse outcomes, like a newborn's death, can trigger many emotions," Lundeen says. "We want to make sure our patients understand what happened and answer any questions they may have. Our goal is to support the emotional, physical and informational needs of our moms and families."

Stephanie Puckett, nurse clinician II, Ben Taub Hospital, volunteers every other week and recalls a touching moment she shared with a mom who lost her baby.

"It's humbling to help moms during this time of their life," she says. "When one mom and family suffered a terrible loss, we just sat and talked about how she was feeling. I shared encouraging words, talked about her faith and encouraged her not to give up."

Besides the volunteers, their medical team stops by to answer any questions the mom may have.

Dr. Jasmine Kalsi, physician, Obstetrics and Gynecology, Ben Taub Hospital, is currently the only physician volunteer on Team HOPES.

"I believe Team HOPES provides an opportunity for addressing all aspects of patient care to ensure our patients have access to the resources they need," she says. "This group allows us to spend time with the patient and explain what happened, which is crucial to readdress after the event when the patient is able to absorb and process information."

Thank you BT Team

TEXAS
Health and Human Services

Texas Department of State Health Services

Thank you!

Suzy Lundeen

Suzanne.lundeen@harrishealth.org

713-873-2828

Session 3: Panel Discussion

Carroll Deighton, MSN, RNC-OB, C-EFM

Facilitator

End of Session 3-Stretch!

TEXAS
Health and Human Services

Texas Department of State Health Services

The Next Phase of the Journey: The TexasAIM Plus Severe Hypertension in Pregnancy Learning Collaborative

