Every Mother at AMCHP
Mobilizing for Action

Andria Cornell, MSPH
Senior Program Manager, Women’s Health, AMCHP

ACOG-CDC Maternal Safety/Maternal Mortality Meeting
May 15, 2016
AMCHP’s Every Mother Initiative

• **Strategic Focus**: Strengthen state maternal mortality surveillance systems and enhance the ability of states to translate data into policy and programs that improve maternal health outcomes.

• **Key Components**:

  - Two 15-month Action Learning Collaboratives with 6 states per cohort
  - Action planning and state sub-awards
  - Peer-to-Peer activities (calls, site visits) & Virtual Learning Events
  - Beta-testing of the CDC Maternal Mortality Review Data System
  - Partners as Technical Experts/Advisors
AMCHP’s Every Mother Initiative

Cohort 1
Cohort 2
Translation Projects

- Maternal Safety Hospital/Provider QI Projects (7)
  - Nurse maternal transport course (DE)
  - Actionable clinician tools for implementation of hypertensive disorders of pregnancy guidelines (NY)
  - Obstetric emergency simulation training for Level I/Level II hospital staff (OH)
  - Statewide implementation pilot of SMM facility review (IL)
  - Host regional workshops on hemorrhage prevention (MO)
  - Hemorrhage and hypertension bundle kick-off and implementation with enrollment in AIM (OK)
  - Hemorrhage bundle kick-off and implementation with Project ECHO distance learning sessions (UT)
Translation Projects

- **Chronic Disease Prevention and Overall Wellness (4)**
  - Raise awareness of family planning services for individuals served in chronic disease clinics (GA)
  - Implement a “Show Your Heart Some Love” Educational campaign for individuals with cardiovascular disease risk factors, conduct a Pregnancy Medical Home pilot project (NC)
  - Reinvigorate or establish three preconception peer educator sites, including two in historically black colleges, each with a maternal health focus (FL)
  - Radio campaign about chronic disease awareness (MO)
Translation Projects

• Injury Prevention (3)
  – Qualitative research on what worked for women who experienced severe depression, substance abuse or intimate partner violence and were able to obtain support (CO)
  – Establish a MMR Injury Review (IL)
  – Host domestic violence trainings for health care providers and develop informational posters/shoe cards for distribution (LA)
ALCs Convene and Engage

PEER SITE VISITS & E-LEARNING EVENTS fostered KNOWLEDGE TRANSFER across 6 states

31 NEW MATERNAL MORTALITY REVIEW COMMITTEE MEMBERS added to strengthen EXPERTISE & SUSTAINABILITY

ALCs Move Data to Action

8,400 heart health messages shared with women (NC)

122 Simulation participants trained to respond to complications (OH)

62 Nurses trained to safely move sick mothers to higher levels of care (DE)

11 Rural providers trained to manage pregnancy complications (CO)

552 HEALTH WORKERS TRAINED to deliver QUALITY care

4,800 Flyers 100 Clinic Videos shared on managing chronic conditions before pregnancy (GA)

337 Providers aware of Severe Blood Pressure in Pregnancy Guidelines (NY)

20 Chronic disease specialists trained to make family planning referrals (GA)

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Sharing Successes

The Ohio Pregnancy Associated Mortality Review: The Use of Simulation Training to Prepare for Obstetric Emergencies

Location: Ohio
Date Submitted: 9/2015
Category: Emerging Practice

BACKGROUND

Pregnancy-associated deaths are those that occur during pregnancy or within one year of the end of pregnancy, regardless of the cause. A sub-set of these are pregnancy-related deaths that occur during pregnancy or within one year of the end of pregnancy who have a cause that is considered to be directly related to the pregnancy. In the United States, pregnancy-related deaths rose significantly from 7.2 per 100,000 live births in 1987 to 17.8 per 100,000 live births in 2009. However, this number does not take into account severe complications that result in near-deaths, which are estimated to have increased by 2% from 1998 to 2005.

Cardiovascular conditions account for most pregnancy-related maternal deaths in the United States. The next most common causes, in order of frequency, are infection, non-cardiovascular medical conditions, cardiomyopathy, hemorrhage, embolism—thrombotic, pulmonary or other, and hypertensive disorders.

fewer resources (i.e. basic newborn care), and comprise 55% of Ohio's maternity units. Level II units fall in between and are equipped for advanced newborn care.

Hospital preferences for how information relating to the PAMR should be disseminated were assessed. The two most popular responses were teaching cases or case studies (58%) and simulation training (54%). Level I centers were more likely than Level II and III centers to use low fidelity (non-programmable) mannequins. These are more rudimentary than high fidelity systems but can still be useful learning tools. High fidelity simulators, however, present a situation closer to an actual clinical environment.

Simulations allow medical professionals and teams to learn from their mistakes without conferring harm to a patient. Respondents felt simulation training was more likely to happen if an outside entity, such as PAMR, provided assistance than when compared attempting such training without PAMR support. 83% vs. 51% respectively (PAMR
Mobilizing for Action

- Members matter
- Work with targets of your recommendations early
- Create a timeline and action steps improves productivity and keeps partners focused
- Engage outside partners in considering the spectrum of options (policy, practice, law, education, funding)
- Balance feasibility and impact
- Collaborative activities take time
- Use what’s worked
Changes in Translation Capacity

- “Our MMR now commits staff time to translation work”
- “Overall stronger”
- “Improved our networking with other partners and data sources, promises opportunities for future collaboration”
- “Stronger program valued by external partners”
- “Formed a PAMR action subcommittee”
- “Translation activities now a standing part of MMR meetings”
- “Recommendations have farther reach”
- “New partnerships with state provider groups”
- “Made PAMR a state priority”
What’s Next?

- **Ongoing technical assistance needs - DATA**
  - Abstracter support: ongoing issues accessing EHRs and ancillary records (mental health, substance use); standardization of abstraction process across multiple abstractors; case backlog
  - Quality of case identification through pregnancy checkbox
  - MMRDS implementation

- **Increased connectivity desired**
  - Resource portal/bank – all resources in one place
  - Access to training
  - Face to face meetings, quarterly calls
  - COMING SOON.....
Maternal Mortality Review Resource Portal

• Assist states without a maternal mortality review in gathering resources, tools, and support to build political and social will to establish a review;
• Connect states with a maternal mortality review to their peers to build capacity to conduct reviews and translate findings into action;
• Raise awareness of the importance of maternal mortality reviews in intervening in maternal death and morbidity and promoting the health and wellness of expecting and new mothers.
• **Expected Launch Date:** Winter 2016
Thank you!

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Andria Cornell, MSPH
Senior Program Manager, Women’s Health, AMCHP
acornell@amchp.org
202-266-3043