Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement

Medicaid and CHIP Maternal Health Webinar Series: Addressing Hypertension Before, During, and After Pregnancy

Tuesday, July 16, 2024, 2:00 – 3:00 pm ET

Kristen Zycherman, Center for Medicaid and CHIP Services
Lekisha Daniel-Robinson, Mathematica
Janet Wright, Centers for Disease Control and Prevention
Amanda P. Williams, California Maternal Quality Care Collaborative
Carrie Edwards and Amy Allen, Oklahoma Health Care Authority

Technical Instructions

Welcome to the CMS Maternal Health Webinar Series!

- All participants are muted upon entry
- **Closed captioning** and WebEx assistance can be accessed at the lower left of the window
- There will be a **Question and Discussion session** at the end of the webinar
  - Please **submit questions using the Q&A panel** throughout the presentation
- Please contact **Derek Mitchell** (Host) through the Q&A panel with any **webinar platform issues**
- There will be a **survey pop-up** at the end of the webinar; please complete this survey before leaving the meeting
- A **recording of the meeting and slides** will be available after the webinar on Medicaid.gov
  - You will receive an email when these materials are posted

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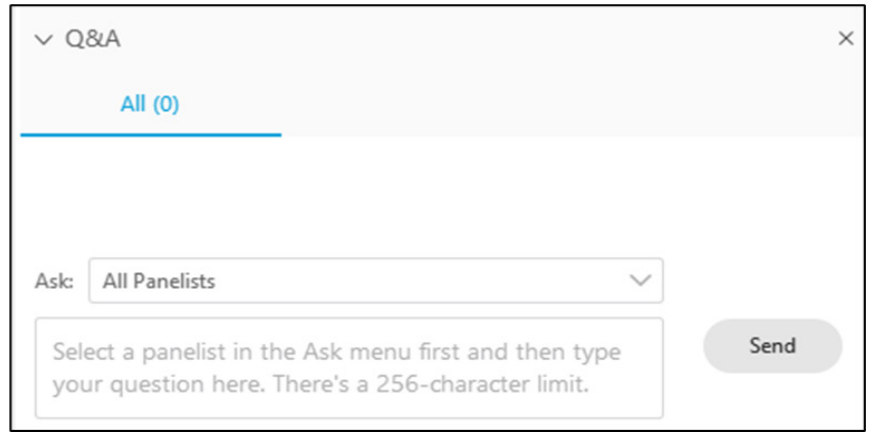
How to Submit a Question

- **Use the Q&A panel to submit questions and comments**
  - To submit a question or comment, click the Q&A panel and select "**All Panelists**" in the "Ask" menu
  - Type your question in the text box and click "Send"
    - Note: Only the presentation team will be able to see your questions and comments; your questions will be read out for all participants to hear both the question and the discussion
  - For webinar platform issues, select "**Host**" in the "Ask" menu



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Maternal & Infant Health Quality Improvement

Agenda

Topic	Speaker
Introduction	Lekisha Daniel-Robinson, Mathematica
CMS Welcome and Objectives	Kristen Zycherman, CMCS
Hypertension in Pregnancy Change Package	Janet Wright, Centers for Disease Control and Prevention
State Spotlight – California	Amanda P. Williams, California Maternal Quality Care Collaborative
State Spotlight – Oklahoma	Carrie Edwards and Amy Allen, Oklahoma Health Care Authority
Questions and Discussion	Lekisha Daniel-Robinson, Mathematica

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Maternal & Infant Health Quality Improvement

Objectives

- Provide an overview of the CMS Maternal and Infant Health Initiative and opportunities to improve maternal health outcomes in Medicaid and CHIP.
- Describe maternal hypertension and its contribution to maternal morbidity and mortality.
- Share information about CDC's new Hypertension in Pregnancy Change Package.
- Describe state strategies to improve screening, treatment, and care coordination of hypertension and other cardiovascular conditions in Medicaid and CHIP delivery systems.

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Maternal and Infant Health Initiative

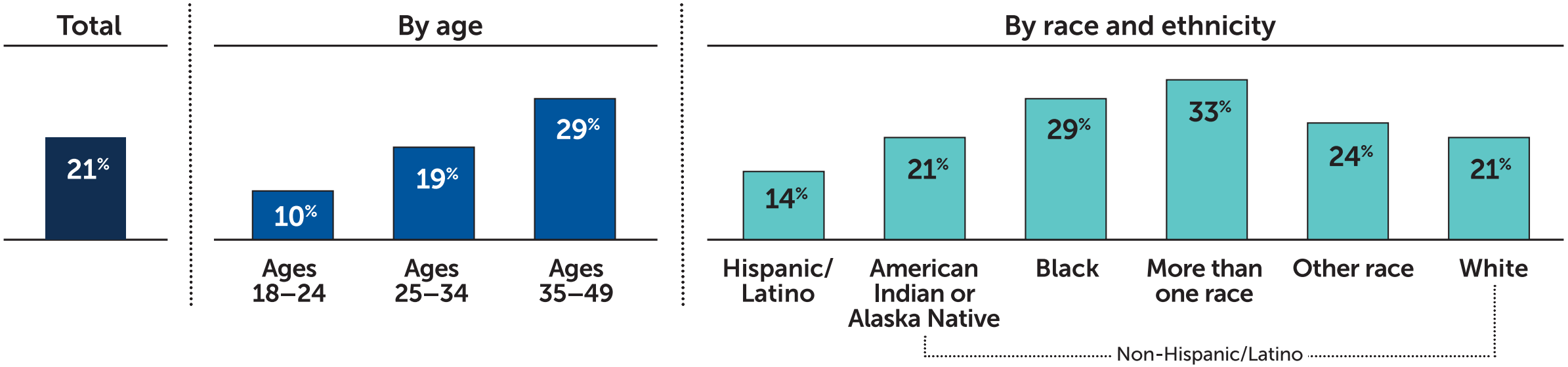
- **The Centers for Medicare & Medicaid Services (CMS) launched the Maternal and Infant Health Initiative (MIHI) in July 2014 to focus on opportunities to improve access and outcomes in Medicaid and CHIP**
  - Emphasizes the need for a comprehensive life-course approach to maternal and infant health
- **Increasing rates of maternal morbidity and mortality and unacceptable disparities led to the White House Blueprint for Addressing the Maternal Health Crisis**
- **Leading drivers of maternal morbidity and mortality in Medicaid and CHIP are associated with treatable conditions such as mental health, substance use disorders, and hypertension and cardiovascular conditions**

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality
Measurement & Improvement

High Blood Pressure Prevalence among Female Beneficiaries in Medicaid and CHIP

Percentage of Female Beneficiaries Ages 18–49 Covered by Medicaid, CHIP, or Other State-Sponsored Health Plans Who Reported They Were Ever Told They Have High Blood Pressure, 2021

(***Lower Rates Are Better***)



Notes: Insurance coverage at the time of the survey and all other data are based on beneficiary self-report. Data on race and Hispanic/Latino origin are presented in the greatest detail possible considering the quality of the data, the amount of missing data, and the number of observations. The total includes race and origin groups not shown separately because the data do not meet criteria for statistical reliability, data quality, or confidentiality. Ever told they have high blood pressure includes the following responses: “yes,” ”yes, but only during pregnancy,” and “told borderline high or pre-hypertensive.” Data include the 50 states, DC, Guam, Puerto Rico, and the U.S. Virgin Islands.

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Hypertension in Pregnancy Change Package

Janet Wright, Centers for Disease Control and Prevention

Hypertension in Pregnancy: The Problem and Solutions

Janet Wright MD, MACC

Director, CDC Heart Disease and Stroke Prevention

July 16, 2024

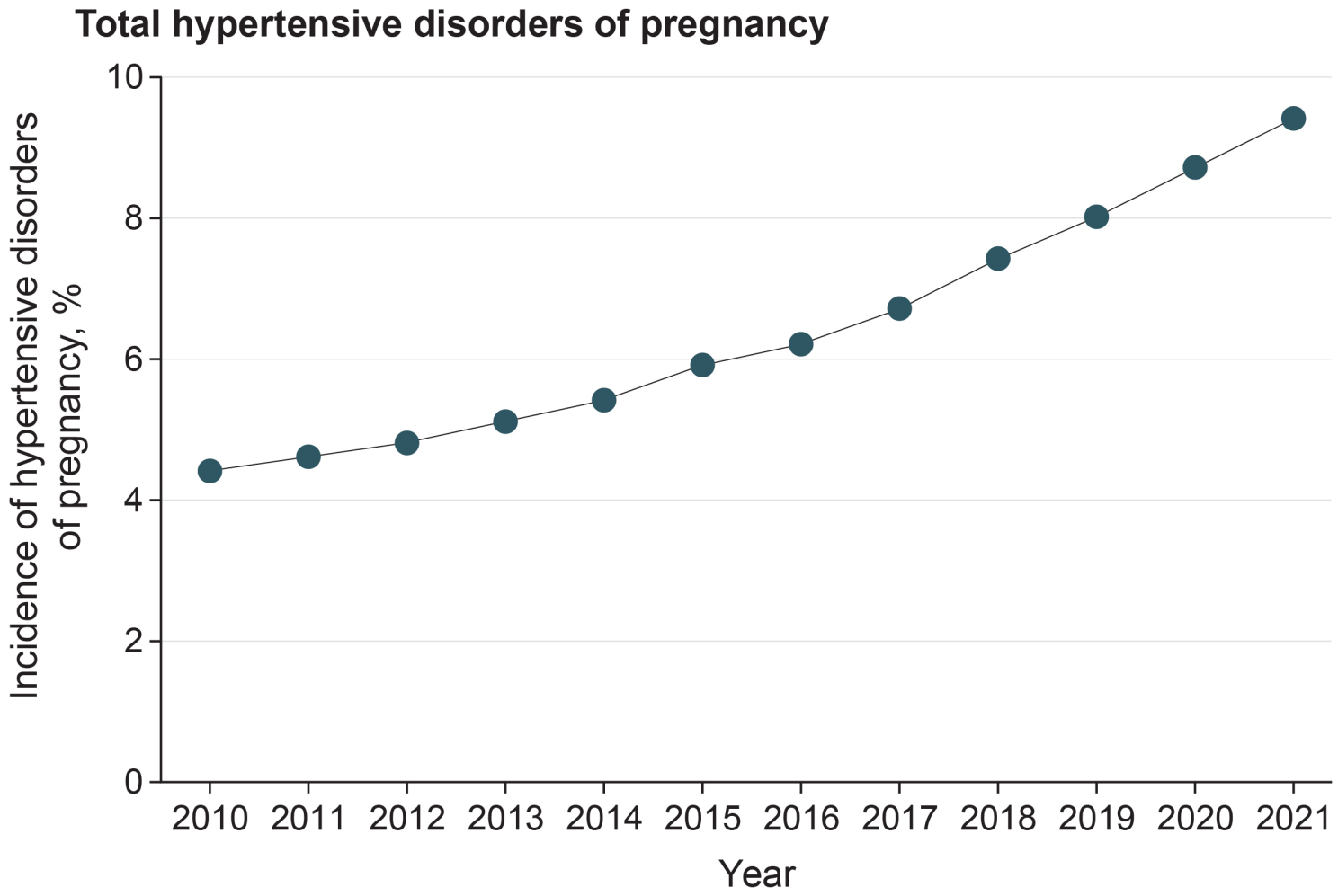
U.S. Department of Health and Human Services

The Case for Hypertension

1. **Hypertension is common; control is not.**
2. **Hypertension harms.**
3. **We are losing ground.**
4. **Hypertension is inequitable.**
5. **Hypertension is costly.**
6. **We know *what works* and it's time to make that *what happens.***

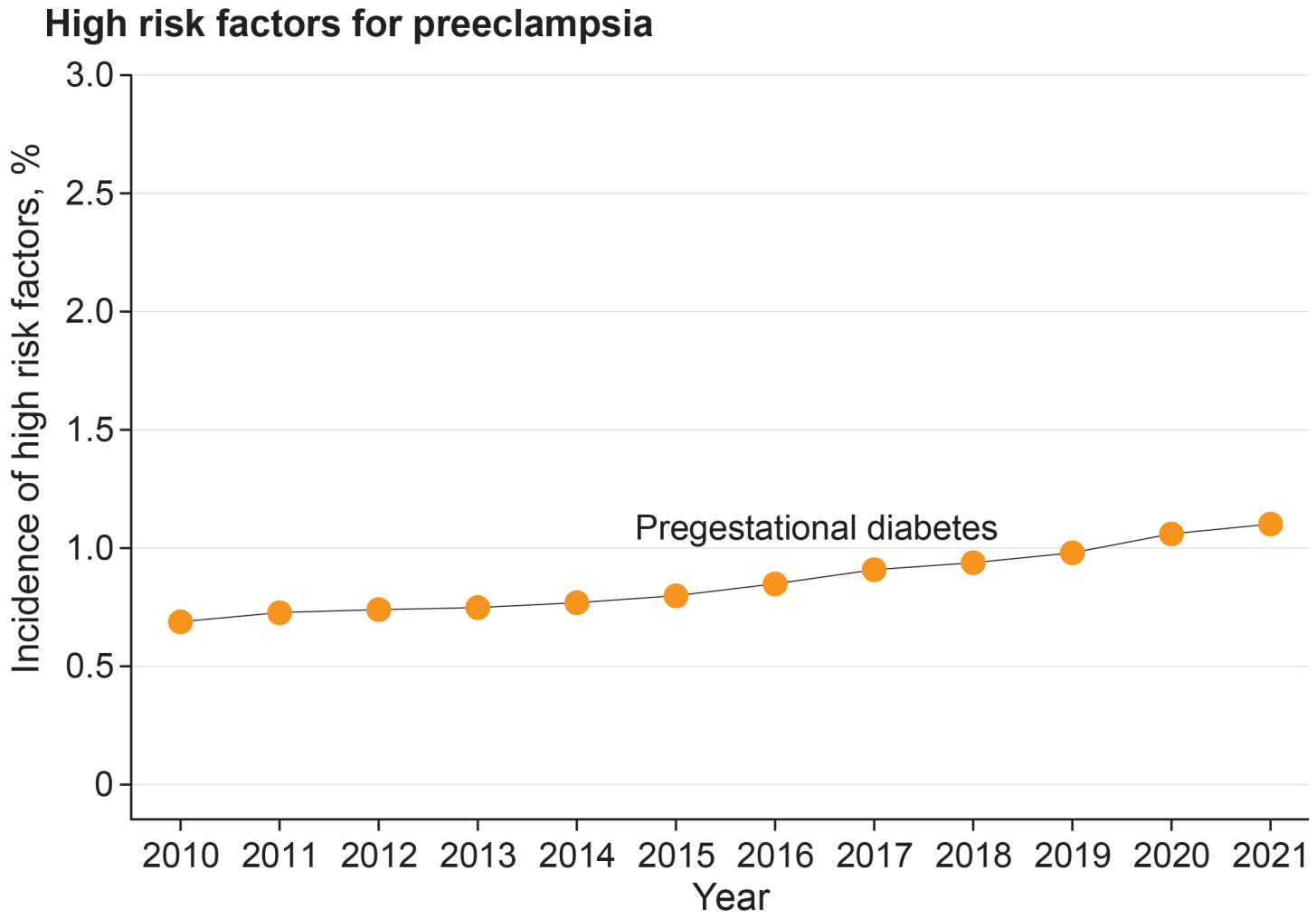
A GENERATIONAL IMPACT

Hypertension in Pregnancy is Increasing in the US.



