ANNUAL SUMMIT SUMMARY AND RECOMMENDATIONS

The Nebraska Perinatal Quality Improvement Colalborative
September 29th, 2023

Executive Summary

The Nebraska Perinatal Quality Improvement Collaborative's 2023 NPQIC Fall Summit: Upstream Solutions to Health Equity was held on Friday, September 29, 2023, in Omaha. This Summit provided an audience of over 100 attendees from academia, clinical settings, public health, community organizations, and policymakers an opportunity to understand better the existing maternal health crisis in our state, including issues that perpetuate health inequities and potential solutions.

Maternity care is failing many pregnant mothers and newborns in our country and right here in Nebraska, especially Black and Brown people, rural families who are geographically isolated, and those whose incomes are near or below the federal poverty threshold. Optimizing the quality of perinatal care is impossible without equity in care delivery. We know we can do better!

The intent of this Summit was for key partners (clinicians, nurses, policymakers, community members, academicians and more) to gain insight into the current state of maternal health and what each sector can do to make it safer for women to experience pregnancy.

Presentations covered the role of racism, equitable approaches to maternal substance use, chronic conditions in pregnancy, severe maternal mortality reviews, and looking at maternal care through the lenses of culture, language, and trauma.

This summary report shares key takeaways from each presentation and NPQIC's recommended upstream solutions to address policies, systems, and environments impacting maternal health in Nebraska.

A Call to Action from NPQIC

The United States is in a maternal health crisis. Maternal mortality rates have risen by 89% over the last five years. Disparities in maternal and neonatal health outcomes disproportionately affect Black and Native Americans. As many as 80% of pregnancy-related deaths are preventable! We must take action now to reverse these trends and right the injustices.

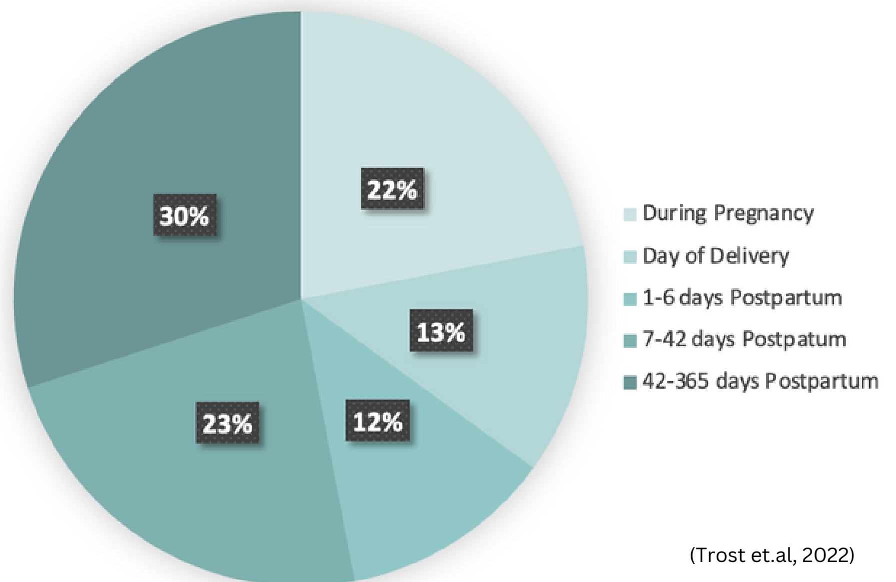
NE ranks 4th in the U.S. for percentage of counties defined as maternity care deserts (51.6% compared to 32.6% nationally)

NE has experienced a net loss of 10 rural birthing facilities since 2017

NE has the 5th highest rates of Infant Mortality for infants born to Black or African American mothers (13.1% compared to 10.6% nationally)

NE received an F on the 2023 U.S. Maternal Mental Health State Report Card

NE received a D- on the 2023 March of Dimes Report Card



(Trost et.al, 2022)

Opportunities for Impact

- Extension of Post-partum Medicaid Coverage to 12 months
- Optimize Pathways for Early Entry to Prenatal Care
- Early Entry into WIC services
- Coverage of Doula Care
- Expansion of Maternal Mental Health Access

KEYNOTE SPEAKER
DR. AMUTAH-ONUKAGHA, PHD, MPH, CHES

NPQIC was pleased to host Dr. Ndidiamaka Amutah-Onukagha, PhD, MPH, CHES, as our 2023 Keynote Speaker. Dr. Amutha-Onukagha is the Assistant Dean for Diversity and Inclusion, as well as the founder of the Maternal Outcomes for Translational Health Equity Research (MOTHER) Lab at Tufts University School of Medicine.

