

Women's Health in Georgia

Status, Initiatives and Opportunities

Maternal Mortality Study Committee / Diane Durrence, APRN, MSN, MPH, Women's Health Director / Nov. 7, 2019

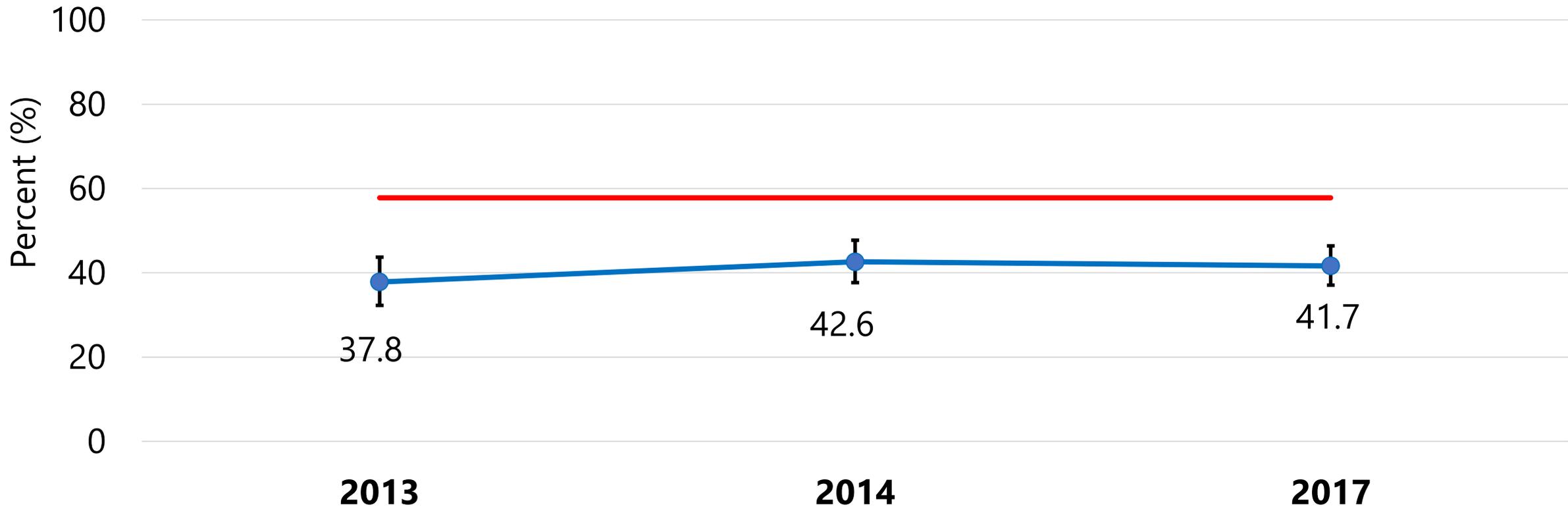
Weight

- In 2017, 33% of Georgia women 18-44 years of age were obese
- In 2017, 26% of live births in Georgia were to women who were overweight pre-pregnancy and 29% were obese pre-pregnancy
- In 2012-2014, 45% of pregnancy-related deaths had a pre-pregnancy BMI of 30 or greater (obese)

Percent of Women with a Healthy Prepregnancy Weight (BMI of 18.5-24.9) by year, Georgia PRAMS 2013, 2014, 2017

Healthy People 2020 Target: 57.8%

— Healthy People 2020



*Note: We recommend to only cautiously compare between years in Georgia. Data from Georgia PRAMS 2014 did not meet the 60% threshold for representativeness per PRAMS protocol.