Ayyash MK, McLaren R, Shaman M, Al-Kouatly HB. Trends in Preeclampsia Risk Factors in the US From 2010 to 2021. *JAMA.* Published online June 10, 2024. doi:10.1001/jama.2024.8931

Hypertension in Pregnancy is Increasing in the US WHY?



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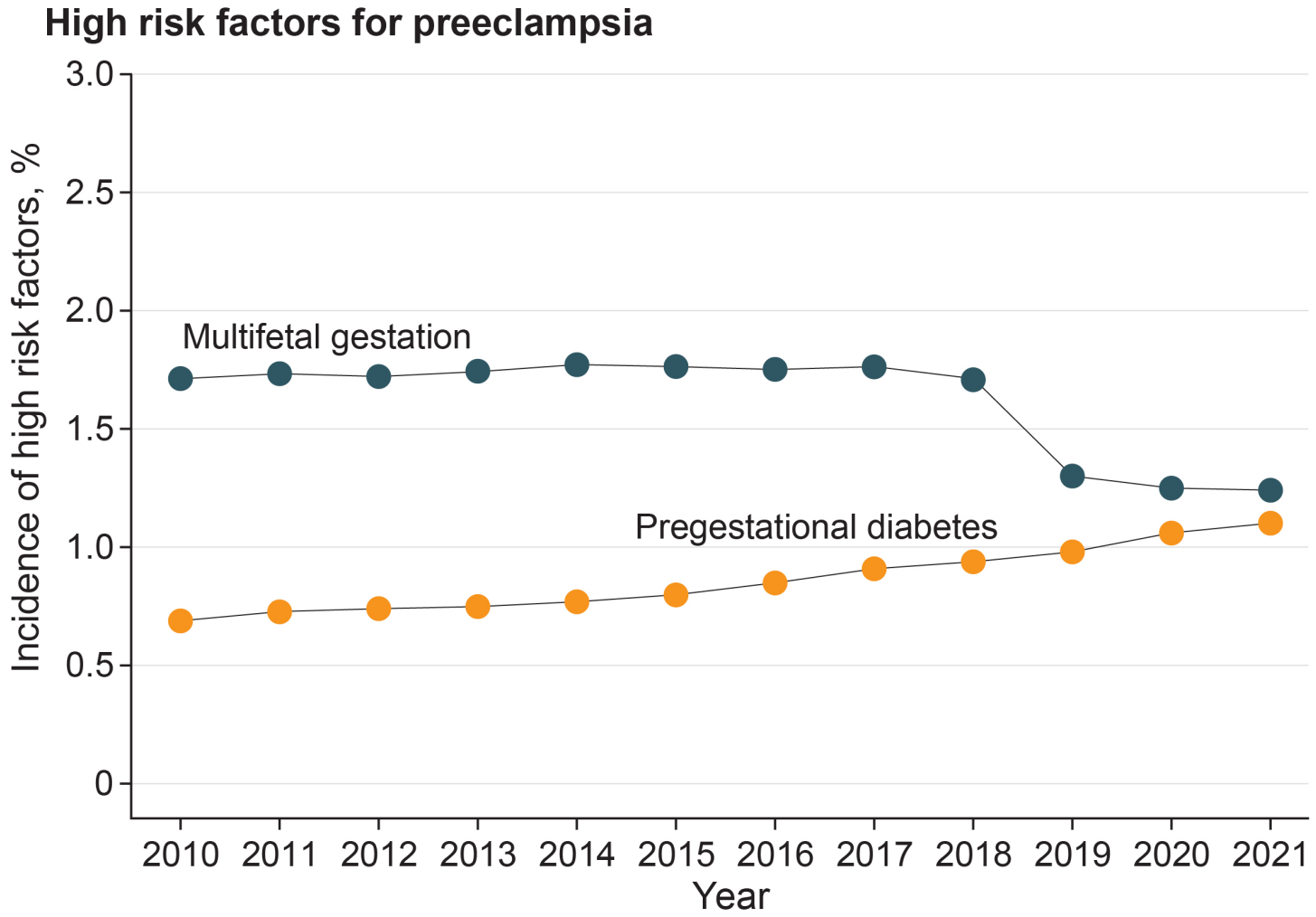

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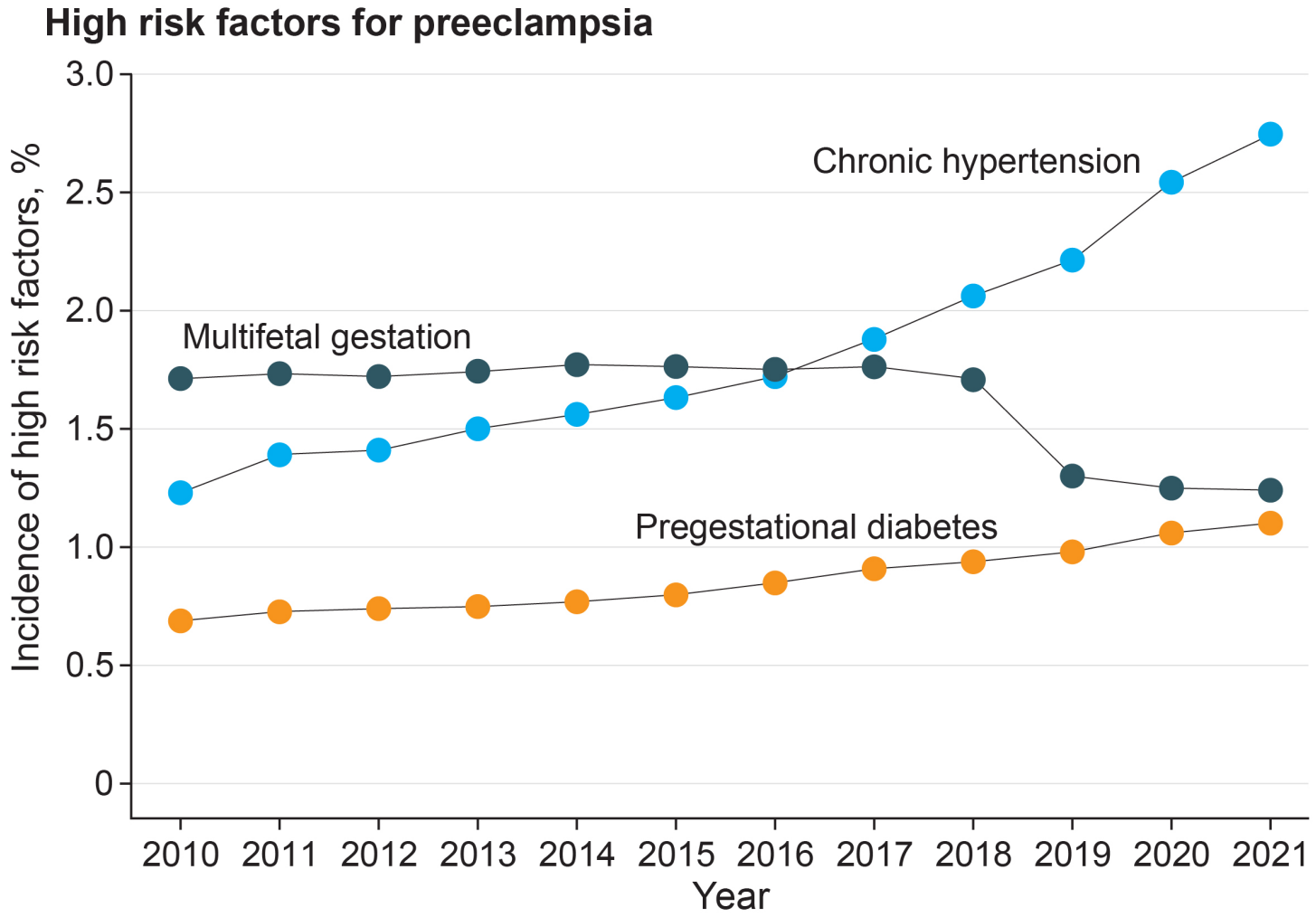

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Maternal and Fetal Complications of Hypertensive Disorders of Pregnancy

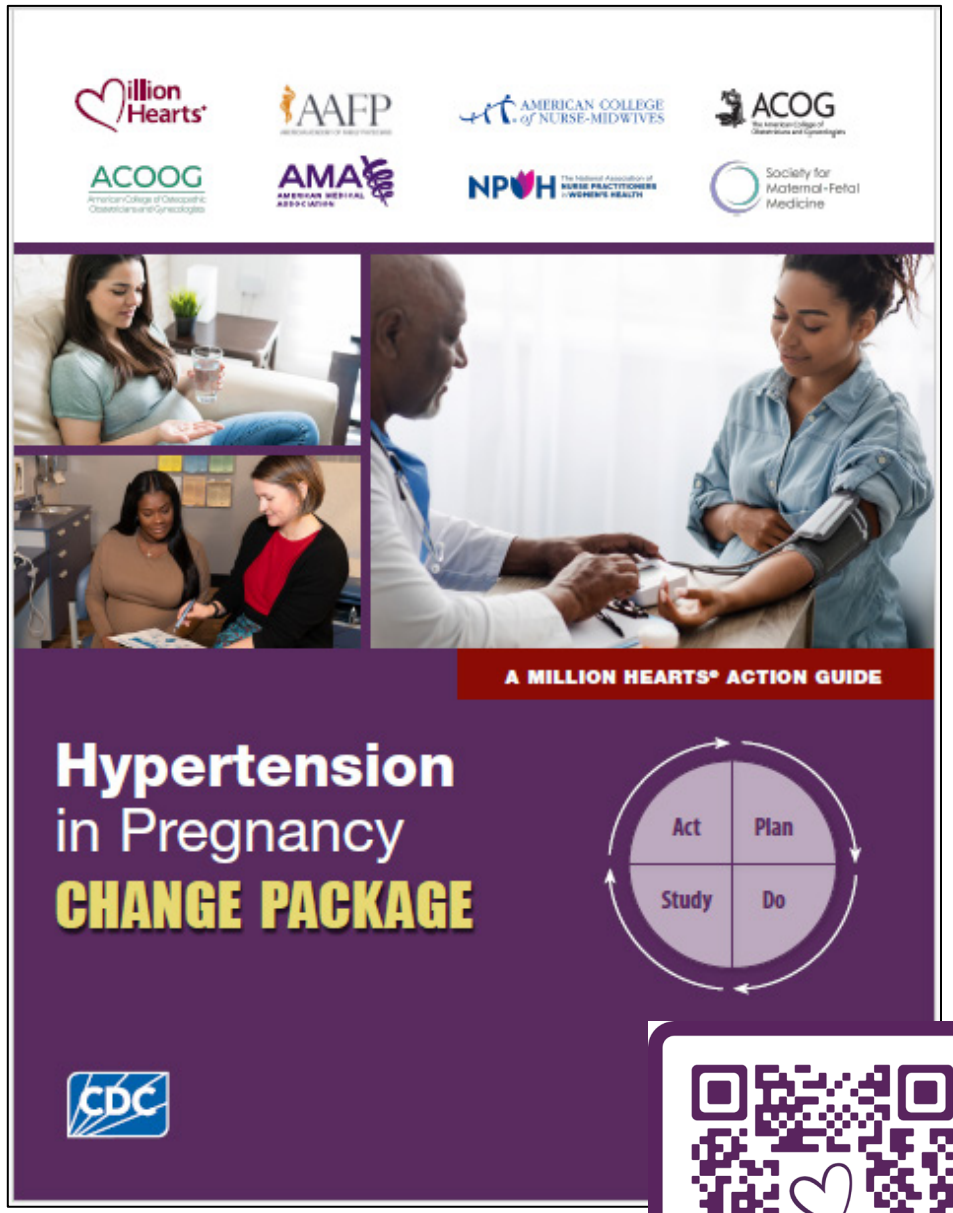
Figure 1. Maternal complications of hypertensive disorders of pregnancy

Short term	Long term
• Mortality	• Hypertension and diabetes mellitus
• Myocardial infarction	• Hyperlipidemia
• Stroke	• Stroke and vascular dementia
• Peripartum cardiomyopathy	• Atrial fibrillation and venous thromboembolism
• Spontaneous coronary artery dissection	• Chronic kidney disease and kidney failure
• Postpartum hemorrhage and placental abruption	• Cardiovascular diseases

Figure 2. Fetal complications of hypertensive disorders of pregnancy

Short term	Long term
• Small for gestational age	• Cardiovascular disease
• Stillbirth	• Stroke
• Preterm delivery	• Hypertension
	• Higher body mass index

Menna, P, Shah S. Hypertension in Pregnancy: Diagnosis, Blood Pressure Goals, and Pharmacotherapy: A Scientific Statement from the American Heart Association. ASN Kidney News. 2022;14(4):29



- A resource to help **outpatient clinical teams** care for pregnant and postpartum women.