Section Subtitle

Carey Eppes
TexasAIM
Medical Director

Jamie Morgan
TexasAIM Deputy
Medical Director

Sue Butts-Dion
TexasAIM
Improvement Advisor

Julie Stagg
TexasAIM Program
Director

Welcome and Introductions

TexasAIM The Journey Continues
Leaving in Action

TexasAIM 2020 Virtual Summit

December 8-9, 2020

Where have we been and where we are heading

What’s new for the hypertension bundle implementation

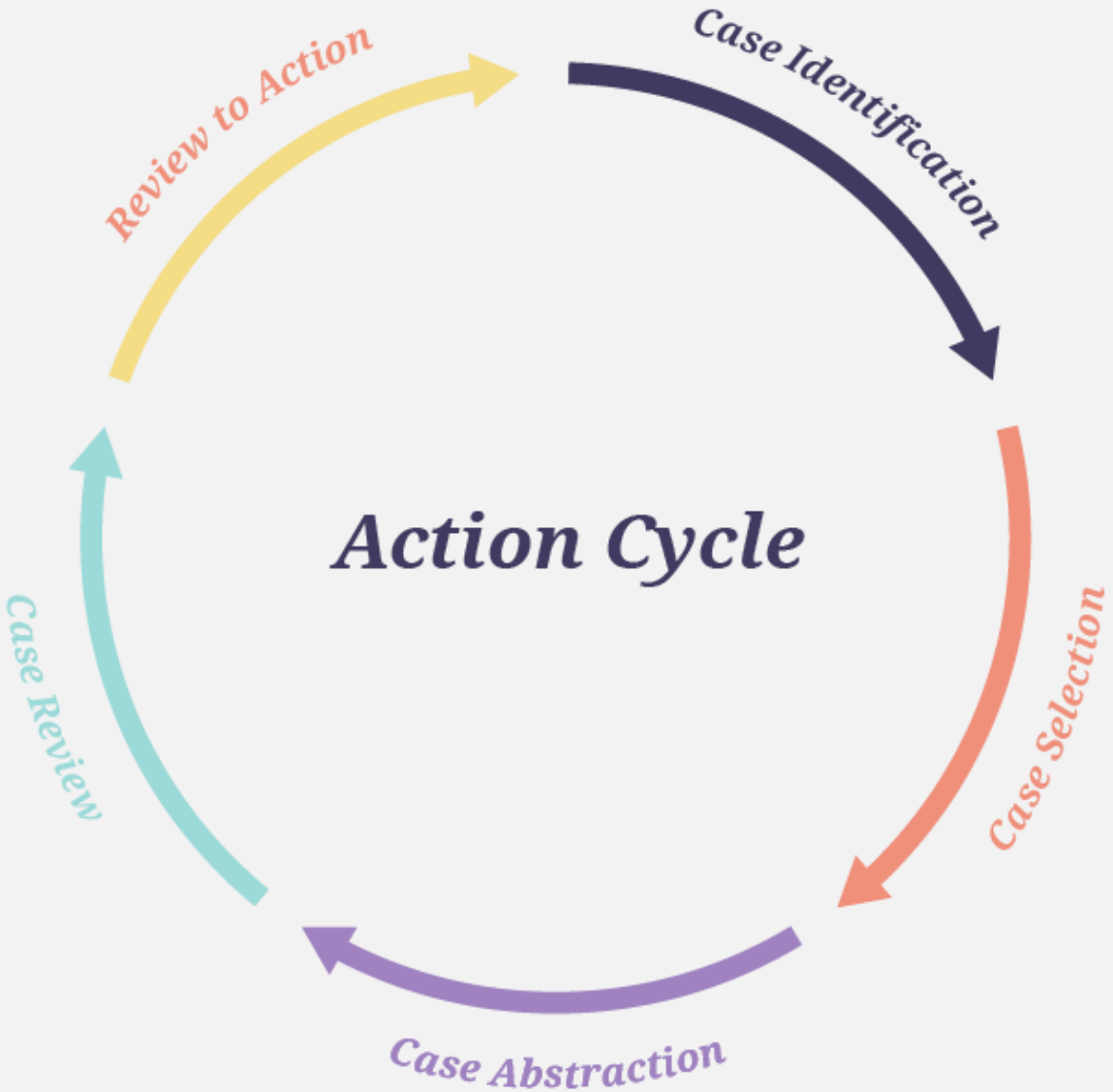
Road map of milestones ahead

Leaving in Action

Bundle Element	Hemorrhage	Hypertension
Standards for Early Warning Signs, monitoring and treatment (MEWS)	✓	✓
Unit education and simulation	✓	✓
Timely access to medications	✓	✓
Patient, Family and Staff Support	✓	✓
Establish and culture of huddles and debriefs	✓	✓
Multidisciplinary case review	✓	✓
Monitor outcomes and processes	✓	✓

TEXAS
Health and Human Services

Texas Department of State Health Services



Future Initiatives

PPH Bundle

HTN Bundle

Opioid Bundle

Introduction to AIM Teams

DSHS TexasAIM Team

John Hellerstedt, MD, DSHS Commissioner

Manda Hall, MD Associate Commissioner Community Health Improvement Division, DSHS