** Georgia PRAMS data from 2015 and 2016 are unavailable.

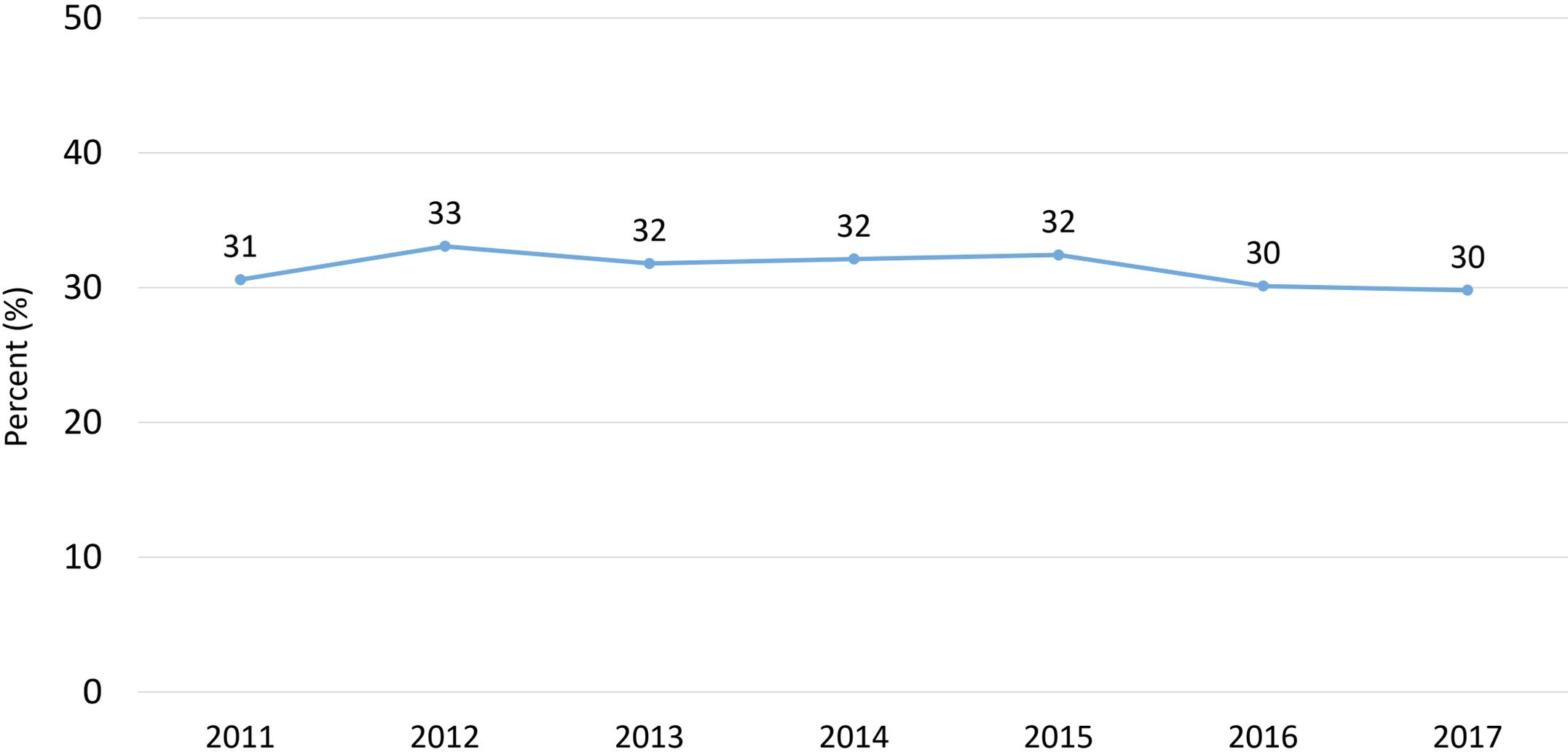
Tobacco and Alcohol Use (2017)

- 16% of Georgia women 18-44 years of age were current smokers (BRFSS)
- 13% of women who recently had a live birth reported having smoked a cigarette in the three months before getting pregnant (PRAMS)
- 50% of women who recently had a live birth reported drinking alcohol in the three months before getting pregnant
- 6% of women who recently had a live birth reported drinking alcohol during the last three months of the pregnancy

Other Drug Use

- 2007 to 2017, the number of deaths for women of childbearing age due to drug overdoses nearly doubled
- 2017: 762 NAS confirmed cases were reported in SENDSS, nearly twice as many as 2016
- Infants reported as an NAS case who had toxicology screening results:
 - 41% (313) positive for cannabinoids
 - 26% (197) positive for stimulants
 - 21% (162) positive for opioids

Reproductive Age Women without Annual Health Check-up



Leading Causes of Death, Women of Reproductive Age

- Overdose
- Motor Vehicle Crashes
- Suicide
- Cancer
- Homicide

Maternal Deaths

A maternal death is the death of a woman while pregnant or within one year of end of pregnancy. **All** maternal deaths are pregnancy-associated.

- Pregnancy-related: The death of a woman while pregnant or within one year of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by pregnancy or its management
- Pregnancy-associated, not related: The death of a woman while pregnant or within one year of the end of pregnancy, due to a cause unrelated to pregnancy
- Pregnancy-associated but unable to determine pregnancy-relatedness