Strategies include

- Timely identification of chronic hypertension
- Use of safe antihypertensive medications
- Self-measured blood pressure monitoring
- Aspirin use to prevent preeclampsia
- Effective transitions of care
- Postpartum counseling to reduce cardiovascular risk

Supports systematic use of these evidence-based interventions…

- Timely **identification of chronic hypertension**
- Appropriate use of **antihypertensive medications and SMBP**
- **Aspirin prophylaxis** for preeclampsia prevention
- Effective **transitions of care**
- **Postpartum counseling** on warning symptoms, long-term CV risk

…Using these types of implementation strategies

- Identification of a clinical champion
- Standardized treatment protocols
- Patient registries
- Clinician audit and feedback reports
- EHR reminders
- Clinician education and training
- Patient education
- Small tests of change (PDSA cycles)

SMBP – self-measured blood pressure monitoring; CV – cardiovascular; EHR – electronic health records; PDSA – plan-do-study-act

Change Concept

Train Direct Care Staff on Interpretation of Blood Pressure Measurements and Diagnosis of Hypertension in Pregnancy

Change Concept

Train Direct Care Staff on Interpretation of Blood Pressure Measurements and Diagnosis of Hypertension in Pregnancy

Change Ideas

- **Provide guidance on diagnosis and classification of HTN in pregnancy**
- **Use algorithms/flowcharts for management of HTN in pregnancy, including recognition of severe HTN**

Change Concept

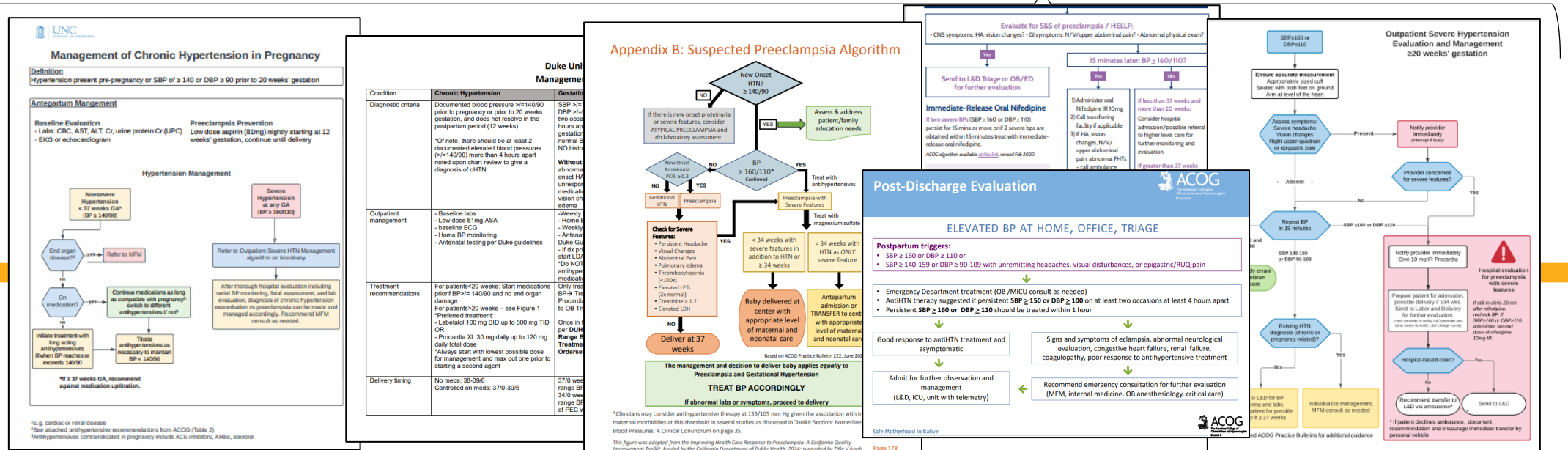
Train Direct Care Staff on Interpretation of Blood Pressure Measurements and Diagnosis of Hypertension in Pregnancy

Change Ideas

Provide guidance on diagnosis and classification of HTN in pregnancy

Use algorithms/flowcharts for management of HTN in pregnancy, including recognition of severe HTN

Tools & Resources



Preferred Antihypertensive Medications – Pregnancy

Preferred Medications in Pregnancy	Starting Dose	Maximum Dose	Precautions and Considerations
First-Line Agents			
Labetalol	100 to 200 mg twice daily	2400 mg per 24 hours	• Asthma, acute decompensated cardiac function, bradycardia • May require three times daily dosing due to increased metabolism during pregnancy
Nifedipine (extended release)	30 mg daily	120 mg per 24 hours	
Methyldopa†	250 mg two to three times daily	3000 mg per 24 hours	
Second-Line Agents			
Hydralazine	10 mg four times daily	300 mg per 24 hours	Reflex tachycardia
Chlorthalidone or hydrochlorothiazide	12.5 mg daily	50 mg per 24 hours	
Clonidine	0.1 mg transdermal daily or 0.1 to 0.3 mg by mouth twice daily	0.3 mg transdermal or 0.6 mg by mouth per 24 hours	Rebound hypertension with abrupt cessation

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Clonidine	0.1 mg transdermal daily or 0.1 to 0.3 mg by mouth twice daily	0.3 mg transdermal or 0.6 mg by mouth per 24 hours	Rebound hypertension with abrupt cessation

No ACE inhibitors or ARBs!

Preferred Antihypertensive Medications – Lactation

Preferred Medications in Lactation	Starting Dose	Maximum Dose	Precautions and Considerations
Nifedipine (extended release)	30 mg daily	120 mg per 24 hours	
Enalapril, captopril, benazepril	Varies by agent	Varies by agent	Close follow-up of infant's weight; counsel on contraceptive plan
Labetalol	100 to 200 mg twice daily	2400 mg per 24 hours	Asthma, acute decompensated cardiac function, bradycardia
Hydrochlorothiazide	12.5 mg daily	50 mg per 24 hours	May decrease milk production
Hydralazine	10 mg four times daily	300 mg per 24 hours	Reflex tachycardia

*Many medications used to treat hypertension do not have robust data surrounding their use in pregnancy and breastfeeding. Long-term use of certain medications should be avoided but they may be appropriate to use in a life-threatening emergency. Please consult pharmaceutical references or other guidance for additional considerations.

†There have been recent shortages of methyldopa. As of February 8, 2024, there is only one manufacturer of methyldopa oral tablets in the United States, which could contribute to future shortages. Prescribing clinicians may want to consider an alternative medication or check for active shortages or supply issues.

Indications for Aspirin Prophylaxis for Preeclampsia Prevention

One or more of the following:

- History of preeclampsia
- Chronic hypertension
- Pregestational diabetes, type 1 or 2
- Kidney disease
- Autoimmune disease
- Multifetal gestation

Two or more of the following:

- Age ≥35 years
- Black race*
- Lower income
- Obesity (BMI >30)
- Family history of preeclampsia in 1st degree relative
- Nulliparity
- >10-year pregnancy interval
- In vitro fertilization
- Previous adverse pregnancy outcome

*Black race is a proxy for racism, and is not a risk factor based on biologic basis.

Aspirin for Preeclampsia Prevention

For pregnant women at high or moderate risk:

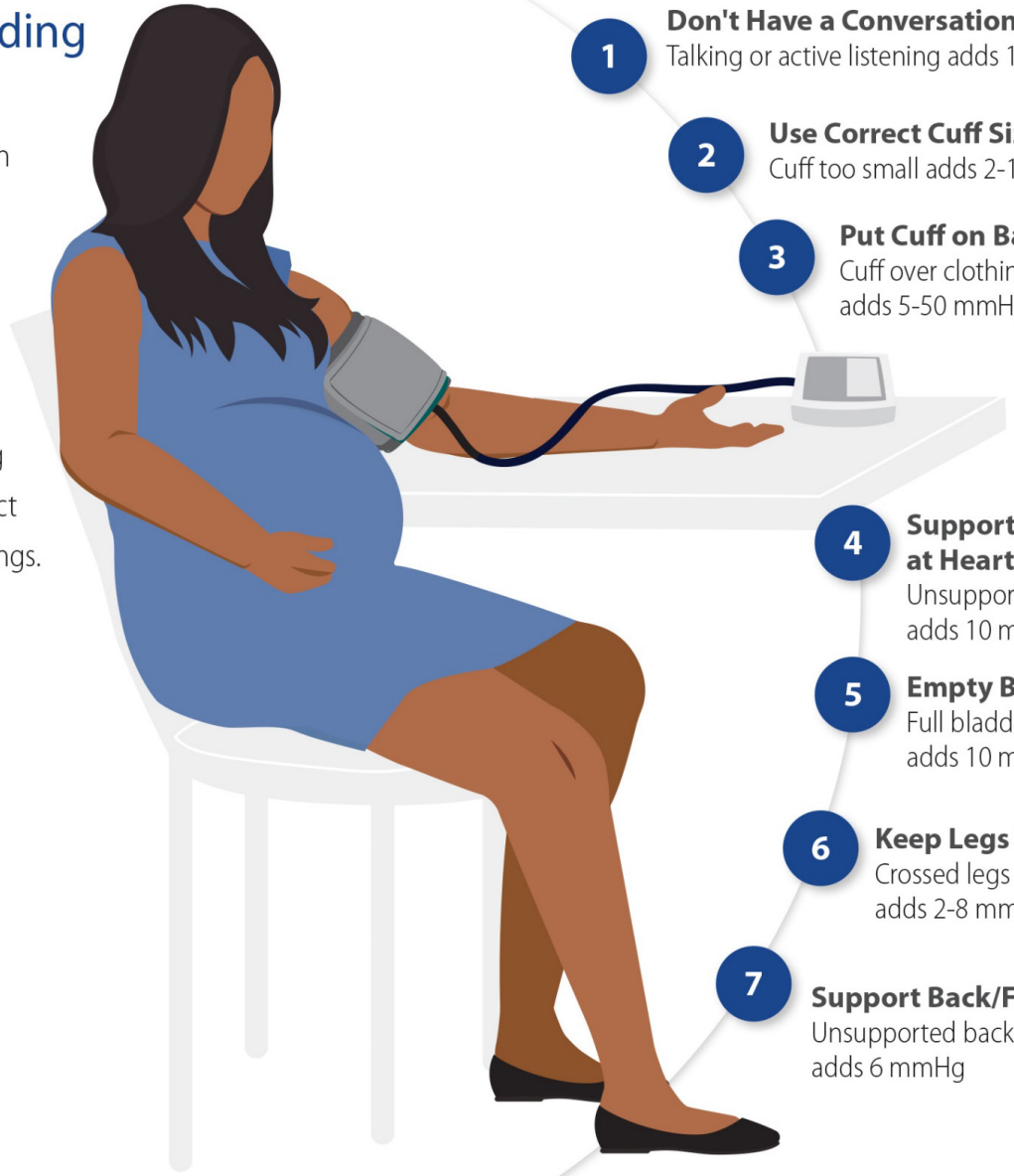
- Started between 12 and 28 weeks of gestation, optimally before 16 weeks
- Daily low-dose (81mg) aspirin until delivery
- **Over $350M in projected cost savings (vs no aspirin) if guidelines were fully implemented**
- Supported by:
  - American College of Obstetricians and Gynecologists (ACOG)
  - Society for Maternal-Fetal Medicine (SMFM)
  - U.S. Preventive Services Task Force (USPSTF)

Putra M, et al. Am J Perinatol. 2021 Mar;38(4):363-369.

7 Simple Tips

To Get an Accurate Blood Pressure Reading

These common positioning errors can result in inaccurate blood pressure measurement. Figure shown is an estimate of how improper positioning can potentially impact blood pressure readings.



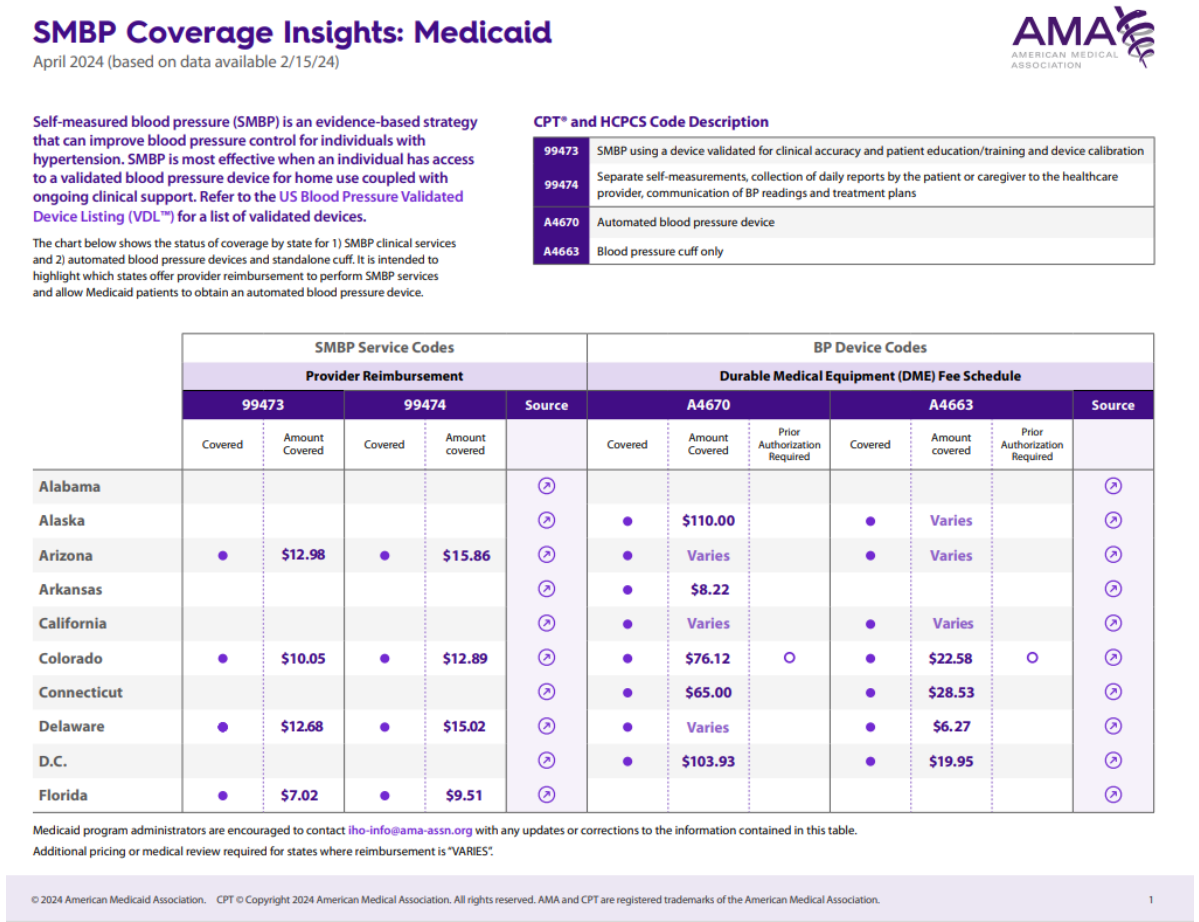
1. **Don't Have a Conversation**
   Talking or active listening adds 10 mmHg
2. **Use Correct Cuff Size**
   Cuff too small adds 2-10 mmHg
3. **Put Cuff on Bare Arm**
   Cuff over clothing adds 5-50 mmHg
4. **Support Arm at Heart Level**
   Unsupported arm adds 10 mmHg
5. **Empty Bladder First**
   Full bladder adds 10 mmHg
6. **Keep Legs Uncrossed**
   Crossed legs adds 2-8 mmHg
7. **Support Back/Feet**
   Unsupported back and feet adds 6 mmHg

Pertinent for in-office blood pressure measurement as well as for SMBP!