Jeremy Triplett Director, Maternal & Child Health Section, DSHS

Michael Spencer, LMSW Director, Maternal & Child Health Unit, DSHS

Julie Stagg, MSN, RN, IBCLC Healthy Texas Mothers & Babies Branch Manager, DSHS

Ashley Steenberger MPH, CHES Maternal Health & Safety Coordinator

Megan Coulter, MPH Maternal Health & Safety Coordinator, TexasAIM Data Lead

Laura Wando, MPH Maternal Health & Safety Coordinator

Rosa-Maria DiDonato, RNC-OB, C-EFM Maternal Health & Safety Nurse Consultant

Aliyah Abdul-Wakil, MPH Maternal & Child Health Epidemiologist

TexasAIM HTN Leadership

Carey Eppes,
MD, MPH
TexasAIM Medical Director

Jamie Morgan, MD
TexasAIM Deputy
Medical Director

Shad Deering,
MD, CHSE, COL(ret) USA
TexasAIM Simulation Chair

Sue Butts-Dion
Improvement
Advisor

TexasAIM HTN Faculty

Lisa Bennett
MSN, RN, CNM, NEA-BC

Carroll Deighton,
MSN, RNC-OB, C-EFM

Shena Dillon,
MD

Rakhi Dimino,
MD, MMM, FACOG

CheyAnne Harris,
MSN, RN, RNC-OB

Patricia A. Heale
DNP, RNC-OB, C-EFM

James Hill,
MD, COL(ret) USA

Jennifer Huber,
MSN, RN, RNC-OB

Nicole Lee Plenty,
MD, MPH

Paula Smith,
DO

Latricia M. Thompson,
MD

Brook Thomson,
MD

Heather Walker,
MSN, RN, RNC-OB,
C-EFM, C-ONQS

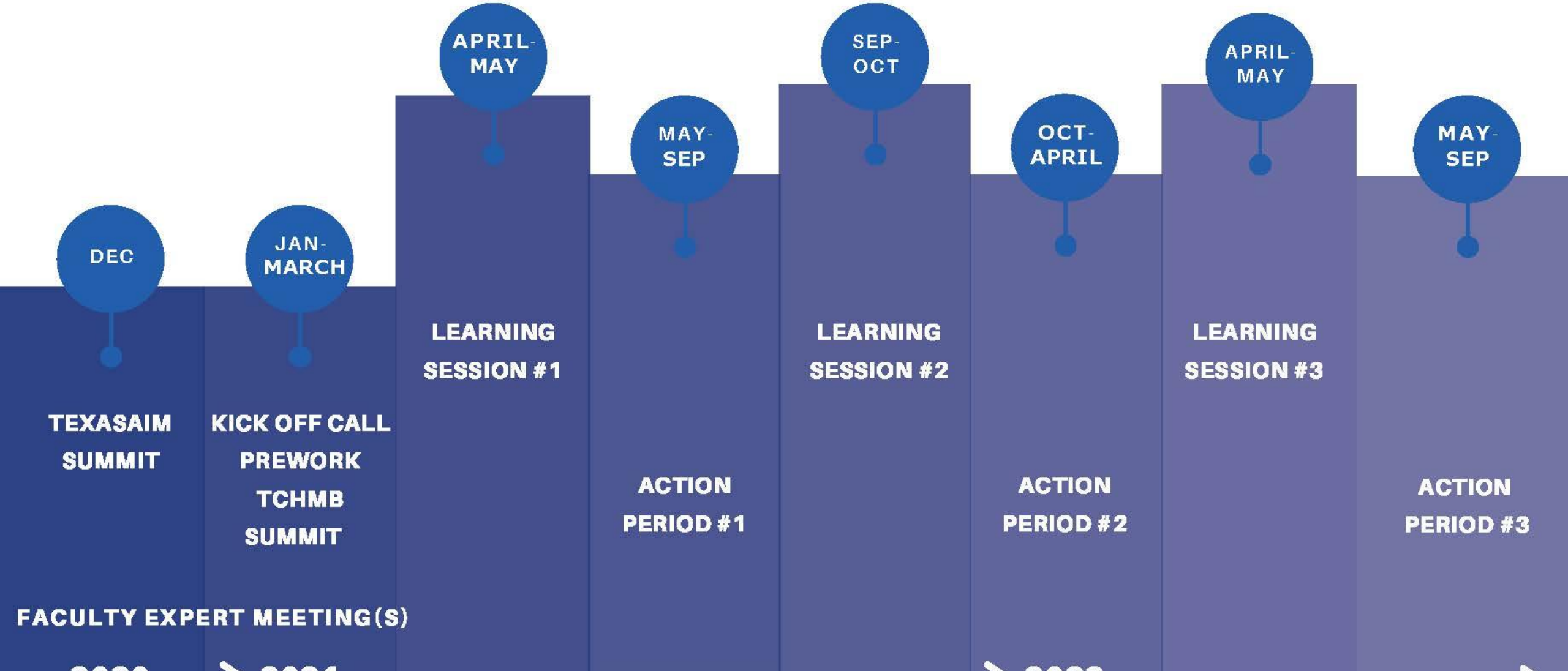
Lashauntee Wellington,
MSN, RN, RNC-OB, C-ONQS

Kendra Folh,
MSN, RNC-OB
Faculty Systems Specialist

Mindy Foster
MSN, RN
Faculty Systems Specialist

TexasAIM Safe Care for Every Mother

HTN Learning Collaborative Timeline



What's new for the Hypertension Bundle?

TexasAIM Postpartum Hypertension Bundle

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE | Hypertension

READINESS

Every Unit

- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

RECOGNITION & PREVENTION

Every Patient

- Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE | Hypertension

RESPONSE

Every case of severe hypertension/preeclampsia

- Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
  - Severe hypertension
  - Eclampsia, seizure prophylaxis, and magnesium over-dosage
  - Postpartum presentation of severe hypertension/preeclampsia
- Minimum requirements for protocol:
  - Notification of physician or primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
  - After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)
  - Includes onset and duration of magnesium sulfate therapy
  - Includes escalation measures for those unresponsive to standard treatment
  - Describes manner and verification of follow-up within 7 to 14 days postpartum
  - Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

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 all severe hypertension/eclampsia cases admitted to ICU for systems issues
- Monitor outcomes and process metrics

How do we support this effort?

Community Partnerships

Work with emergency departments and urgent care

Include patient and family partners

Virtual Platform

- Learning Sessions
- Simulations
- Action Period
- Regional Integration with PCRs