Maternal Mortality Review, 2012-2014

250 maternal deaths reviewed

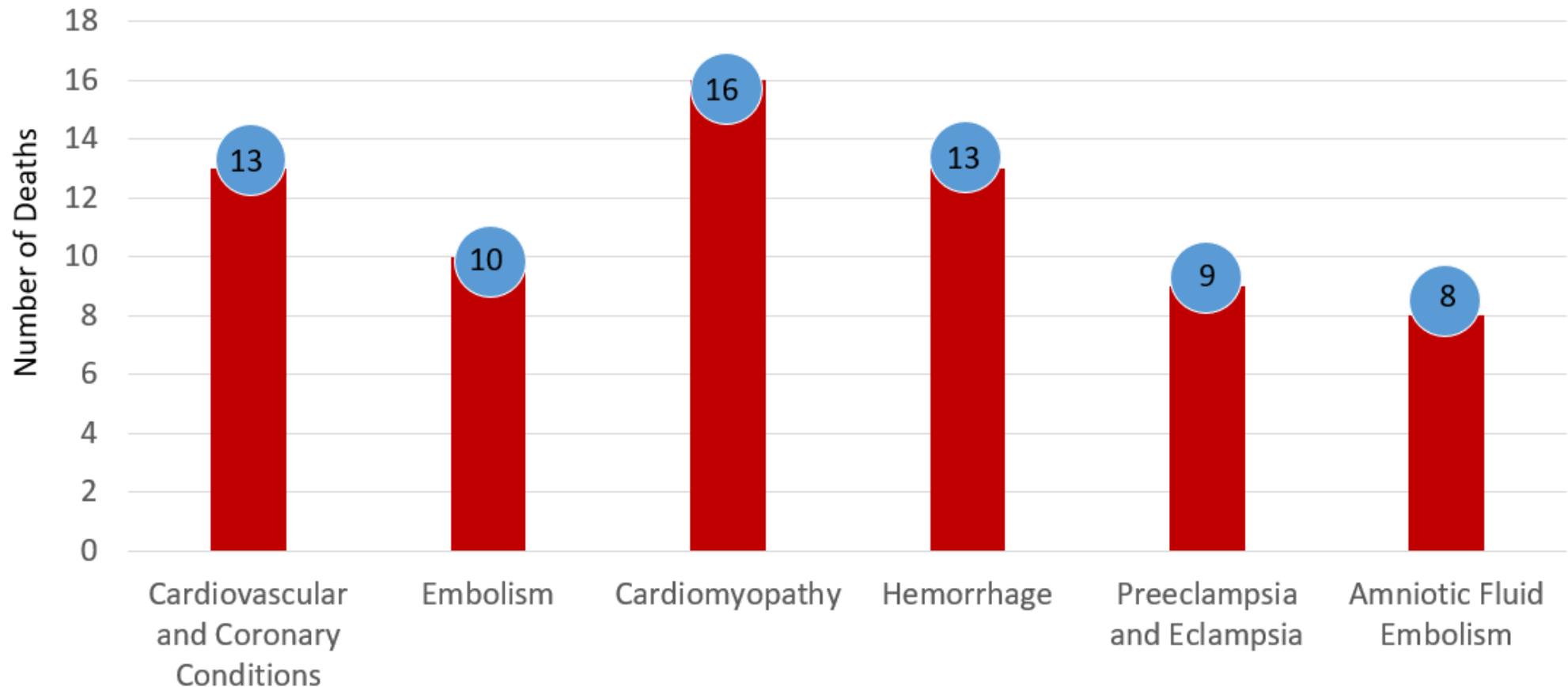


101 (40%) of maternal deaths were determined to be **pregnancy-related deaths**

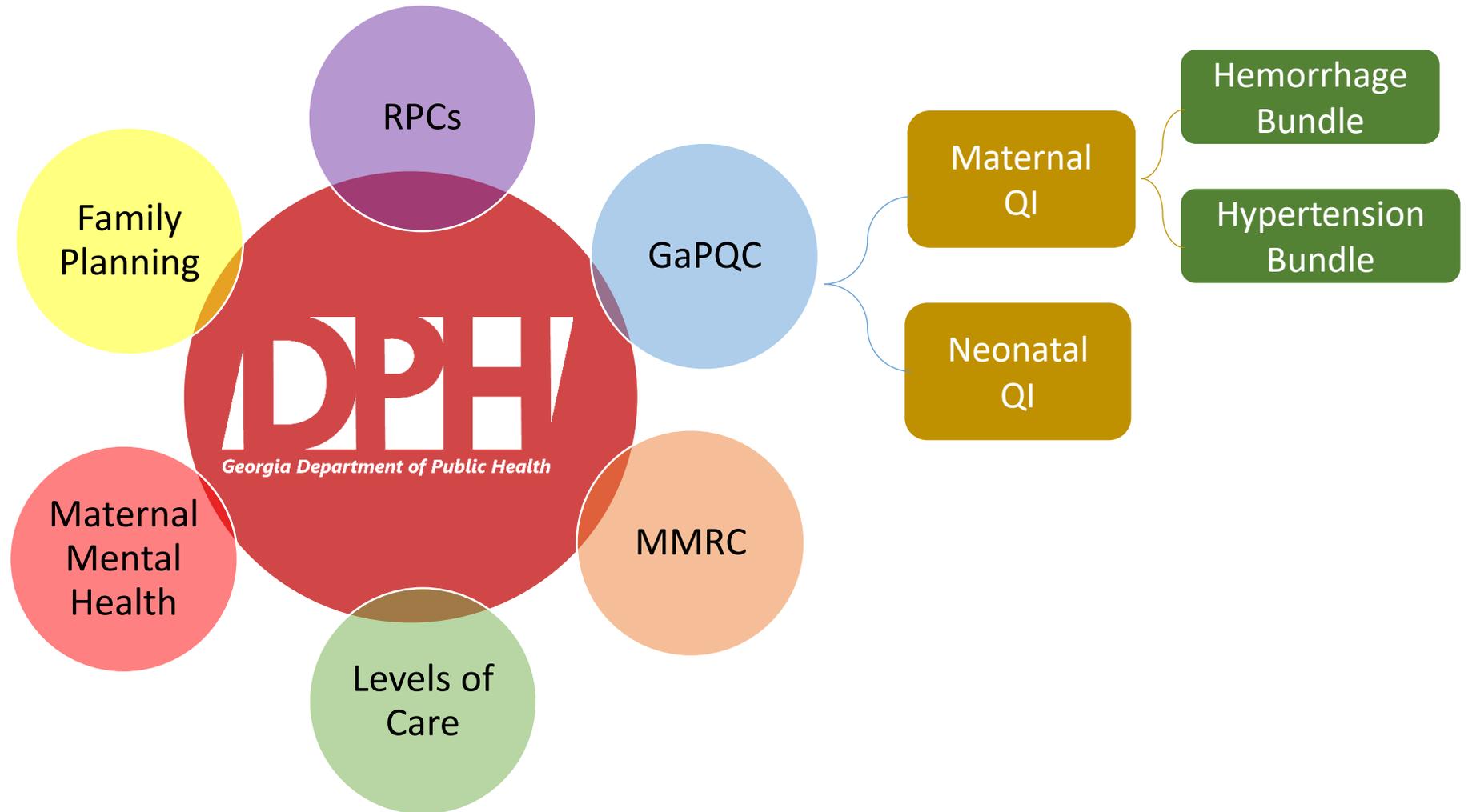


62 (~60%) of the pregnancy-related deaths were deemed **preventable**

Leading Causes of Pregnancy-Related Deaths Georgia 2012-2014



DPH Initiatives to Improve Women's Health



Maternal Mortality Review Committee (MMRC)

- Abstract and review all maternal deaths within 2 years of occurrence of death:
 - Increase the number of abstractors reviewing records
 - Increase the frequency of MMRC meetings
 - Complete 2016 and 2017 case abstraction and review in 2020
 - Complete 2018 and 2019 case abstraction and review in 2021
- Key informant interviews and more in-depth assessment of socio-economic findings to better understand contributing factors
- Robust communication of findings and recommendations

Georgia Perinatal Quality Collaborative (GaPQC)

- CDC seed funding through 2022
- Options for sustainability
- Identify new bundles and initiatives to implement