Black Women & Maternal Health Inequities: Addressing the Role of Racism

Throughout history, women of color have suffered reproductive injustices. Black women experience higher allostatic loads and higher blood pressure as a result of chronic stress. This increases risk for preterm birth and severe maternal morbidity.

The presence of a doula supports: improved communication between clinicians, birthing people and their families; improved quality of maternal care services; use of fewer obstetric interventions; less use of pain medications.

Doulas play a critical role in addressing social determinants of health. It is crucial that doulas are welcome on Labor & Delivery floors.

Dismissal of Concerns in Clinical Encounters
Provider implicit bias results in poorer health outcomes and can negatively influence:
-diagnosis and treatment
-pain management
-patient-provider interactions
-patient-centeredness and patient autonomy

Poor experiences with hospital staff contribute to patients' dissatisfaction and avoidance of healthcare systems due to mistrust.

"Racism in medical education is pervasive, and race-based physiological myths have long influenced medical practice."
One study found physicians twice as likely to underestimate Black patients' pain relative to other groups.

Methods to advance maternal care with a racial equity lens:

- Recognize the complexity of decision-making and intentions about sexuality and reproductive health and support individuals in seeking reproductive autonomy, health, and wellbeing.
- Ensure everyone has access to information, culturally-responsive services, and other supports.
- Utilize an intersectional and social determinants of health lens to consider an individual's choices or lack thereof around reproduction to address racism, health care delivery and other research gaps.
- Value the voices and lived experiences of the people whom we aim to serve.

SARAH NEWMAN, DNP, APRN, NNP-BC

Dr. Sarah Newman is a Lead Neonatal Nurse Practitioner at Nebraska Medicine. Sarah is also an expert on NOWS and Eat Sleep Console.

Equitable Approaches to Addressing Maternal Opioid Use and Infant Care

Substance abuse is a public health epidemic nationwide and abuse occurs across all cultural, ethnic, religious, and socioeconomic groups. Perinatal substance use is an issue critical to the health of mothers and newborns.

Who should be screened?

- Both ACOG and American Society for Addiction Medicine (ASAM) recommend universal verbal screening of pregnant women for drug and alcohol use.

When should screening occur?

- Screen at first prenatal visit (ACOG and ASAM)
- Repeat in mid-second trimester (24-28wks)

How to screen?

- Universal verbal screening
- Completed in private setting
- Interview based or self-administered questionnaire
- 4Ps Plus
  - Parents, Partner, Past, Pregnancy

More than 100 people die each day from opioids in the U.S. more deaths than car accidents or gun violence. Opioid prescriptions have decreased by 44% between 2011-2020.

The U.S. Child Abuse and Prevention Act (CAPTA) requires that all states have policies to identify newborns exposed to substances

- ACOG opposes criminalization of substance use during pregnancy and the use of biologic testing of newborns as a proxy for child abuse or neglect.
- AAP recommends hospitals develop screening policies to detect maternal substance abuse.
- Per AAP, If presence of at least 1 risk factor is a potential indication for newborn drug testing.
- Neither organization currently endorses universal testing of biological samples.

MIKAYLA WICKS

Mikayla Wicks is the Assistant Vice President of Medical Pathways at Nebraska Children and Families Foundation. Previously a Program Specialist at Nebraska DHHS, Mikayla played a key role in developing the Prenatal Plans of Safe Care.

SUSAN MARTINEZ

Susan Martinez serves as the Comprehensive Addiction and Recovery Act (CARA) Program Specialist with the Prevention Team in the NE DHHS Central Office.

Plans of Safe Care

The Comprehensive Addiction and Recovery Act of 2016 (CARA) is a provision of the Child Abuse and Prevention Treatment Act (CAPTA). CARA puts focus on infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

The CARA Act of 2016 requires:

- States to develop policies and procedures to address the needs of infants born and identified as being exposed to maternal substance use.
- Healthcare providers involved in the delivery or care of an infant born and identified as being affected by substance use or misuse (not just illegal substances) notify the child protective services system.
- A plan of safe care to address the needs of both infants and their families or caretakers who are affected by maternal substance use disorder.
- States to submit an annual report of related data to the federal government.

“We cannot wait to provide resources until the birth event. Prenatal plans of safe care are critical. This is a preventive practice to increase empowerment of women and reduce instances of removing a child from the home.”

DR. KAREN CARLSON, MD, FACOG, AOA

Dr. Karen Carlson, board certified OBGYN, graduated from the Medical College of Wisconsin in Milwaukee, WI. Dr. Carlson currently serves as an Associate Professor at UNMC and the Vice Chairperson of Student and Outreach Education. She also serves as the director of the UNMC midwifery group and a member of the Quality Triad Council for Labor and Delivery at NE Medicine.