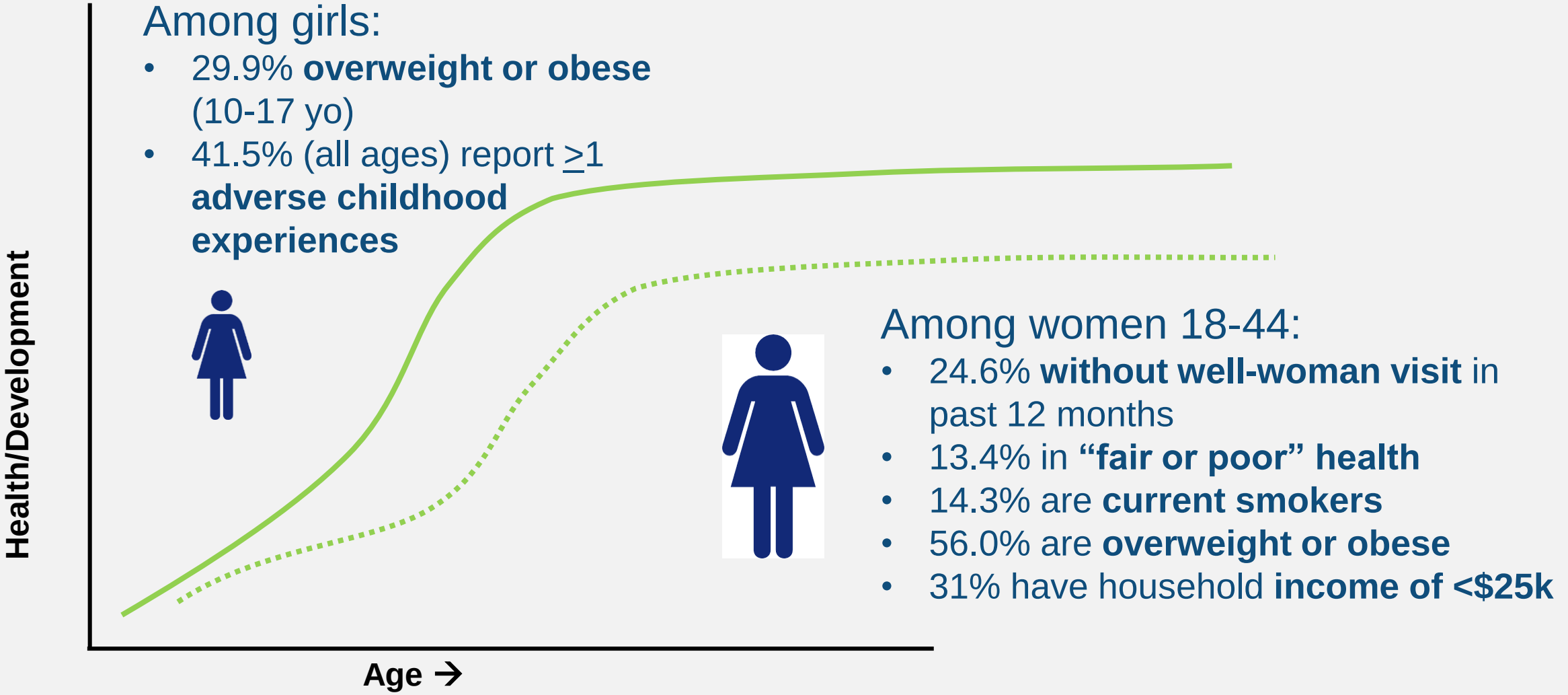
How do we support this effort?

Life course approach for womens health

Equity and Bias

HHS Action Plan to Improve Maternal Health In America

Life Course Approach



Adapted from the Life Course Toolkit by CityMatCH. Available at: http://www.citymatch.org/projects/mch-life-course-toolbox . Based on: Lu, M.C. & Halfon, N. Matern Child Health J (2003) 7: 13

Girls' health data comes from the National Survey of Children's Health (2017-18); women's health data comes from the Behavioral Risk Factor Surveillance System (2018).

The Action Plan outlines THREE SPECIFIC TARGETS to help the nation improve its maternal mortality outcomes:

TARGET 1:

Reduce the maternal mortality rate by 50 percent in 5 years.

TARGET 2:

Reduce the low-risk cesarean delivery rate by 25 percent in 5 years.

TARGET 3:

Achieve blood pressure control in 80 percent of women of reproductive age with hypertension in 5 years.

Read more about the *HHS Action Plan* and the *Surgeon General's Call to Action* here:
www.womenshealth.gov

4 KEY GOALS

designed to achieve the overall vision, which reflect the importance of bringing a life course perspective to improving maternal and infant health outcomes.

Check out the **HHS ACTION PLAN** & **THE SURGEON GENERAL'S CALL TO ACTION** for more info.

www.womenshealth.gov

POSTPARTUM

maintain ongoing touch points for women with medical and social service providers to ensure warning signs are identified and addressed, and by providing accessible information on parenting skills, self-esteem building and stress management, as well as other family supports

GOAL 1

Healthy Outcomes for All Women of Reproductive Age

GOAL 2

Healthy Pregnancies and Births

GOAL 3

Healthy Futures

GOAL 4

Improve Data and Bolster Research

PRE-PREGNANCY

perform recommended screenings and treat all young girls, adolescents, and women for a variety of health risk factors