- Expanding efforts to the outpatient and community setting

GaPQC Hospital Participation

As of 11/1/19

- 62 participating hospitals
 - 44 hospitals implementing AIM Obstetrical Hemorrhage
 - 36 hospitals implementing AIM Severe Hypertension in Pregnancy
 - 47 hospitals implementing the Neonatal Abstinence Syndrome program from the Vermont Oxford Network (VON)
- Percent of GA births impact – 87%

AIM-Supported Patient Safety Bundles

- Maternal Venous Thromboembolism Prevention
 - Postpartum Care Basics for Maternal Safety: Birth to the Comprehensive Postpartum Visit
 - Postpartum Care Basics for Maternal Safety: Transition From Maternity to Well-Woman Care
 - Obstetric Care for Women with Opioid Use Disorder
- **Obstetric Hemorrhage**
 - **Reduction of Peripartum Racial/Ethnic Disparities**
 - Safe Reduction of Primary Cesarean Birth
 - **Severe Hypertension in Pregnancy**
 - Severe Maternal Morbidity Review
 - Support After a Severe Maternal Event

Hemorrhage Cart

Instruments and Supplies:

- Set of vaginal retractors
- Long weighted speculum
- Sponge forceps
- Vaginal Packs
- Uterine balloon
- Banjo curettes

Medications:

- Pitocin 10-40 units per 500-1000 mL NS
- Hemabate 250 mcg/mL 1 ampule
- Cytotec 200 mcg tablets 5 tabs
- Methergine 0.2 mg/mL 1 ampule



Quantitative Blood Loss

1. Estimate blood content of canister
 - Mark canister after infant is delivered and amniotic fluid has been suctioned
 - Mark canister again at the end of procedure prior to irrigation - irrigation fluid should not be counted as blood.
 - Subtract first marked amount from the second marked amount to obtain canister blood estimate
2. Weigh lap sponges
 - Document counts for lap sponges, lap hangers, and red bags weighed to obtain accurate dry weight
 - Weigh red bag containing laps and lap hanger(s)
3. Document total weight in grams on QBL form



Clinical Simulation Drills

Clinical scenario:

30 y/o G3P3003 who just delivered a 4210-gram infant by spontaneous vaginal delivery

Placenta delivered spontaneously, nurse concerned with amount of blood loss

Patient did not have an episiotomy, does have an IV with oxytocin running currently

The estimated blood loss at time of delivery was 350cc



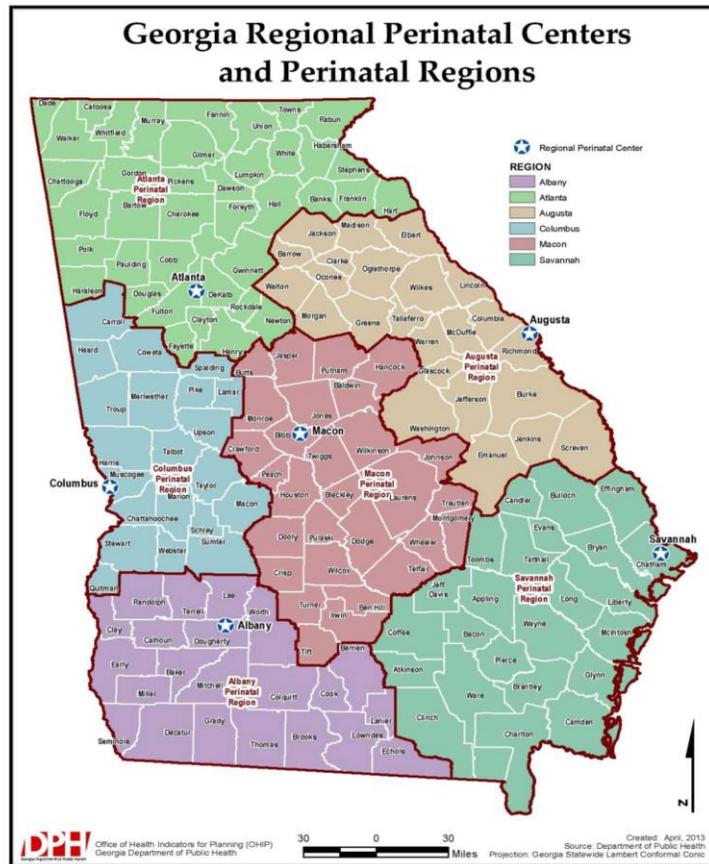
Debriefs

1. What medications, procedures or blood products used?
2. What did patient require post-hemorrhage?
3. Was blood loss measurement done?
4. Is there transfusion documentation?
5. What went well during the response – communication, assessment?
6. What human factors could be improved?
7. What non-human factors could be improved?
8. Who participated in the debrief?