Chronic Conditions in Pregnancy: Optimizing Care to Lower Morbidity and Mortality

Severe maternal morbidity (SMM) is defined as unintended outcomes of the process of labor and delivery that can result in significant short-term or long-term consequences to a woman's health.

The prevalence of obesity among women of reproductive age is increasing. Obesity in the perinatal period is associated with maternal mortality, as well as co-morbidities, including diabetes, gestational hypertension, preeclampsia, stroke, and obstructive sleep apnea.

Referral to culturally congruent nutritionist could positively impact the outcomes of chronic conditions in pregnancy.

> We need to prioritize addressing severe maternal morbidities in order to decrease mortality.

Diabetes affects 1 in 6 pregnancies worldwide. Between 2000-2019, prevalence of type 2 diabetes increased from 1.8 to 7.3 per 1,000 deliveries. Chronic diabetes complications increased from 2.7% to 5.6%.

Optimizing diabetes care in childbearing age is a major public health importance. Recommend patients of childbearing age consume folic acid and refer to dietician if diabetes diagnosis.

Hypertensive disorders of pregnancy is one of the leading causes of maternal and perinatal mortality worldwide. Pathogenesis of preeclampsia is poorly understood.

ELIZABETH RUTTEN-TURNER, LCSW

Elizabeth Rutten-Turner is a social worker and counselor at the Saint Alphonsus Center for Global Health and Healing in Boise, Idaho, as well as the Social Services Director for the Saint Alphonsus Program for Survivors of Torture. She is also a trained birth and postpartum doula, a childbirth educator, and an adjunct professor at BSU.

Looking at Maternal Care Through the Lenses of Language, Culture, and Trauma

A large proportion of birthing people have experienced trauma previous to pregnancy. We should approach patient care through the following lenses in order to have a reparative encounter and to limit new trauma for all birthing people.

Lens 1: Culturally-responsive care
It is important to do self-study because we all have culture. People see the world along spectrums such as: from individual to collectivist, direct to indirect communication, and relationship-oriented to time-oriented. Think, “Am I centering myself and assuming they share the same values as me?”

Lens 2: Linguistically-appropriate care
Someone’s preferred language can be fluid and depends on many factors, such as language formality and dialects. Another consideration is the social location (identities) of the interpreter- things like age, gender, race/ethnicity, education, years in country, and more. Check in with the patient to ensure the selected language and interpreter are a good fit. Lastly, a person’s condition is not their identity; use person-first language.

Lens 3: Trauma-informed care
Pillars of trauma-informed care include: safety; peer support; trustworthiness and transparency; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender considerations.

We can not change what our patients have experienced before our interactions with them, but we can provide care that is culturally responsive, linguistically appropriate, and trauma informed.

DR. DAN CONNEALY, MD, MBA, FACOG

Dr. Connealy is a Maternal Fetal Medicine specialist at Methodist Women's Hospital in Omaha, NE. Currently Dr. Connealy serves as chair of the Maternal-Child department and as chair of the Maternal Care Working Group for Nebraska Perinatal Quality Improvement Collaborative.

ERICA MEIER, MSN, RN, RNC-OB, C-EFM, C-ONQS

Erica Meier is a Clinical Resource Nurse for OB services at Methodist Women's Hospital in Omaha, NE. Erica has obtained three different certifications in perinatal nursing and a Nurse Executive MSN degree.

Severe Maternal Morbidity: Why and How to Review

The CDC, ACOG, and SMFM define severe maternal morbidities (SMM) as the "unexpected outcomes of labor and delivery that have serious short or long-term impacts." Identifying and understanding how and why SMM occurs is critical to reducing the impact in our communities.

SMM is not necessarily a sentinel event; the key is unexpected vs expected, and the review process is often different.

Identification of Cases:

- Population Level: ICD-10 Codes (21 Indicators)
- Hospital Level:
  - Admission to ICU
  - Transfusion of greater than or equal to 4 units of blood

Where to Begin: A Standardized Approach

- Building a Committee:
  - Hospital Support
  - Multidisciplinary- reflective of providers and staff
    - Not a peer review, but rather an expert review focused on improving systems.
- Resources:
  - Data Extraction
- A step-by-step approach to the review process is key to efficient utilization of time and resources.

Where are we in NE:

- NPQIC is currently piloting institutional-level SMM reviews
  - Committee formation, abstraction tools, and process implementation

Challenges

- Lack of well established levels of care, organized perinatal networks, and funding/resources
- Consolidation of resources on the Eastern side of the state

Rates of SMM are on the rise, with 60,000 occurrences annually in the U.S. (0.3-2.4% of all deliveries).

SMM events are associated with a 2.5-fold increase in cost compared to uncomplicated deliveries.