DURING PREGNANCY

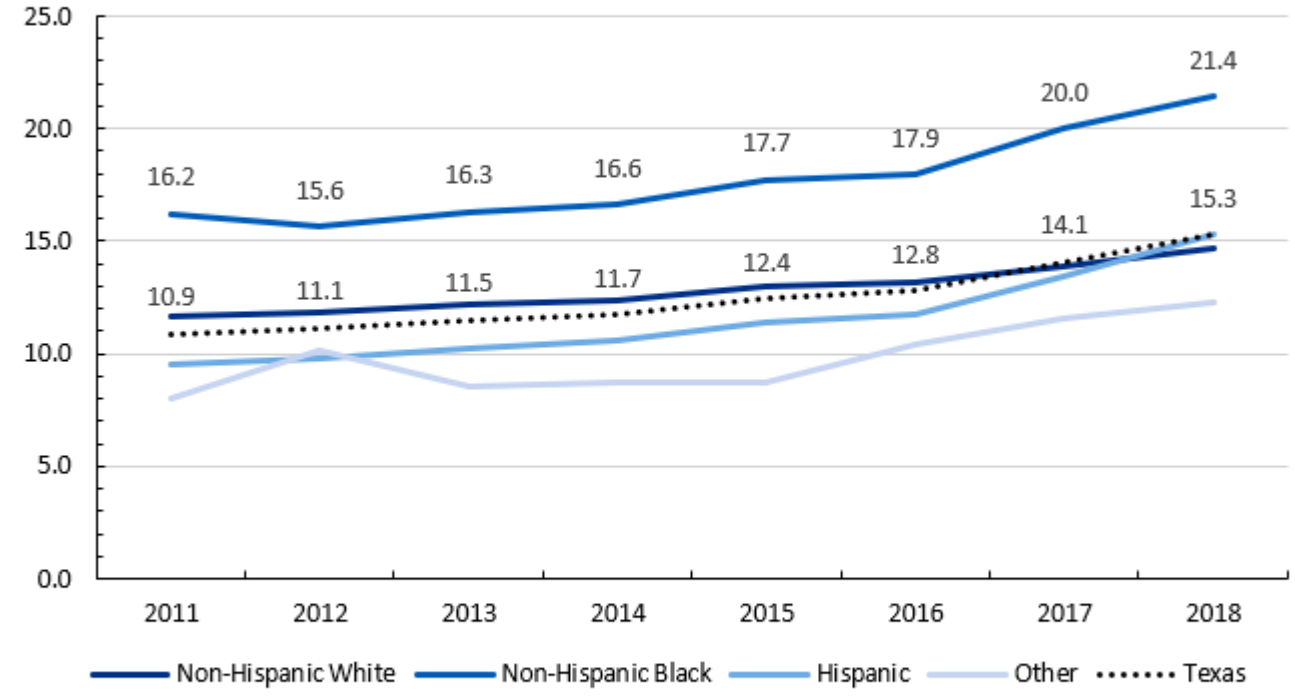
continue prevention efforts into pregnancy to prevent or mitigate the development of complications

Focus on Equity

Disparity in Hypertension

Rates of delivery hospitalizations involving hypertensive disorder were highest among Non-Hispanic Black mothers and varied by county.

Figure H-4: Delivery Hospitalization Involving Hypertensive Disorder Rates by Race/Ethnicity, Texas, 2011-2018[i]



[i]PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

- Understanding QI Basics
- Using QI Data, including REaL Data
- Implementing a QI Project

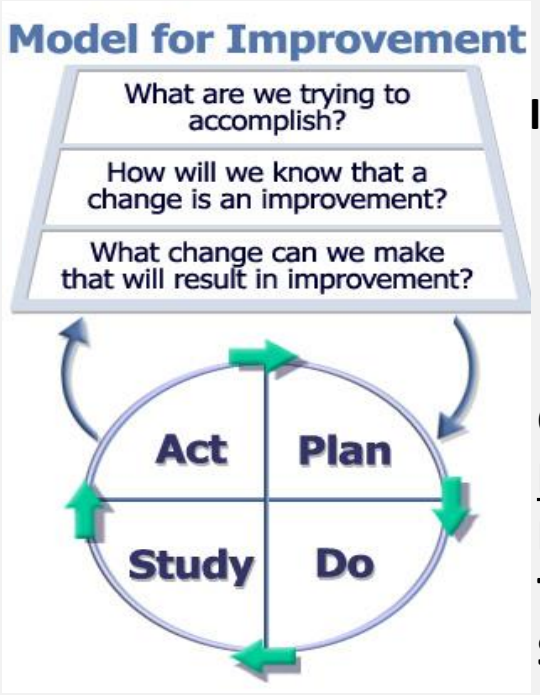
Simulation

Emphasis on Data

Creating a Culture of Improvement: What to Expect

Sue Butts-Dion, Improvement Advisor

Our Method for Executing and Accelerating Change and Improvement



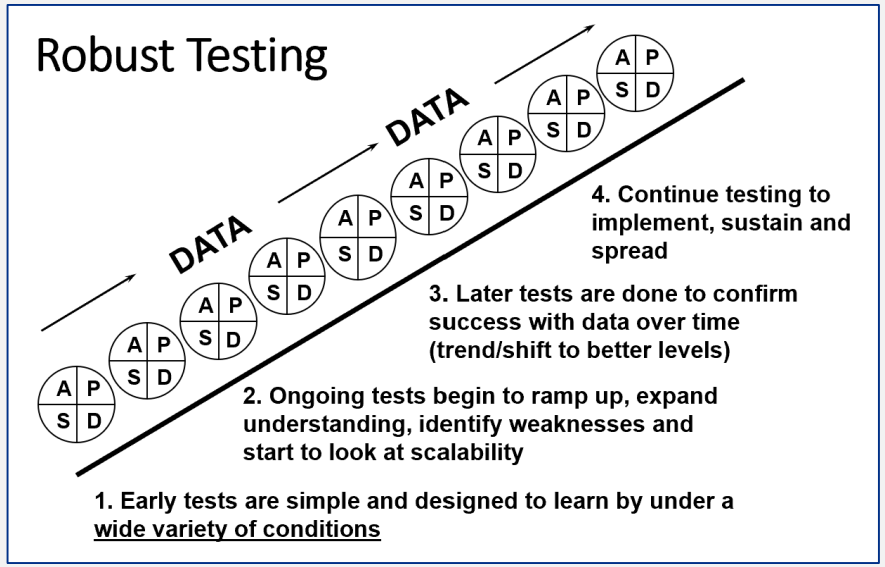
Source: Langley, et al, The Improvement Guide, 2009