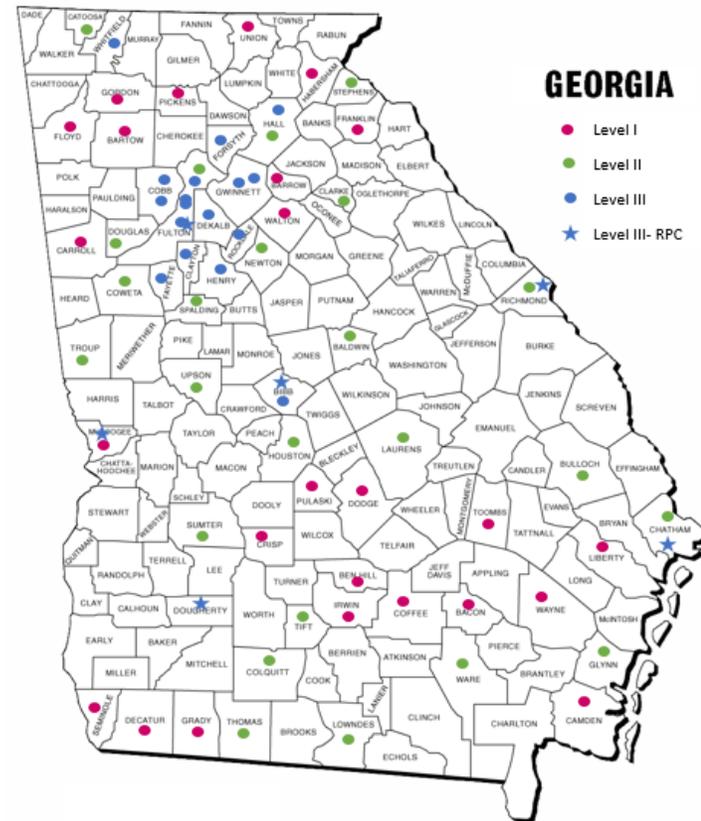


Perinatal Care System

Regional Perinatal Centers



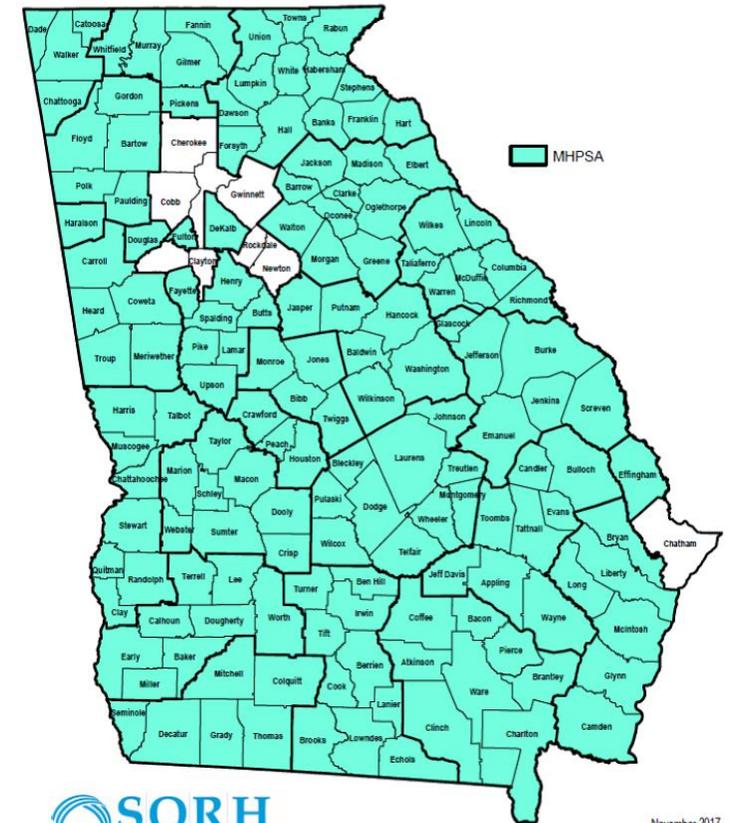
Maternal and Neonatal Levels of Care



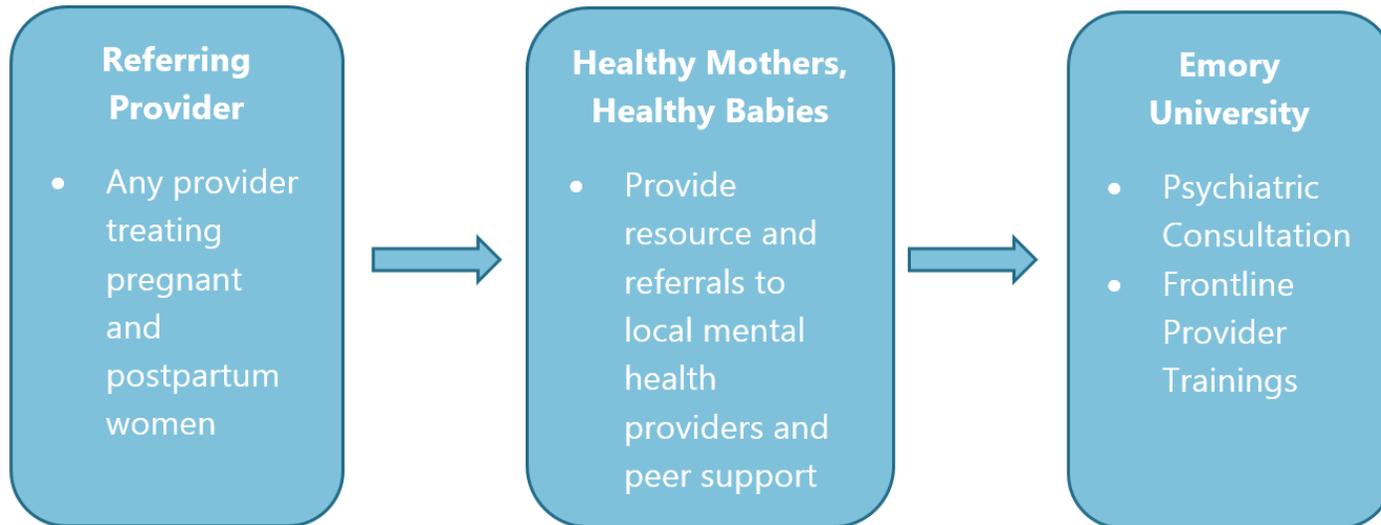
Perinatal Psychiatry Access Program

- Rapid telephone consultation for frontline providers
- Local capacity building through frontline provider training
- Referrals to community supports and local mental health providers