SMBP – self-measured blood pressure monitoring

Self-Measured Blood Pressure Monitoring (SMBP) Considerations

- Medicaid coverage for device and services
  - AMA SMBP Coverage Insights: Medicaid
- Use devices validated in pregnant populations
  - U.S. Blood Pressure Validated Device Listing; filter by pregnant under populations served
- Measure and **remeasure** arm circumference with weight changes
- Proper BP measurement preparation and positioning



SMBP Coverage Insights: Medicaid

April 2024 (based on data available 2/15/24)

AMA AMERICAN MEDICAL ASSOCIATION

Self-measured blood pressure (SMBP) is an evidence-based strategy that can improve blood pressure control for individuals with hypertension. SMBP is most effective when an individual has access to a validated blood pressure device for home use coupled with ongoing clinical support. Refer to the US Blood Pressure Validated Device Listing (VDL™) for a list of validated devices.

The chart below shows the status of coverage by state for 1) SMBP clinical services and 2) automated blood pressure devices and standalone cuff. It is intended to highlight which states offer provider reimbursement to perform SMBP services and allow Medicaid patients to obtain an automated blood pressure device.

CPT® and HCPCS Code Description

99473	SMBP using a device validated for clinical accuracy and patient education/training and device calibration
99474	Separate self-measurements, collection of daily reports by the patient or caregiver to the healthcare provider, communication of BP readings and treatment plans
A4670	Automated blood pressure device
A4663	Blood pressure cuff only

	SMBP Service Codes					BP Device Codes						
	Provider Reimbursement					Durable Medical Equipment (DME) Fee Schedule						
	99473		99474		Source	A4670			A4663			Source
	Covered	Amount Covered	Covered	Amount covered		Covered	Amount Covered	Prior Authorization Required	Covered	Amount covered	Prior Authorization Required	
Alabama					↗							↗
Alaska					↗	●	$110.00		●	Varies		↗
Arizona	●	$12.98	●	$15.86	↗	●	Varies		●	Varies		↗
Arkansas					↗	●	$8.22					↗
California					↗	●	Varies		●	Varies		↗
Colorado	●	$10.05	●	$12.89	↗	●	$76.12	○	●	$22.58	○	↗
Connecticut					↗	●	$65.00		●	$28.53		↗
Delaware	●	$12.68	●	$15.02	↗	●	Varies		●	$6.27		↗
D.C.					↗	●	$103.93		●	$19.95		↗
Florida	●	$7.02	●	$9.51	↗							↗

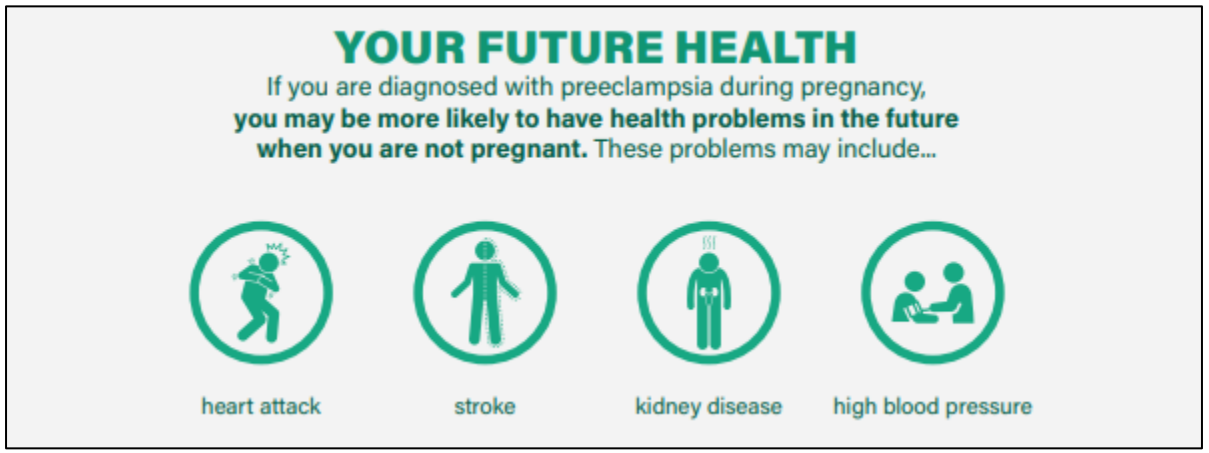
Medicaid program administrators are encouraged to contact iho-info@ama-assn.org with any updates or corrections to the information contained in this table.

Additional pricing or medical review required for states where reimbursement is "VARIES".

AMA – American Medical Association; SMBP – self-measured blood pressure monitoring

Preeclampsia – Patient Education

- Pay attention to warning signs
- Can occur during pregnancy or in the postpartum period
- Self-measured blood pressure monitoring may be useful



[Preeclampsia and Pregnancy (acog.org)]

Where Can Medicaid and CHIP Programs Start?

1. Support care transition teams from pregnancy care to primary care and/or cardiology and mental health providers
   - Promote case management outreach and appointment reminders for pregnant individuals
2. Set quality metrics for Medicaid and CHIP programs and managed care contracting
3. Promote Medicaid and CHIP enrollment for pregnant people
4. Create easy Medicaid enrollment pathways for pregnant people
5. Expand reimbursements for
   - CHW, doulas, pharmacists as part of the care team
   - BP checks without appointments
   - Validated BP monitors with range of cuff sizes
   - Virtual and telehealth appointments
6. Promote standardized treatment protocols

CHW: Community Health Workers; HTN – hypertension

Million Hearts® Hypertension in Pregnancy Action Forum

- **First Meeting – August 6, 2024, 11am-12pm ET**
- For those committed to timely detection and management of hypertension in and following pregnancy
- Open to clinicians and teams, public health professionals, and community-based partners
  - Exchange best and promising practices
  - Identify solutions to common obstacles
  - Share resources

- Register at Meeting Registration - Zoom (zoomgov.com)

Asks: Hypertension in Pregnancy Change Package (HPCP)

- **Disseminate the HPCP**
  - Share with networks
  - Newsletters
  - Social media
  - Presentation opportunities
  - Annual meetings
  - Highlight in publications
- **Join the Action Forum**
- **Implement the HPCP**
  - Quality improvement collaborations
  - Communities of practice
  - Leadership commitments
- **Fill gaps**
  - Tools and resources
  - Research
  - Feedback

Million Hearts® Hypertension in Pregnancy Resources

- **Million Hearts Learning Lab**
  - Using Self-Measured Blood Pressure Monitoring to Improve Maternal Health Equity and Reduce Maternal Mortality – pre-work and recording (January 2024)
- **Million Hearts SMBP Forum**
  - Community Approaches to SMBP in the Maternal Health Space (September 2023) – slides and recording
  - Maternal Health and SMBP – slides and recording (December 2022)
  - SMBP for Pregnant and Postpartum Women – slides and recording (June 2020)
- **Supportive Partner Campaigns**
  - HEAR HER®
  - Release the Pressure

Thank you

Questions?

Hilary Wall--hwall@cdc.gov
Janet Wright—jwright@cdc.gov

State Spotlight – California

Amanda P. Williams, California Maternal Quality Care Collaborative

California Maternal Quality Care Collaborative (CMQCC) Hypertensive Disorders of Pregnancy Tools :

Keeping our highest risk patients safe and seen

Amanda P. Williams, MD, MPH, FACOG
Clinical Innovation Advisor
California Maternal Quality Care Collaborative
Adjunct Clinical Associate Professor
Department of Obstetrics and Gynecology
Stanford University School of Medicine
National Mission Advancement Council,
March of Dimes
July 16, 2024

INTRODUCTION TO CMQCC

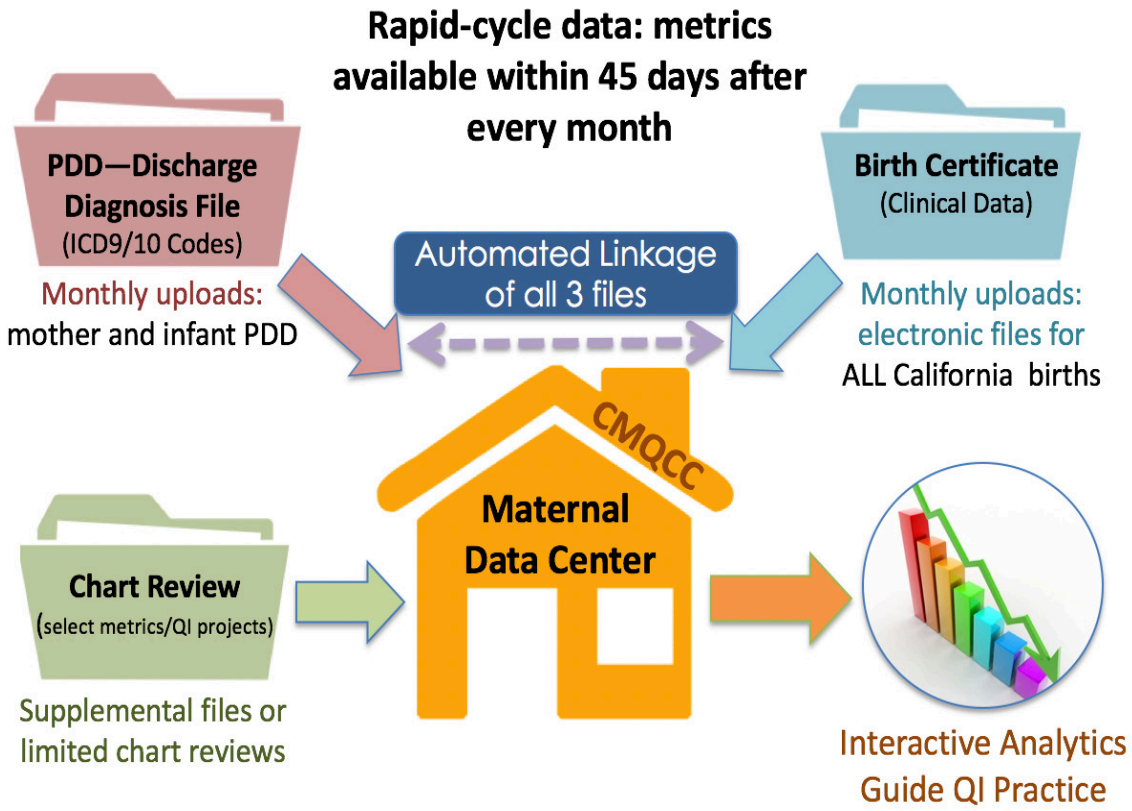
The California Maternal Quality Care Collaborative

Mission:
To end preventable morbidity, mortality and racial disparities in maternity care.

- Celebrating 18 years!
- Multi-stakeholder collaborative since 2006
- Launched with funding from California Department of Public Health to address rise in maternal mortality
- Committed to evidence-based and data driven quality improvement
- Effector arm of the March of Dimes Prematurity Research Center – funding current LDA work

How We Achieve Our Mission

Maternal Data Center



Driving Maternity QI at Scale

TOOLKITS
Evidence-based toolkits on leading causes of preventable maternal morbidity and mortality

MATERNAL DATA CENTER
Near real-time benchmarking data to support hospitals' quality improvement

IMPLEMENTATION
Coaching on how to implement best practices and sharing among member hospitals

ENGAGEMENT
Engaging partners around aligned goals and promoting patient awareness

Links over 1,000,000 mother/baby records each year!

PDD – Patient Discharge Data

MATERNAL MORTALITY CONTEXT

HEALTH , LIFE

BLACK MATERNAL HEALTH WEEK: SERENA WILLIAMS SHARES NEAR-FATAL BIRTHING STORY

Image: Axelle/Bauer-Griffin/FilmMagic.

By Jenn Barthole | April 11, 2022

Racism Alone Is Not Killing Black Mothers. Inaction Is.