Identify Aim - what, how good, by when, for whom, where, why

Measure data over time using run or control charts

Generate ideas using logical, conceptual, creative thinking

Cycle of Improvement
Rapid Testing
Think BIG
Start SMALL

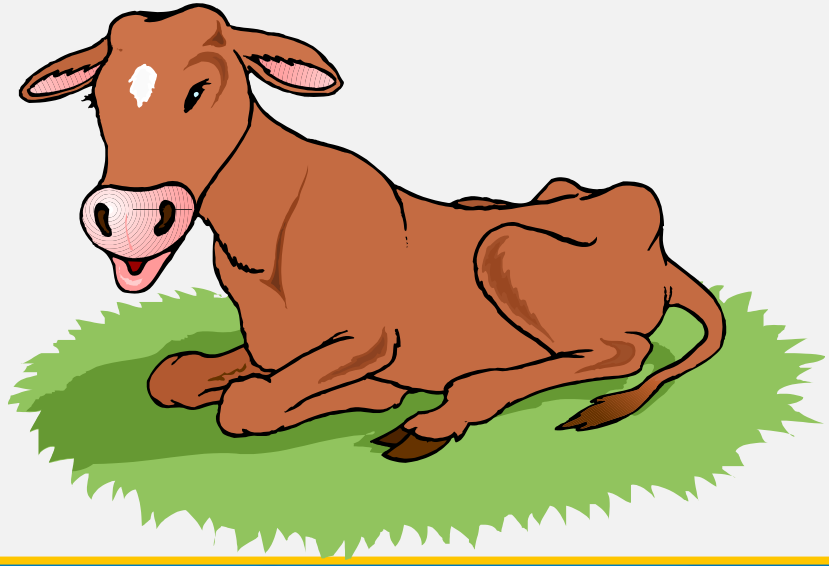


Adapted from IHI Coach Improvement Program

Measures for Improvement

You can't fatten a cow by weighing it. **Palestinian Proverb**

- Our work is about improving care and reducing harm and not about measurement….
- BUT, we need measures to know if what we are doing is, or isn't, resulting in improvement
  - All measures have limitations, but the limitations do not negate their value
  - Measures are one "voice" of the system. Hearing the voice of the system gives us information on how to act with the system
  - Measures tell a story; goals give a reference point



Balanced Set of Measures

1-2 Outcome: The “so what?” How does the system impact the values of pts/clients, their health and wellbeing. Impacts of other stakeholders? Allows you to see whether you are reaching your goal

3-4 Process: **H**elp you track your progress with your key activities. These measures you can impact directly; should correlate to the key things you want to change to reach your goal

1-2 Balance: are changes designed to improve one part of the system causing new problems in other parts? Helps you keep your eyes on things that may be inadvertently affected by your changes

1-2 Structure: Conditions under which the care or work is performed (i.e Material Resources, Human Resources, Policies, Organizational characteristics and arrangement.)

Expectations for Teams

- Baseline assessment (and baseline data where available)
- Monthly reporting of small set of measures including Outcome, Process, Structure and Balancing (if helpful)
- Monthly reporting of breakthroughs, barriers, learnings, next steps, and progress on quality journey
- Stratification of data by race and ethnicity wherever possible

Coaching Support to Teams

- Assistance with thinking through data collection and reporting process
- Assistance with thinking about stratification of data by race and ethnicity as to advance equitable care
- Support with analyzing data for improvement
- Coaching support on improvement action most appropriate based on data analysis
- Coaching support with testing and implementing changes in processes to achieve goals