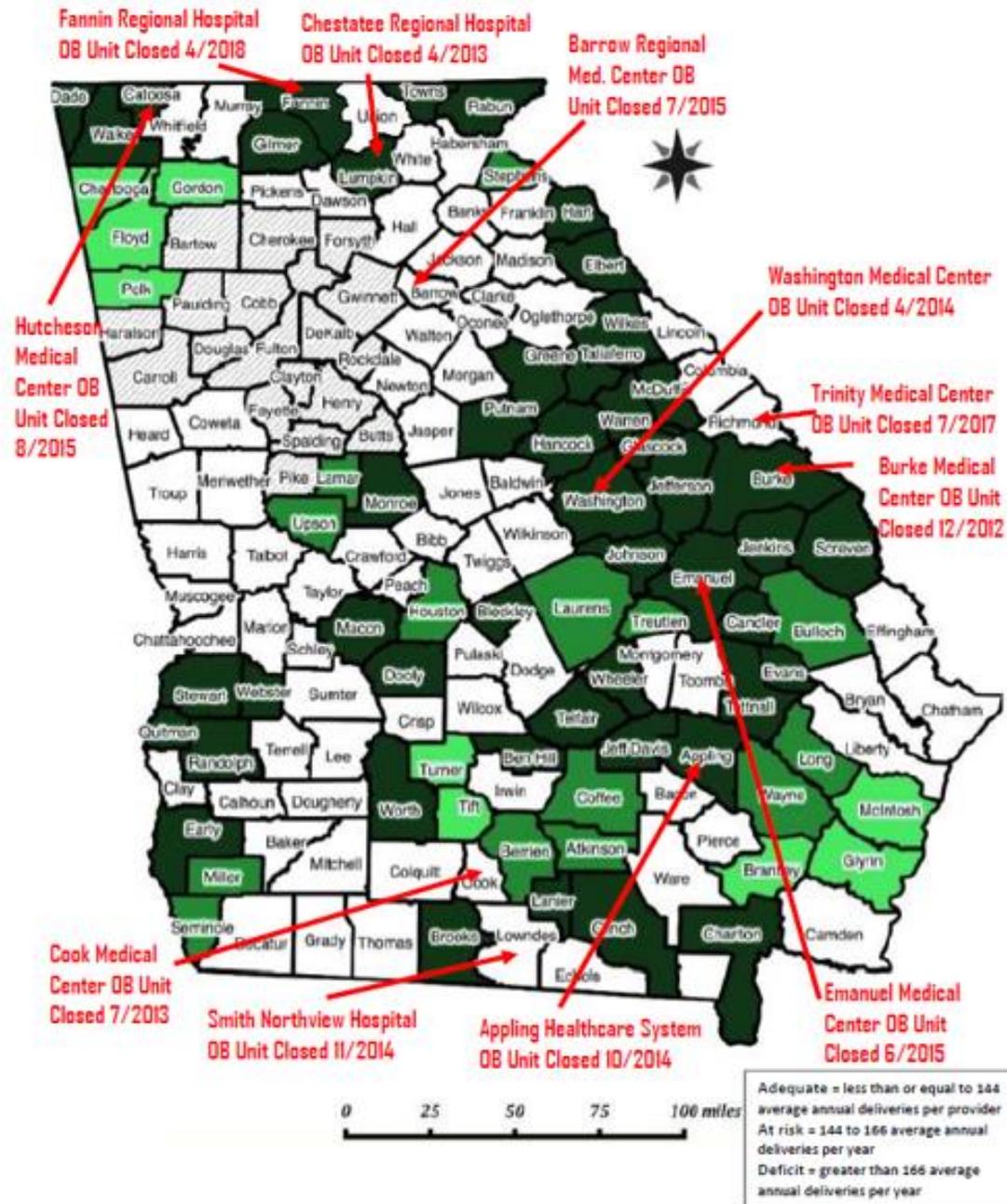
Mental Health Professional Shortage Areas (MHPSA)
State of Georgia