Lisa Fitzpatrick Contributor

I write about public health and health innovation for the underserved

RIO DE JANEIRO, BRAZIL - AUGUST 13: Tori Bowie of ...
GETTY IMAGES

'I Don't Want to Die': Fighting Maternal Mortality Among Black Women

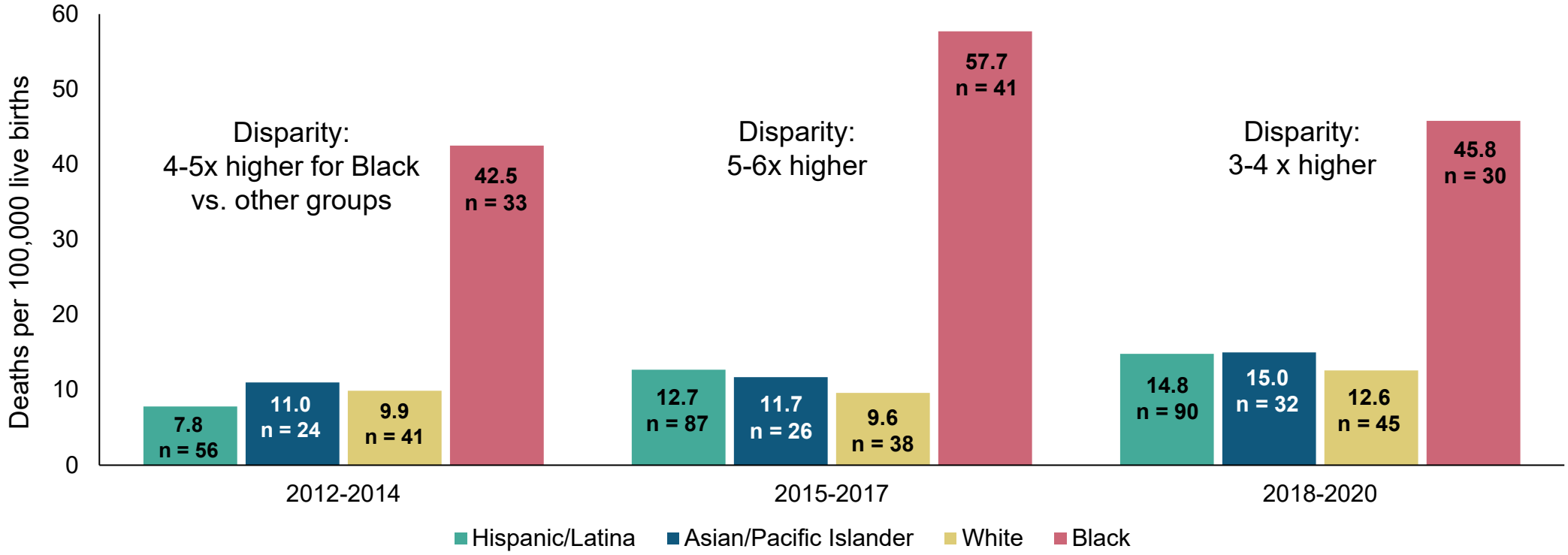
Childbirth Is Deadlier for Black Families Even When They're Rich, Expansive Study Finds

Allyson Felix wants to raise awareness of health disparities Black moms face, so she is sharing the harrowing details of her own near-death experience

Meredith Cash Jun 9, 2022, 5:00 AM PDT

Pregnancy-Related Mortality Ratio by Race and Ethnicity

California 2012-2020

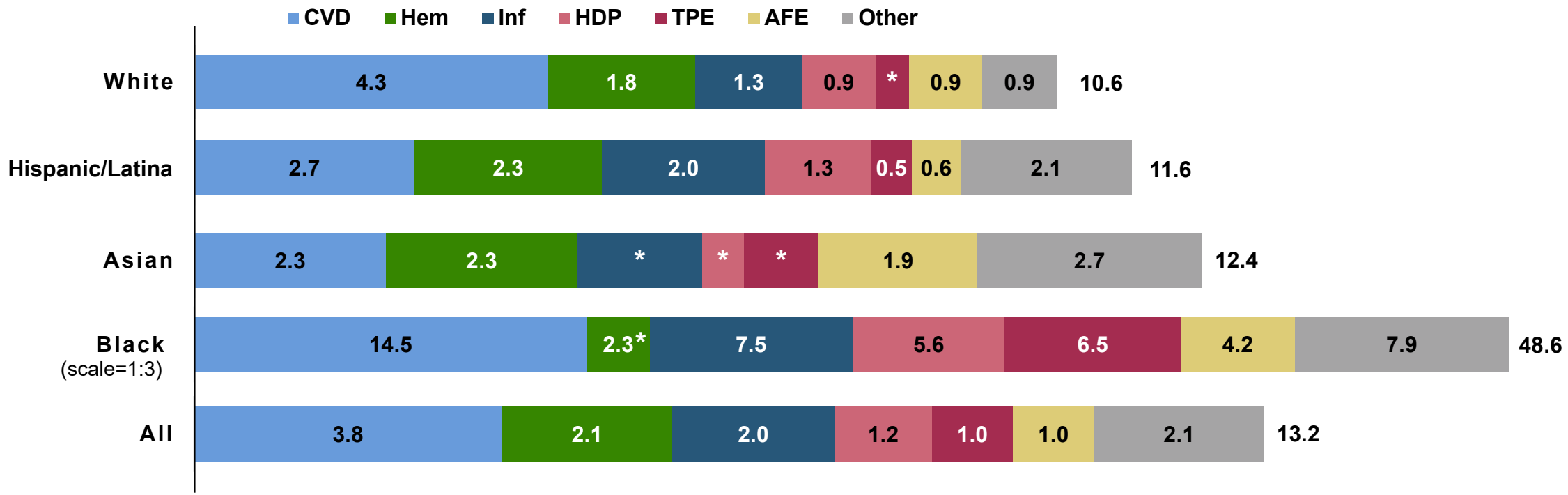


Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births. Pregnancy-related deaths include deaths within a year of pregnancy from causes related to or aggravated by the pregnancy or its management, as determined by expert committee review.

CDPH | mcah

Pregnancy-Related Mortality Ratio by Race and Ethnicity and Cause

California 2012-2020 (N=564)



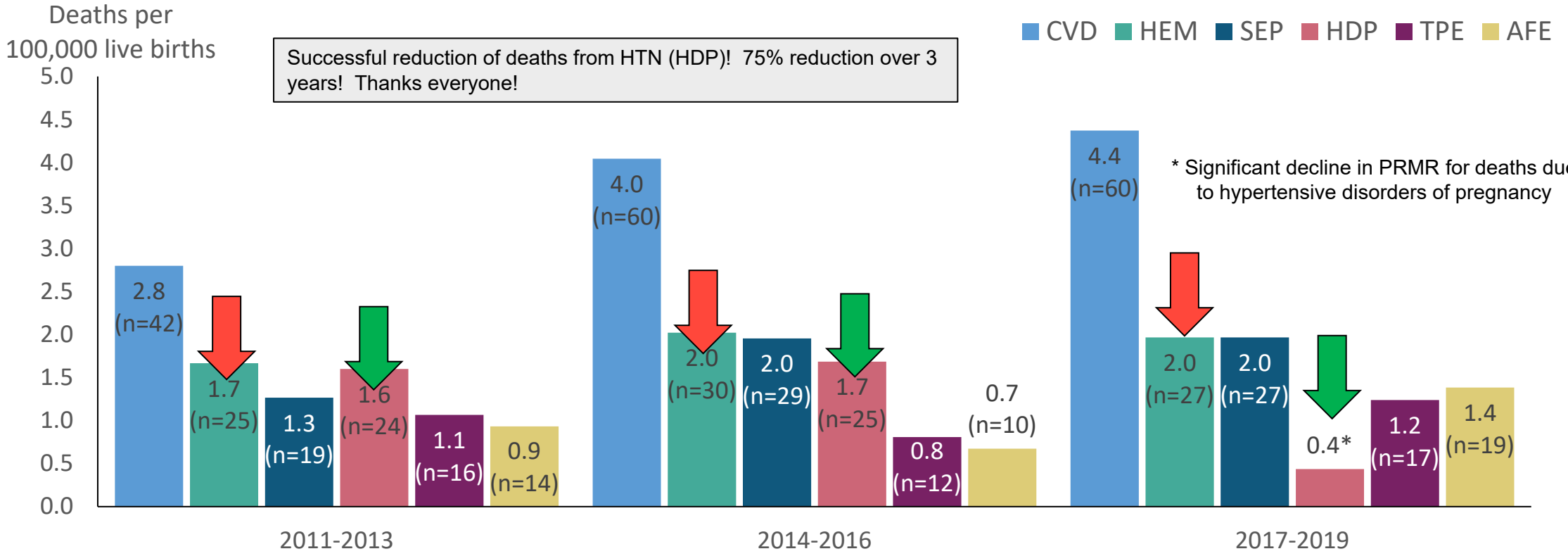
Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births. Pregnancy-related deaths include deaths within a year of pregnancy from causes related to or aggravated by the pregnancy or its management, as determined by expert committee review.

Abbreviations: CVD = Cardiovascular disease; Hem = Hemorrhage; Inf= Sepsis or infection; HDP= Hypertensive disorder of pregnancy; TPE = Thrombotic pulmonary embolism; AFE = Amniotic fluid embolism. PRMRs of American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple-race and other races not shown due to small counts

*Unstable ratio; n<10

Pregnancy-Related Mortality Ratio by Cause, California 2011-2019

CA-PMSS: Pregnancy-Related Deaths in California, 2011-2019. Sacramento: California Department of Public Health, Maternal, Child and Adolescent Health Division. 2022.



Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births, up to one year after the end of pregnancy. Pregnancy-relatedness determinations were made through a structured expert committee case review process. Abbreviations: CVD = Cardiovascular disease; Hem = Hemorrhage; Sepsis = Sepsis or infection; HDP = Hypertensive disorders of pregnancy; TPE = Thrombotic pulmonary embolism; AFE = Amniotic fluid embolism.

HYPERTENSION TOOL KIT

California Maternal Quality Care Collaborative

CMQCC

Hypertensive Disorders of Pregnancy

Hypertensive disorders of pregnancy (HDP) are one of the leading causes of pregnancy-related mortality and leading contributors to premature birth. Following the California Pregnancy-Associated Mortality Review, preeclampsia-related deaths were determined to have a significant chance of prevention. To help healthcare providers implement best practices for early recognition and treatment of hypertensive disorders of pregnancy, CMQCC recently published the Improving Health Care Response to Hypertensive Disorders of Pregnancy toolkit. This toolkit is an update to the California Department of Public Health and CMQCC's Preeclampsia toolkit from 2014 and contains expanded content to cover all hypertensive disorders of pregnancy.

The toolkit is available to download in the "Resources" section of our website:

Improving Health Care Response to Hypertensive Disorders of Pregnancy

In addition to our toolkit, CMQCC is currently collaborating with the March of Dimes on a low-dose aspirin initiative to reduce preeclampsia using a hospital-community approach. *Check back for more information soon!*

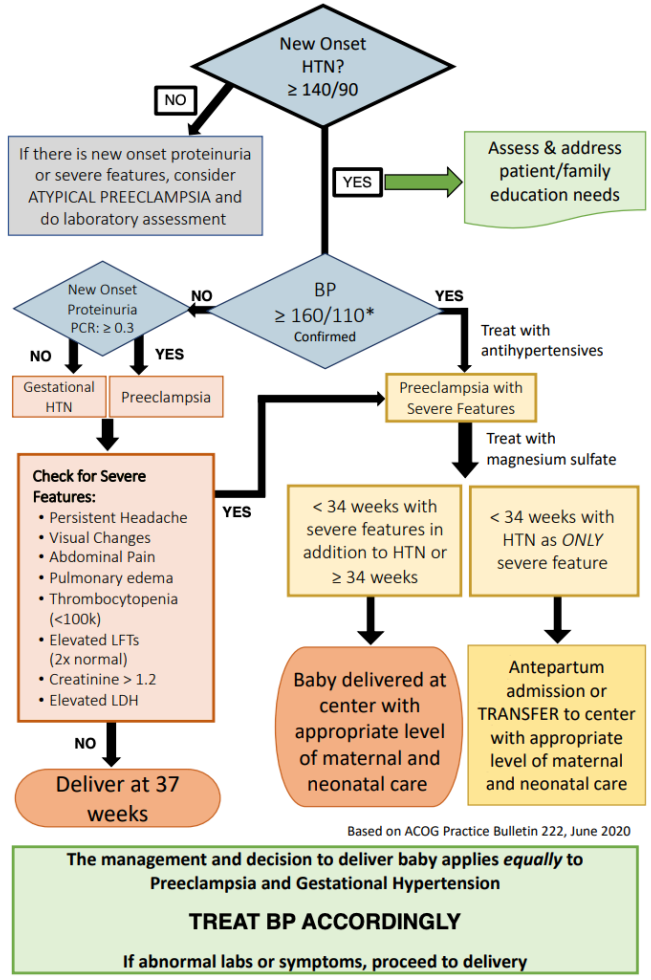
CMQCC member hospitals are also encouraged to monitor their hypertension and preeclampsia metrics in our Maternal Data Center.

WHAT'S IN A CMQCC TOOLKIT?

Evidence based resources used to make systematic quality improvement to prevent obstetric morbidity and mortality

- Educational slide decks
- Webinar recordings
- Diagnostic and treatment algorithms
- Clinical workflows
- Communication scripts
- Patient education tools
- Equipment recommendations
- Simulation scenarios and tools
- FAQs for providers, staff and patients
- Order set recommendations for EMR
- Debrief tools

Appendix B: Suspected Preeclampsia Algorithm



*Clinicians may consider antihypertensive therapy at 155/105 mm Hg given the association with increased maternal morbidities at this threshold in several studies as discussed in Toolkit Section: Borderline Severe-Range Blood Pressures: A Clinical Conundrum on page 35.

This figure was adapted from the Improving Health Care Response to Preeclampsia: A California Quality Improvement Toolkit, funded by the California Department of Public Health, 2014; supported by Title V funds. Page 178

WHAT'S IN A CMQCC TOOLKIT?