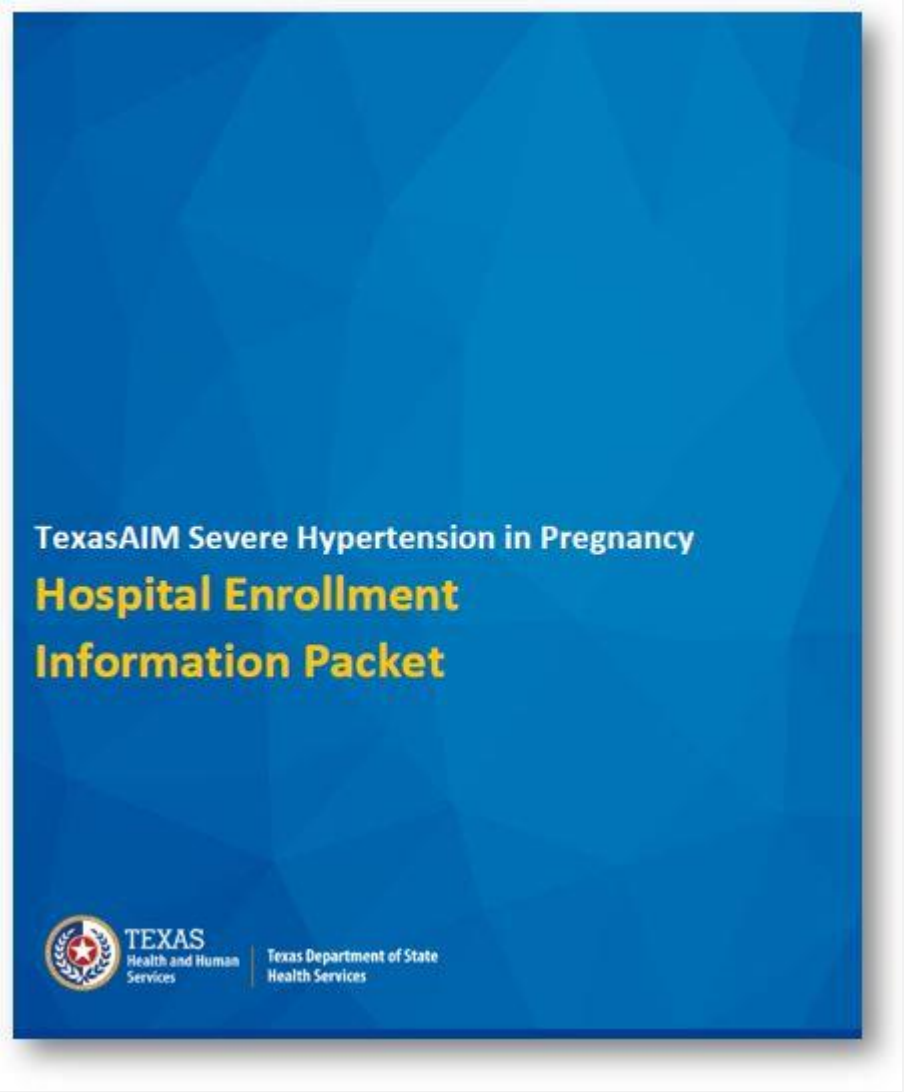
Leaving in Action

Ramping up for the HTN LC

- Debrief your OBH experience
- Look at sustainability and plan for hypertension
- E-modules from Council for Patient Safety
- The Joint Commission Perinatal Standards
- Develop a robust team
- QI workshops with TCHMB (equity)

By Next Tuesday

- Review Enrollment Packet
- Review the AIM Bundle
- Think about, and make a plan, for developing a robust team:
  - Core roles
  - Patient partner(s)
  - community partners
- Develop your “ask” for leadership



Lo-Fi simulator for each TexasAll... hospital

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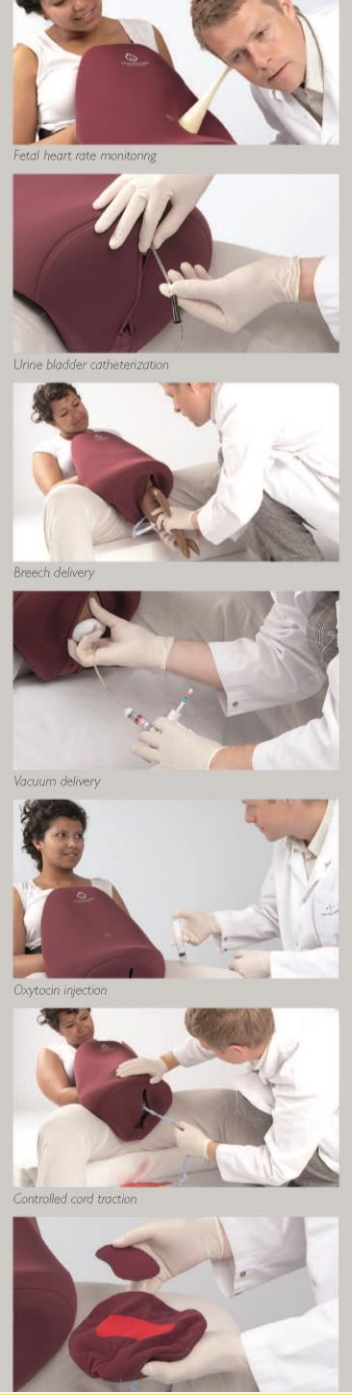
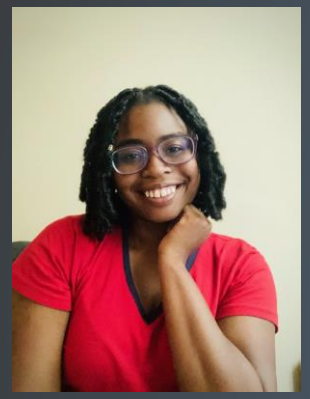
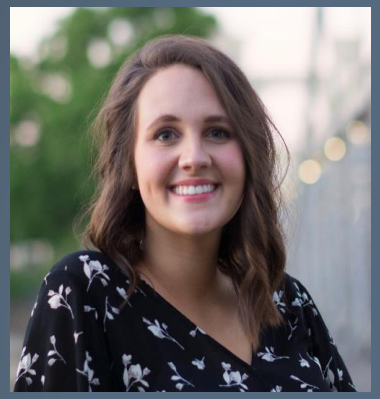
COMING SOON!