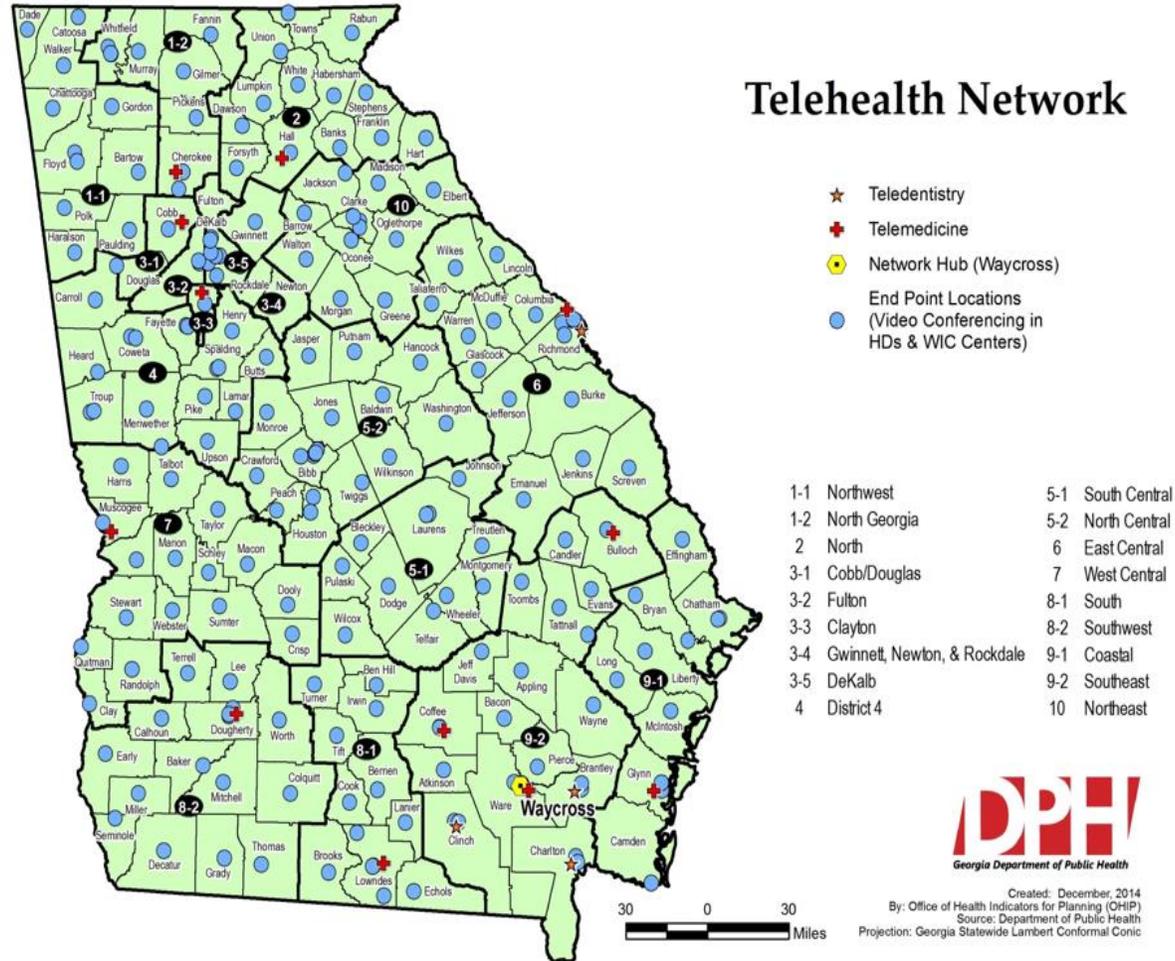
November 2017
<https://dch.georgia.gov/sorh>



Shortages of Obstetric Providers & Closed OB Units, Georgia 2018



Increase Access to Prenatal Care – Expand Telehealth



- Prenatal care in local health departments
- Remote OB supervision
- Local CNM or NP providers
- MOUs with delivery providers
- Remote MFM consultation when indicated
- Increased capacity for local management of higher risk pregnancies
- Increased availability of locally available of postpartum care

Group Prenatal Care

- Increase education and social support for pregnant women
- Prenatal care provided in a group setting that includes facilitated discussion and education in three health department locations
- In FY19, \$500,000 appropriated to DCH to establish criteria and implement reimbursement for group prenatal care
- DCH pilot in four group prenatal care locations began in February 2019



Case Management

- MMRC recommendation for increased case management during and after pregnancy
- The Pregnancy Medical Home Program and Pregnancy Care Management partnership between the North Carolina Division of Public Health, Medicaid, and Community Care of North Carolina

Questions

For more information, please contact:

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