Appendix J: Sample Script: Physician Explanation of Hypertensive Disease Process and Management Plan

Maurice L. Druzin, MD, OB-GYN, Stanford Health

Dr. Druzin: After introducing the health care team, I start by asking the patient if she can tell us in a few words what she understands about preeclampsia and hypertensive disorders of pregnancy (HDP). This will often give me a snapshot of the patient and her family's understanding of the situation and all-around health literacy.

[Overarching description]

Preeclampsia is a disease seen only in pregnant or postpartum women. The main problem your health care team has identified is that your blood pressure is high. There is often protein in your urine, or you may have other symptoms like headache, pain in your abdomen or swelling of your face, hands, and feet.

[Emphasis on safety and protection]

Remember, there are two patients here, you and your baby, and we are going to take care of both of you. And, very importantly, what is happening to you now is NOT your fault and is not because of anything you did or did not do. We do not fully understand why some people develop this disease, and why most do not, although there are many theories.

Hospital Discharge Follow-up

Optimizing care for patients with Preeclampsia and other HDP

1

BP Checks

BP cuff distribution

Walk in BP locations

Remote monitoring or telephone calls

2

Symptom Education

Headaches, blurry vision, RUQ pain

Rapid onset swelling, chest pain, shortness of breath

3

Early appointment

Within 72 hours

Can use remote patient monitoring or leverage technology

4

Transition to PCP

Increased risk of chronic hypertension and stroke over lifetime (double rate of CVD compared to women with no preeclampsia)
Medication changes (during and after breastfeeding)

LOW DOSE ASPIRIN COLLABORATIVE

Introduction

An Overview of LDA Facts

1. *Hypertensive disorders of pregnancy (HPD)* complicate between 13 to 16% of all pregnancies nationally, while *preeclampsia* complicates 3 to 4% of pregnancies yearly, causing maternal and newborn morbidity and mortality.

2. Prophylactic LDA (81 mg) for those who have screened at risk reduces fetal growth restriction, preeclampsia, preterm birth, and perinatal death, and is the only intervention for the primary prevention of preeclampsia

3. The development of preeclampsia increases the risk of chronic hypertension and cardiovascular disease later in a birthing patient's *and the offspring's* life.

4. LDA commenced between 12 and 16 weeks and taken daily through delivery for those who meet the criteria is still in need of wide implementation in a standardized fashion nationwide.

5. Screening for preeclampsia risk provides the ability for early intervention, prevention, and closer monitoring during pregnancy when indicated

6. In 2021, the U.S. Preventive Services Task Force (USPSTF), American College of OBGyn (ACOG), and Society for Maternal-Fetal Medicine (SMFM) made a joint recommendation for daily prenatal LDA for birthing patients with any high-risk preeclampsia factor, or >1 moderate risk factor.

...But These Recommendations Have Been Slow To Become Widely Used!

- Multiple studies find that less than 25% of eligible women are offered or take LDA.
- Women with chronic hypertension are the highest utilizing group but among them only ~50% take LDA.
- Among Black pregnant people who are eligible, only 10% received LDA.

Parrinella K, Wong MS, Wells M, Gregory KD. Identification of criteria missed by clinicians among patients not prescribed aspirin prophylaxis for preeclampsia. SMFM, 2022.

US Preventative Task Force Recommendation, Journal of the American Medical Association (JAMA)

Medical Information & Prescribing Are **Not Enough**: *Barriers To Adoption*

- Information overload, confusion about preeclampsia.
- Difficulty obtaining prescription.
- Difficulty with pill-taking (“pregnancy fog”, health and personal challenges).
- Fear of medication in pregnancy.
- Perception of mixed messages among health care providers about aspirin safety.
- Perception of stigma about risk categories e.g., obesity.

Source: Vinogradov R, Smith VJ, Robson SC, Araujo-Soares V. Aspirin non-adherence in pregnant women at risk of preeclampsia (ANA): a qualitative study. Health Psychol Behav Med. 2021 Aug 6;9(1):681-700. doi: 10.1080/21642850.2021.1951273. PMID: 34395057; PMCID: PMC8354178

LDA Implementation:
Research and Hospital/ Clinic Outreach

Surveys

- Patient Surveys
- Provider Surveys

QI Collaborative Meetings

- Hospital site Leads
- Clinic champions
- Community-based organizations (CBOs)
- Patient Advisory Committee (PAC)

MDC Data Collection

- Data gathered in the hospital during the med reconciliation process
- Will be reviewed by our MDC team in a few minutes

Prevent Preeclampsia with Low-Dose Aspirin

Am I at risk for preeclampsia?

Ask your healthcare provider if aspirin is right for you.

#LETSDOASPIRIN

MARCH OF DIMES

CMQCC
California Maternal Quality Care Collaborative

For more information, scan the QR Code with the camera on your smart phone.

TO KEEP BABY AND YOU SAFE FROM PREECLAMPSIA

Let's Do Aspirin!

What is preeclampsia?
Preeclampsia is a serious disease during pregnancy where high blood pressure and other complications can put baby and you at risk.

How can I prevent preeclampsia?
Low-dose aspirin, as recommended by your healthcare provider, is the only known effective solution to prevent preeclampsia.

How can low-dose aspirin keep baby safe?
Studies have shown that taking low-dose aspirin during pregnancy may help reduce your risk for serious problems, like preeclampsia and premature birth.

Ask your healthcare provider,
"Am I at risk for preeclampsia?"

#LETSDOASPIRIN

MARCH OF DIMES

CMQCC
California Maternal Quality Care Collaborative

Scan the QR Code to access the **MARCH OF DIMES** Health Action Sheet to prevent preeclampsia and premature birth.

LDA Campaign Patient Scorecard Created

Should I do Aspirin...

TO KEEP ME AND MY BABY SAFE?

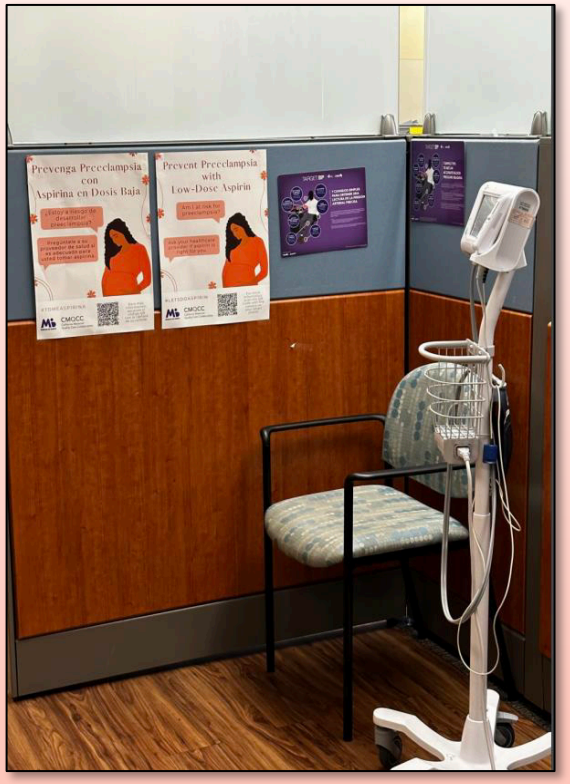
PLEASE MARK BELOW	HAVE YOU BEEN TOLD YOU HAVE ANY OF THE FOLLOWING?
YES NO	Preeclampsia ("toxemia") in a previous pregnancy
YES NO	Twins or triplets in the current pregnancy
YES NO	Hypertension (high blood pressure)
YES NO	Diabetes mellitus (type 1 or type 2)
YES NO	Kidney disease
YES NO	Autoimmune disorder (lupus, rheumatoid arthritis, etc.)
YES NO	Antiphospholipid or anticardiolipin syndrome
YES NO	Did your mother/sister have preeclampsia ("toxemia") while pregnant?
YES NO	Are you 35 years old or older?
YES NO	Did you weigh less than 5.5 lbs (2.5 kg) at birth?
YES NO	Do you identify as Black or are of African or Afro-Caribbean ancestry?*
YES NO	Will this be your first child?
	IF YOU HAVE PREVIOUS CHILDREN:
YES NO	Is your youngest child 10 years or older?
YES NO	Any previous child weighing less than 5.5 lbs (2.5 kg) at birth?

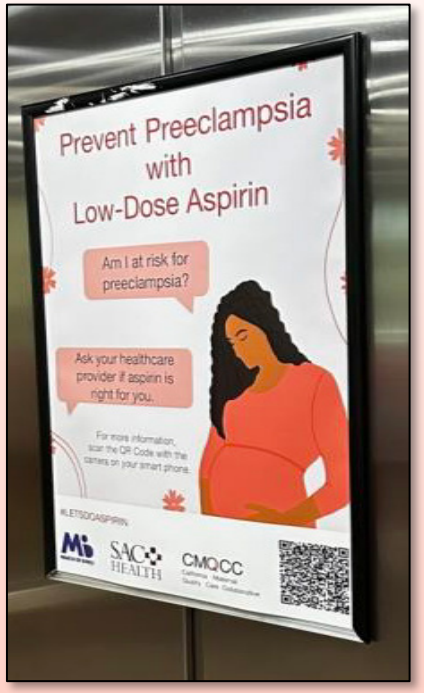
*Individuals who identify as Black experience more stress due to heightened exposure to racism.

- The original preeclampsia risk screening tool was created in collaboration between the US Preventive Services Task Force (USPSTF), the American College of Obstetricians and Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine (SMFM)

Site Visits


Prevent Preeclampsia
with
Low-Dose Aspi
Let's
Do
Aspirin
Should I do Aspirin...
PARA PROTEGERSE A USTED Y SU
BEBE DE PREECLAMPSIA
¡TOME ASPIRINA!
Tome
Aspirin


Prevenga Preeclampsia
con
Aspirina en Dosis Baja
Prevent Preeclampsia
with
Low-Dose Aspirin


Prevent Preeclampsia
with
Low-Dose Aspirin
Am I at risk for preeclampsia?
Ask your healthcare provider if aspirin is right for you.
For more information, scan the QR Code with the camera on your smart phone.
#LETSDOASPIRIN
SAC HEALTH
CMQCC

Education & Resources – Webinars

LDA Patient Advisory Committee Members

"As a preeclampsia & HELLP Syndrome survivor, my passion is to advocate for all future mommas of different colors, shapes, and sizes. I joined to share my experience, be their voice, educate and spread awareness about preeclampsia and other pregnancy complications."

"I am excited to contribute to the research and knowledge that will change the experiences and mortality rate of pregnant African Americans."

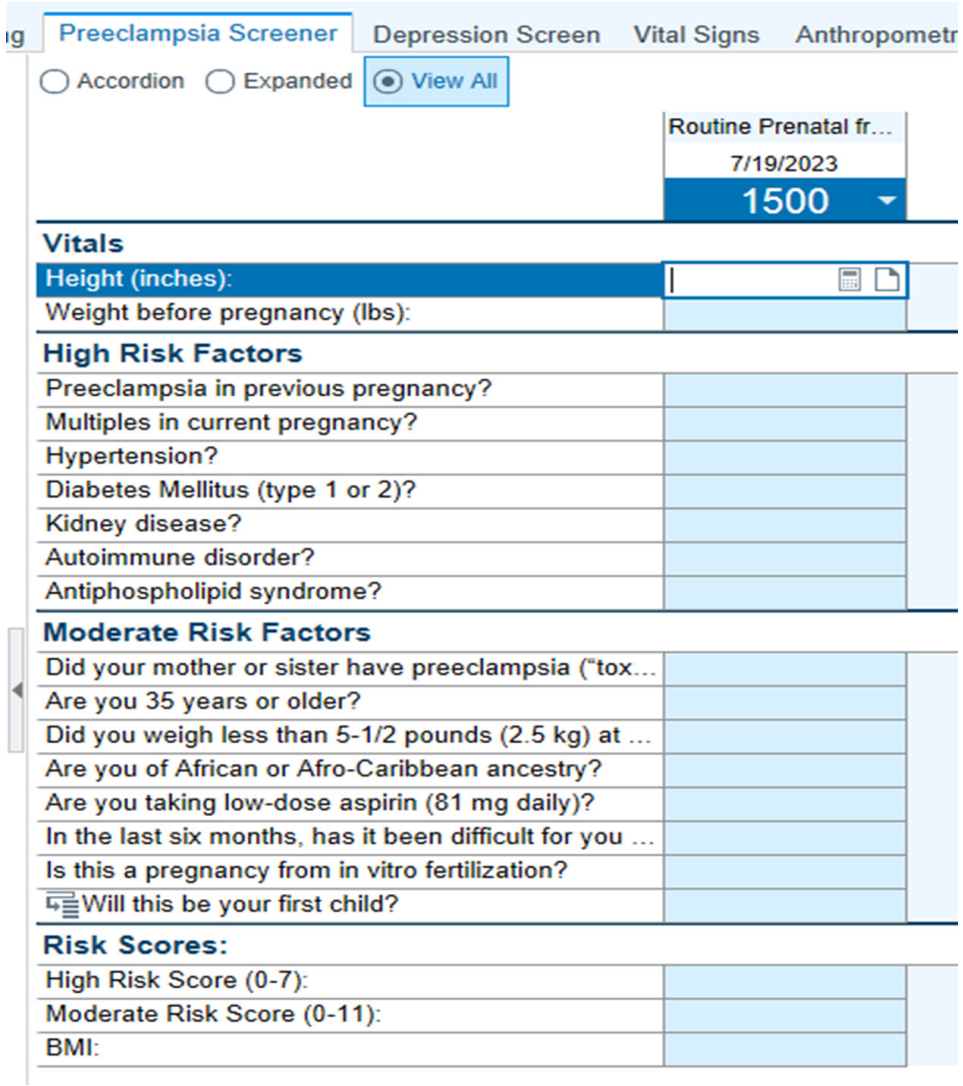
"To encourage, inspire and educate the African American birthing community. I am not a medical professional, but I am a living testament to a broken system."

"I want to help spread awareness to moms with risk factors of preeclampsia so they get the greatest prenatal care, deliver safely, and make it home… it should not be a death sentence for mom or baby."