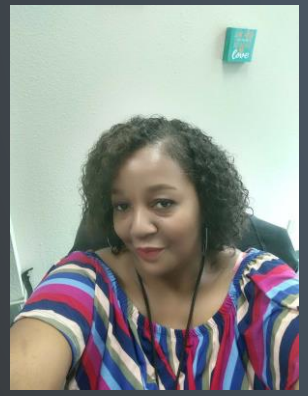
THANK YOU!

Healthy Texas Mothers & Babies Team

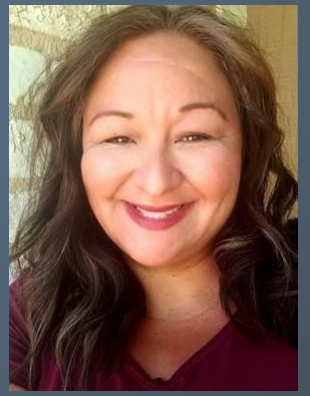




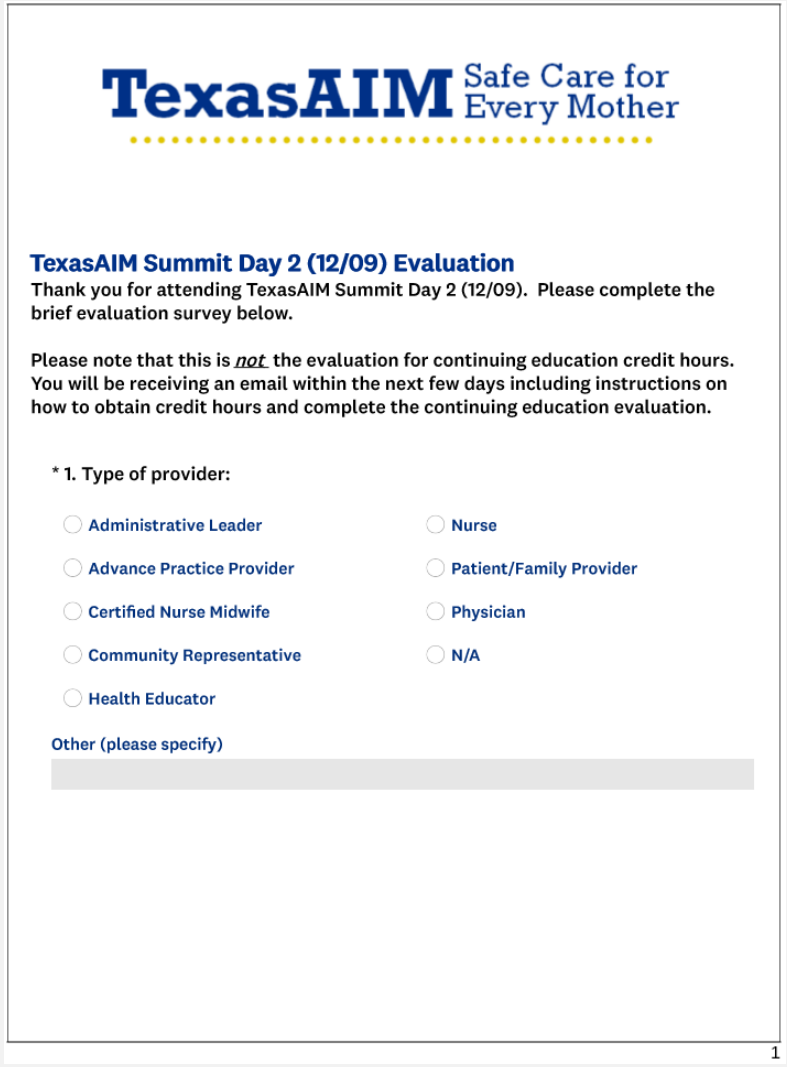







TexasAIM Summit Day 2 Evaluation



TexasAIM Safe Care for Every Mother

TexasAIM Summit Day 2 (12/09) Evaluation

Thank you for attending TexasAIM Summit Day 2 (12/09). Please complete the brief evaluation survey below.

Please note that this is *not* the evaluation for continuing education credit hours. You will be receiving an email within the next few days including instructions on how to obtain credit hours and complete the continuing education evaluation.

* 1. Type of provider:

- Administrative Leader
- Advance Practice Provider
- Certified Nurse Midwife
- Community Representative
- Health Educator
- Nurse
- Patient/Family Provider
- Physician
- N/A

Other (please specify)

1

We want to hear from you!

- **Please complete the brief TexasAIM Summit Day 2 Evaluation: https://tinyurl.com/TexasAIMDay2Eval**
- A link to the evaluation will be posted in the **Chat box**
- You will also receive the survey link in a **follow-up email** sent to you later today
- Please note that this is *not the evaluation for continuing education credits*