SMM may serve as an important predictor of mortality. Almost 1/2 of cases are preventable, and no delivery institution is immune.

The Birth Justice Program Manager at I Be Black Girl, Jessica earned her Master of Science in Public Health from Meharry Medical College in Nashville, TN. She has over a decade of experience in health equity work and is passionate about creating systems change that ensures the overall health and well-being of communities.

Centering Community to Drive Transformative Change in Nebraska

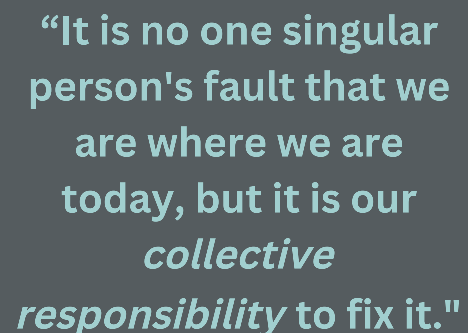
I Be Black Girl recently published a report shedding light on the experiences of Black women in Nebraska. Many reported: not feeling like provider was listening, lack of autonomy in birthing experience, perceived bias from provider, lack of access to providers of color, and a desire for a decision-making partner. One key takeaway: Black women desire a relationship with their healthcare provider that is built on trust.

How did we get here?

Weathering & Epigenetics: the “Weathering” Effect results from the accumulation of stress and disadvantage due to the impacts of racism over a lifetime.
Access to Quality Care: The Flexner Report (1910) intended to establish the biomedical model as “gold standard” in medical training. This resulted in closing all but 2 Black medical schools and portrayed Black education as deficient in general.
Regulation of Midwifery: Granny midwives were the main providers of obstetric care in rural and Black communities. They also served as doulas, lactation counselors and more. Articles and legislation delegitimatized midwifery care and drastically decreased the availability of culturally congruent birth workers for Black communities.

Racism and Bias:
Connecting HIstory to Present

Today, many medical students and residents still falsely believe there are biological differences that impact pain tolerance of Black patients. In fact, Black and Hispanic women are more likely to report pain but less likely to receive adequate medication than white women. Provider bias has been an issue with deadly consequences for Black women throughout history and still today.



“We need to be grounded in history because we need to know where we’re coming from to know where we can go from here.” -Jessica Ehule

UPSTREAM SOLUTIONS

In order to address the maternal health crisis in Nebraska, we must think upstream: what policy, systems, and environmental changes can be made to prevent morbidities, mortality, and inequity? Because health is heavily impacted by social and political factors, we need multi-sectoral partners working together to address structural racism and maximize the safety of birthing people in our state. While these changes could benefit all Nebraska mothers, they have the greatest potential to impact populations that have historically born the greatest burden of morbidity and mortality.

Policy

Policy changes can be made at multiple levels: legislative, internal to health systems, managed care organizations, and more. Here are some specific recommended policy changes:

1. Reimburse for doula support, nutritionists during pregnancy, and preventive measures
2. Reimburse for more than 1 postpartum visit
3. Statewide paid sick and family leave
4. Reimbursement for telehealth
5. Increased reimbursement rates for Medicaid deliveries
6. Hospital policies that are welcoming to doulas

"Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."
-Atul Gawande

Systems

Healthcare systems should implement the following systems changes:

1. Closely monitor cases at risk for SMM, and utilize preventive measures to avoid near-misses
2. Implement equitable and respectful care practices
3. Institutionalize Severe Maternal Morbidity reviews
4. Complete Plans of Safe Care for every substance-exposed pregnancy
5. Include patients, doulas, families, and community members in QI work
6. Address social determinants of health with appropriate referrals

Environment

The following environmental changes should be made to the clinical environments with which birthing people interact throughout pregnancy, delivery and postpartum:

1. Integrate doulas into the care team
2. Implement regular, quality bias training for clinical teams
3. Implement practices that are informed by trauma, language and culture
4. Cultivate a more diverse obstetric workforce in Nebraska

RESOURCES MENTIONED IN THIS REPORT

Access the links below to learn even more about the state of maternal health in Nebraska and the United States.

2023 March of Dimes Where You Live Matters: Maternity Care Deserts and the Crisis of Access and Equity in Nebraska

2023 NE March of Dimes Report Card

2023 U.S. Policy Center for Maternal Mental Health State Report Card

A Broken Healthcare System: Racism and Maternal Health | Dr. Amutah-Onukagha | TEDxTufts

Ain't I A Woman: A Person Centered Approach to Reproductive Care for Black Women

ALIGN NE Prenatal Care and Infant Mortality Policy Brief

Maternal Outcomes for Translational Health Equity and Research (MOTHER) Lab

NE DHHS Comprehensive Addiction And Recovery Act (CARA)

For additional questions, please contact us here.