"To share my experience and empower women of color with information to advocate for themselves and their babies. I joined the committee be a living testament about the severity of uncontrolled preeclampsia. "

"I believe that small groups can be impactful, and this group is part of the change."

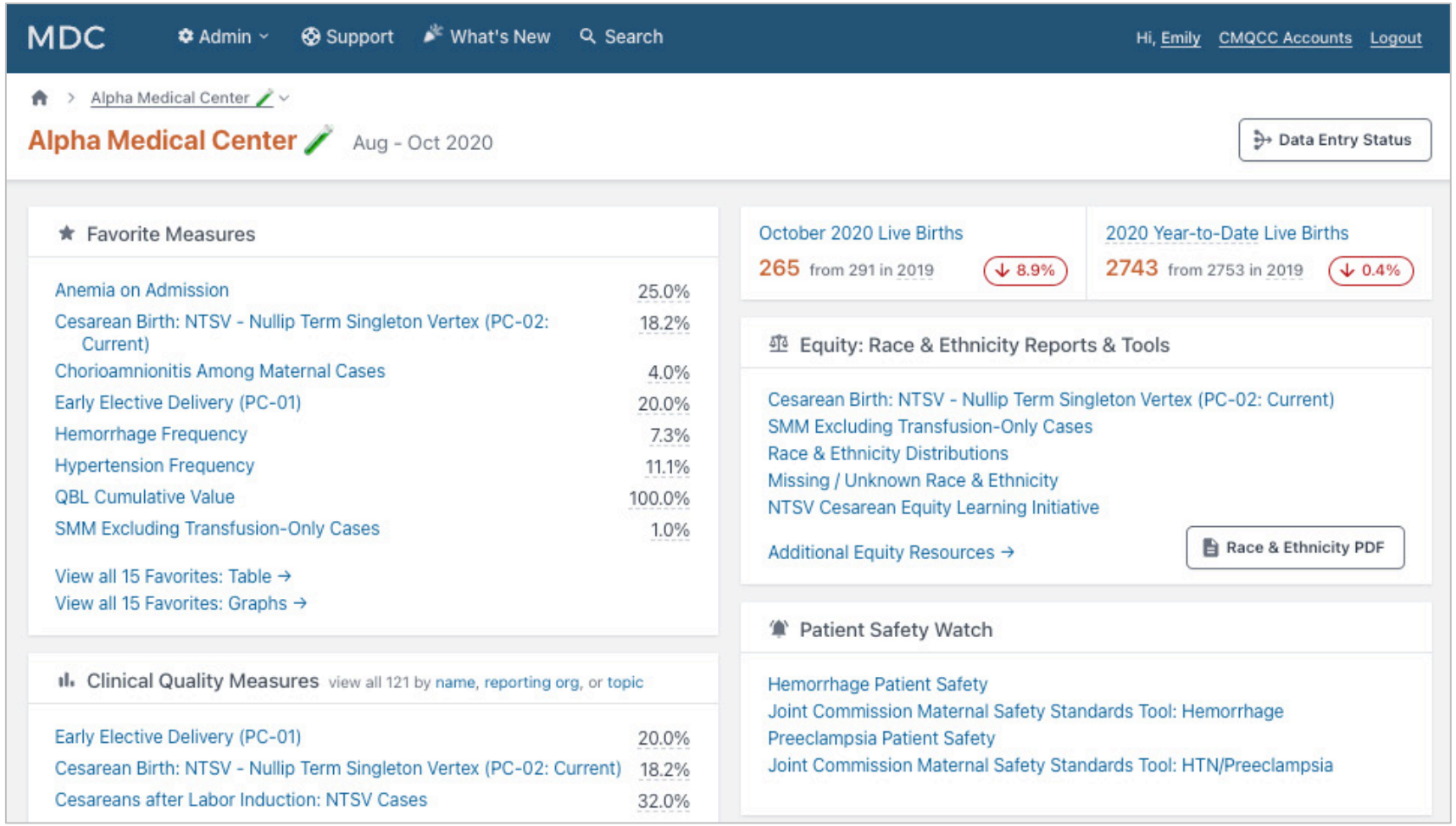
Data Collection



CMQCC Maternal Data Center

Tools to Support Low-Dose Aspirin (LDA) Initiative

CMQCC's Maternal Data Center (MDC) is a confidential tool designed to support hospitals' quality improvement efforts. Almost every hospital in CA participates in the MDC.



THANK YOU!

State Spotlight – Oklahoma

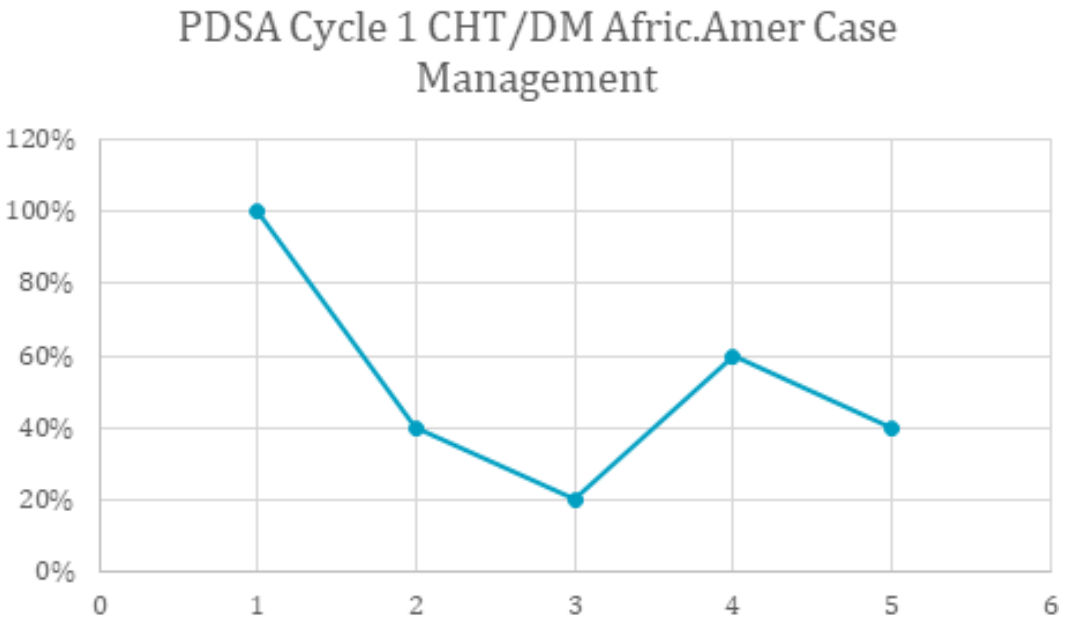
Carrie Edwards and Amy Allen, Oklahoma Health Care Authority

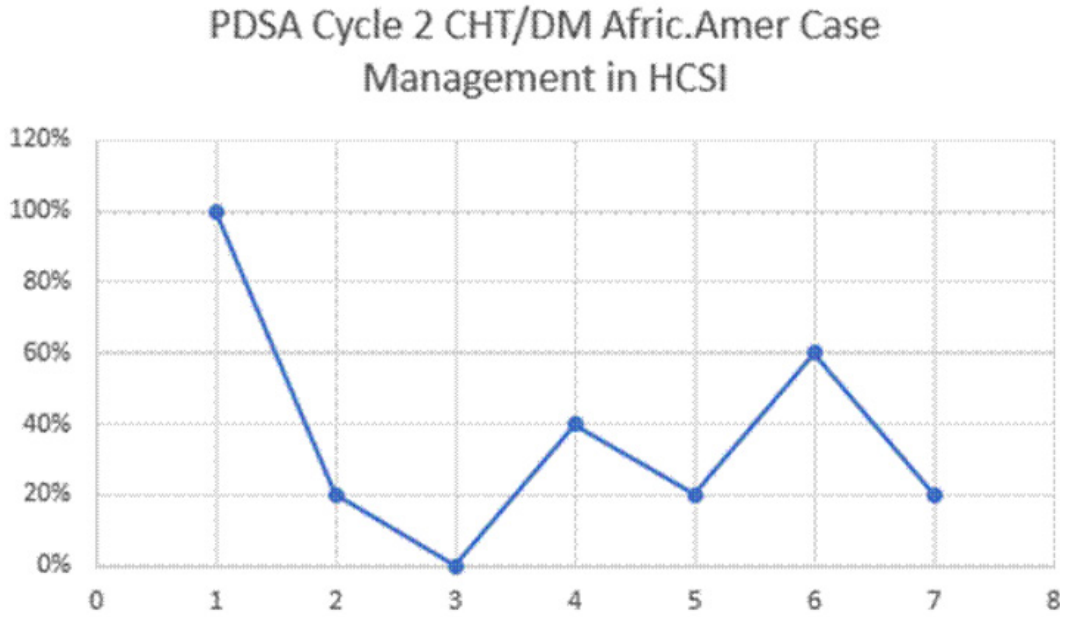
PERINATAL CARDIOMYOPATHY CARE MANAGEMENT

Presented by State of Oklahoma Medicaid

Amy Allen | RN, CCM

Carrie Edwards | BSN, RN, CCP





HOW IT STARTED

- CMS Improving Postpartum Care Affinity Group, June 2021
- 2 PDSA (Plan Do Study Act) Cycles completed in Case Management 9/21-3/22
- Did not find that our PDSA cycles were successful
- End of our cycles, members were sent to our chronic care unit for follow-up care

CHT = Chronic hypertension; DM = Diabetes mellitus; Afric.Amer = African American; HCSI = Health and community services

NOW WHAT?

- Research: Jan 2022 noted that 60% of maternal deaths over the most recent 5-year period were determined to be preventable per the Oklahoma Maternal Health Morbidity and Mortality Annual Report.
- 2 factors: Hemorrhage and Cardiomyopathy

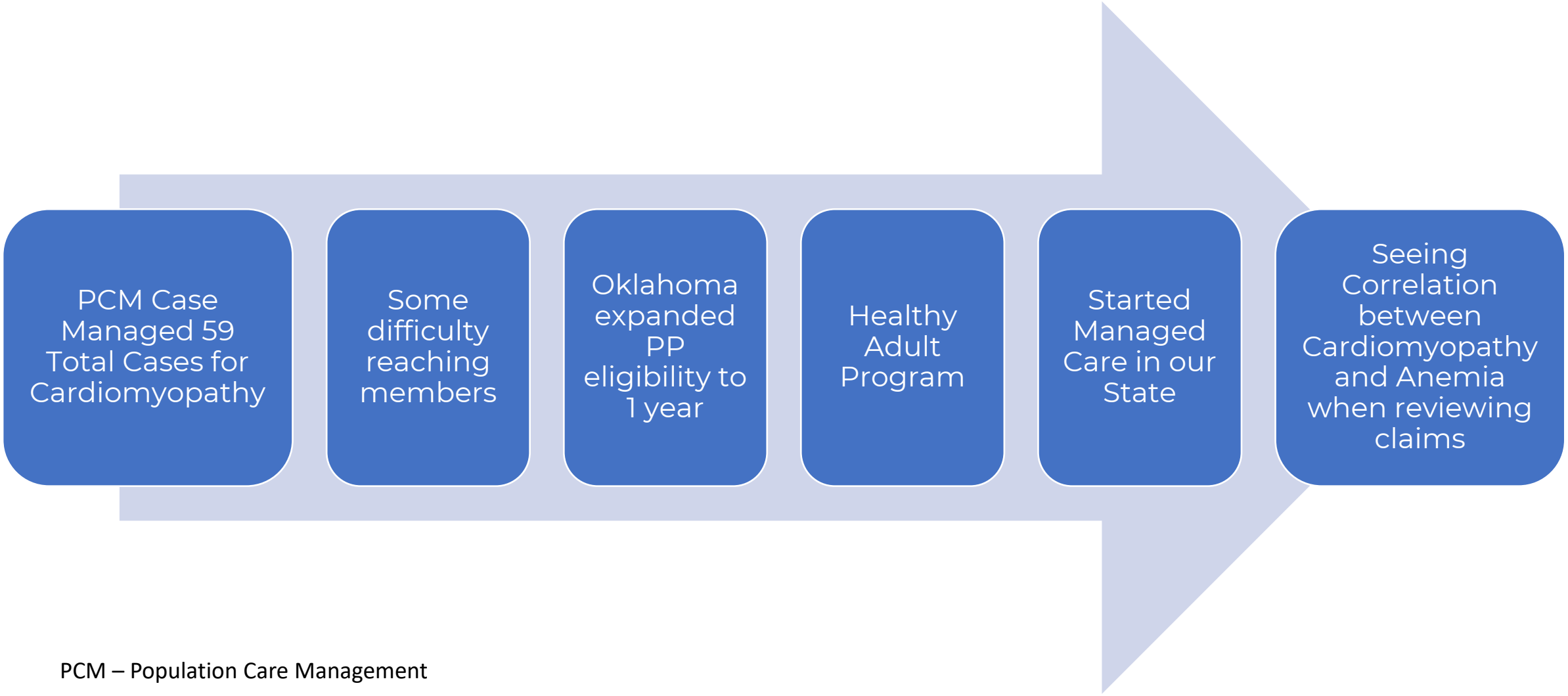
- 30,000 births with SoonerCare.
- 1.5% develop cardiomyopathy
- This is also in the vein of chronic care
- Cases found that met criteria:
  - 92 cases 2022
  - 67 cases 2023
  - 104 cases so far from 1/2023 to 4/2024

WORKING WITH MEMBERS WITH CARDIOMYOPATHY

Create Cases	Send Intro letters, UTC and Closure Letters	Monthly Calls	Education
Appointment Reminders	Surveys	Warm Handoff at Postpartum to the Chronic Care Unit with Supervisor Carrie Edwards RN., BSN	

UTC = Unable to contact

DISCOVERY AND FACTORS IN PCM



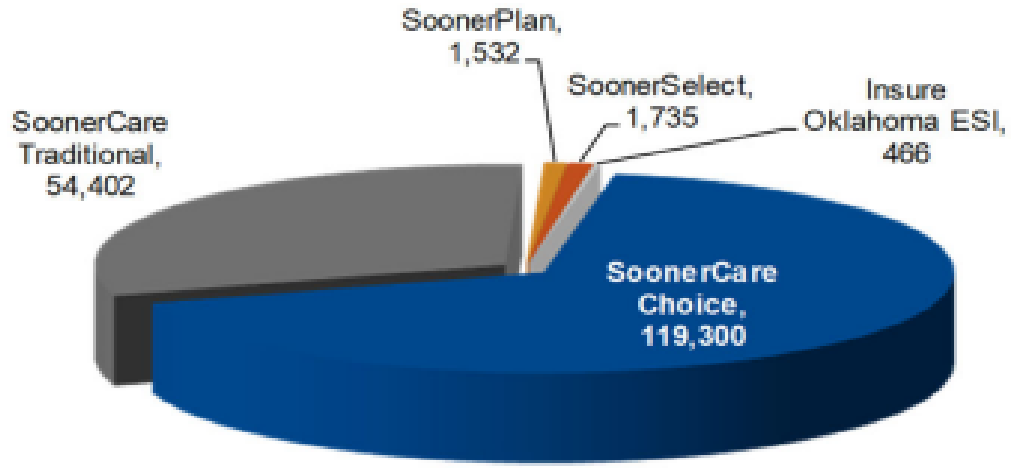
PCM – Population Care Management

SOONERCARE NATIVE POPULATION

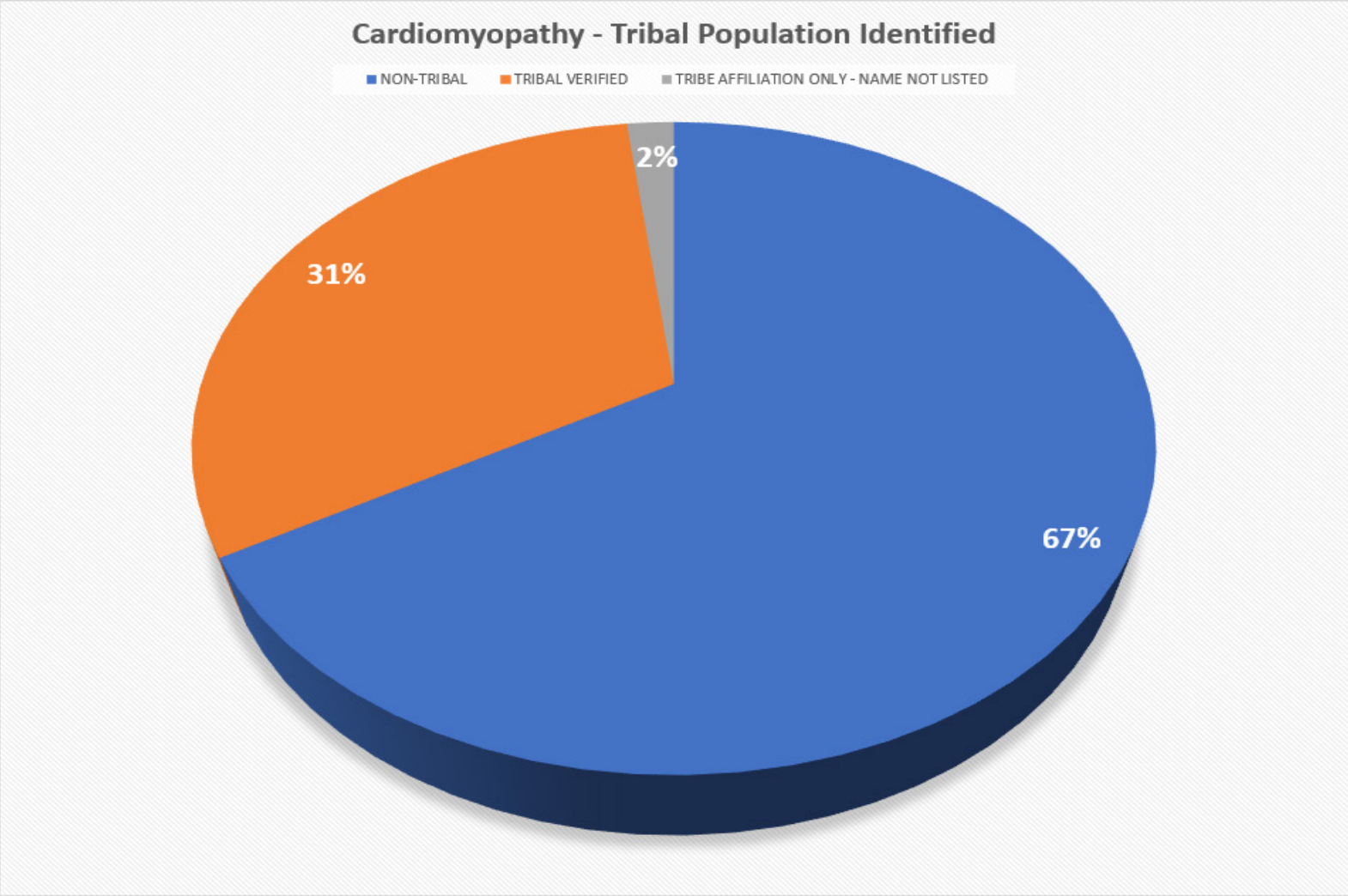
AMERICAN INDIAN FAST FACTS • MAY 2024

Validation Percent	Total American Indian Enrollment	Total Enrollment (includes Insure Oklahoma)	Percent of Total
Self-Reported: 45% Verified: 55%	177,435	1,046,955	17%

American Indian Enrollment by Delivery System



TRIBAL POPULATION IDENTIFIED



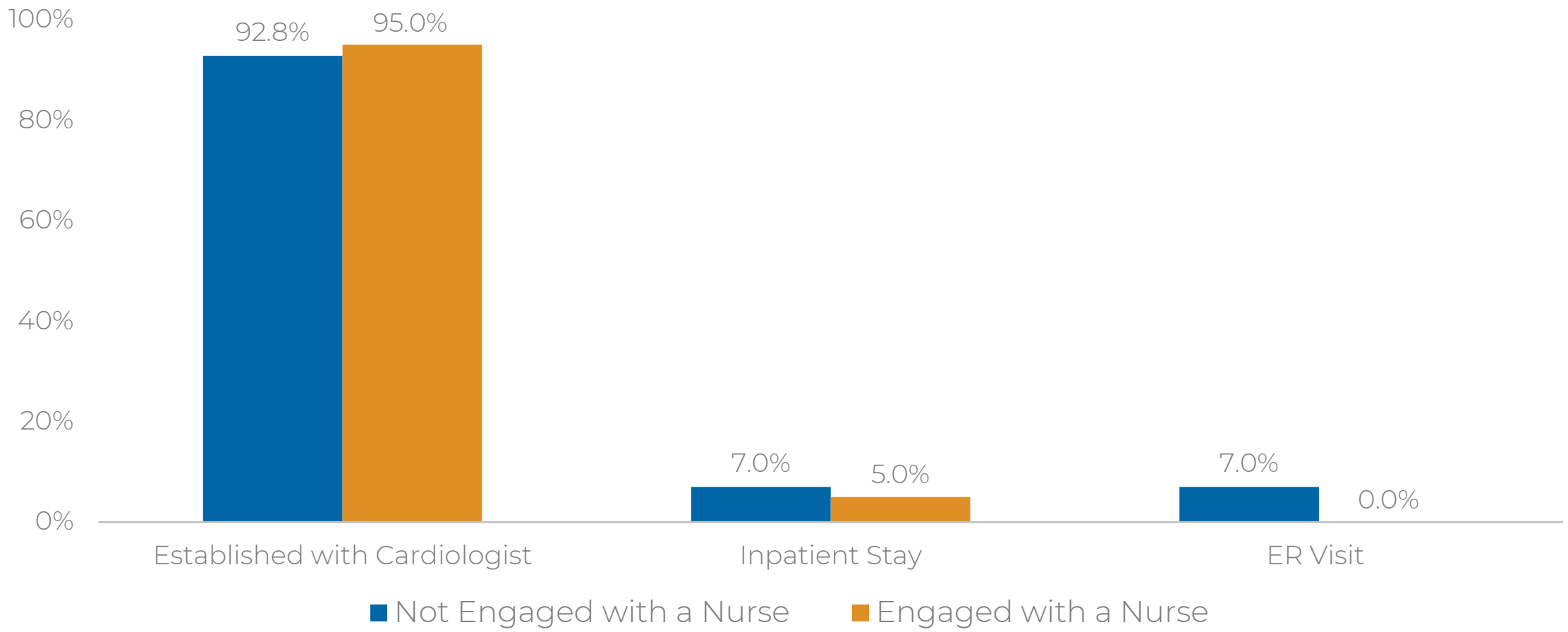
ONGOING CARE MANAGEMENT EFFORTS

CASE SORTING

104 potential cases for care management:

- **59** managed by PCM then referred for continued care management
- **14** additional received warm hand-off to SoonerSelect
- **15** lost eligibility upon referral to Chronic Care Management
- **28** referred to externally contracted care management partners
- **12** referred to SoonerSelect (managed care)
- **45** followed by Chronic Care Management

CARE MANAGEMENT OUTCOMES



KAREN'S STORY

-Susan, NCM

Diagnosis: Peripartum cardiomyopathy, chronic pulmonary edema, heart failure, anemia

- Delivered healthy baby girl in December 2023
- Inpatient stay for cardiomyopathy in January 2024
- Engaged in Chronic Care Management in March through data mining report

- Motivational Interviewing
- Medication reconciliation
- SDOH and Behavioral Health assessments
  - Transportation needs
  - Food insecurity
- Establish care with PCP
- Cardiology referral for medication management

OKLAHOMA
Health Care Authority

Amy Allen, Supervisor
Phone: 405-522-7870
Email: Amy.Allen@okhca.org

Carrie Edwards, Supervisor
Phone: 405-522-7107
Email:
Carrie.Edwards@okhca.org

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73145

okhca.org
MySoonerCare.org

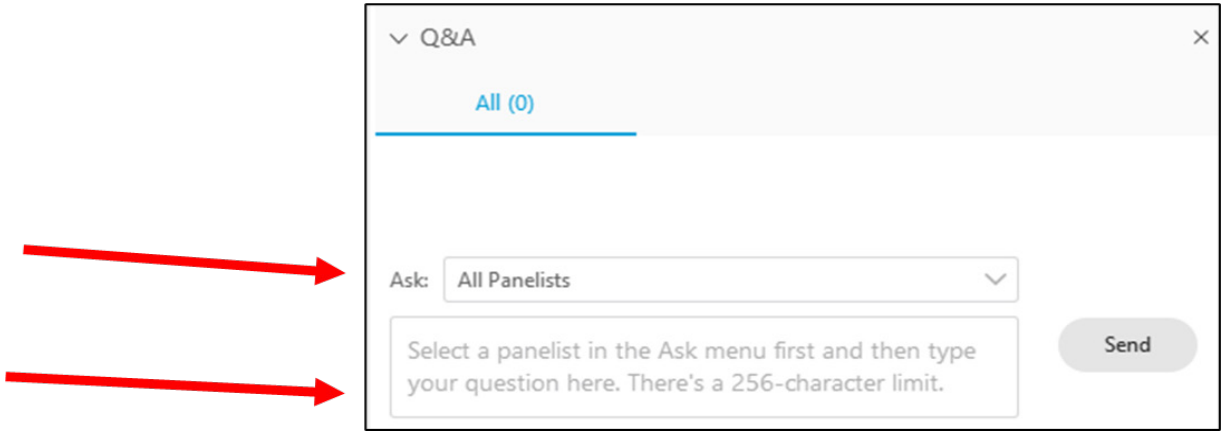
Agency: 405-522-7300
Helpline: 800-987-7767

Questions and Discussion

Lekisha Daniel-Robinson, Mathematica

How to Submit a Question

- **Use the Q&A function to submit questions or comments.**
  - To submit a question or comment, click the Q&A window and select "**All Panelists**" in the "Ask" menu
  - Type your question in the text box and click "Send"
    - Note: Only the presentation team will be able to see your questions and comments; your questions will be read out for all participants to hear both the question and the discussion



Upcoming Events and Opportunities

Lekisha Daniel-Robinson, Mathematica

Maternal Health Webinar Series

- **Medicaid and CHIP Program Collaboration with Hospitals on AIM Bundles (August 20, 2024, 2:00 pm ET)**

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement

Maternal Health Affinity Groups

- **Expression of Interest Webinar (August 6, 2024, 2:00 pm ET)**
  - Action-oriented affinity groups will support state Medicaid and CHIP programs and their partners in identifying, testing, and implementing evidence-based change ideas to address maternal health
  - Two Affinity Groups focused on
    - **Addressing Maternal Mental Health and Substance Use**
    - **Improving Maternal Hypertension Control**
  - More information will be available soon!

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement

Transforming Maternal Health Model Opportunity

- To learn more visit the TMaH model webpage at https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model
  - Applications are due September 20, 2024.
  - **NOFO Link**: https://grants.gov/search-results-detail/354874
  - **NOFO Webinar Registration Link**: https://deloitte.zoom.us/webinar/register/WN_7-FGcVZ5RSqAERoH3BDmdQ#/registration
- ***Participating in a MIHI affinity group does not preclude state Medicaid agencies from participating in the TMaH model***

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health Quality Improvement

Maternal Health Resources

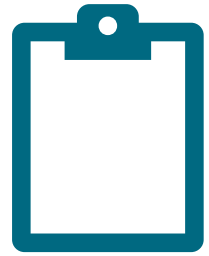
Visit the 2024 Medicaid & CHIP Beneficiaries at a Glance: Maternal Health Infographic on Medicaid.gov for a snapshot of maternal health demographics, health outcomes, risk factors, and more.

Visit the Improving Maternal Hypertension Control and Cardiovascular Health landing page on Medicaid.gov for information about the upcoming webinars and affinity groups.

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement

Thank you for participating!

- Please complete the survey as you exit the webinar.



- If you have any questions, email MedicaidCHIPQI@cms.hhs.gov

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement