

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

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

Q&A

All (0)

Ask: All Panelists

Select a panelist in the Ask menu first and then type your question here. There's a 256-character limit.

Send

Q & A

All (0)

Ask: Host

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 |

Objectives

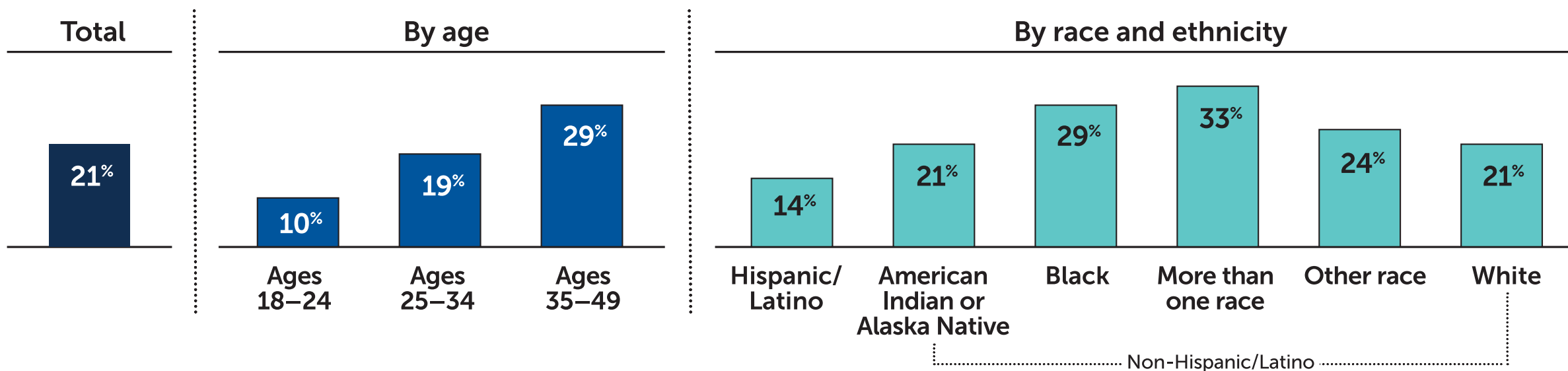
- **Provide an overview of the CMS Maternal and Infant Health Initiative and opportunities to improve maternal health outcomes in Medicaid and CHIP.**
- **Describe maternal hypertension and its contribution to maternal morbidity and mortality.**
- **Share information about CDC's new Hypertension in Pregnancy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

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**

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.

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

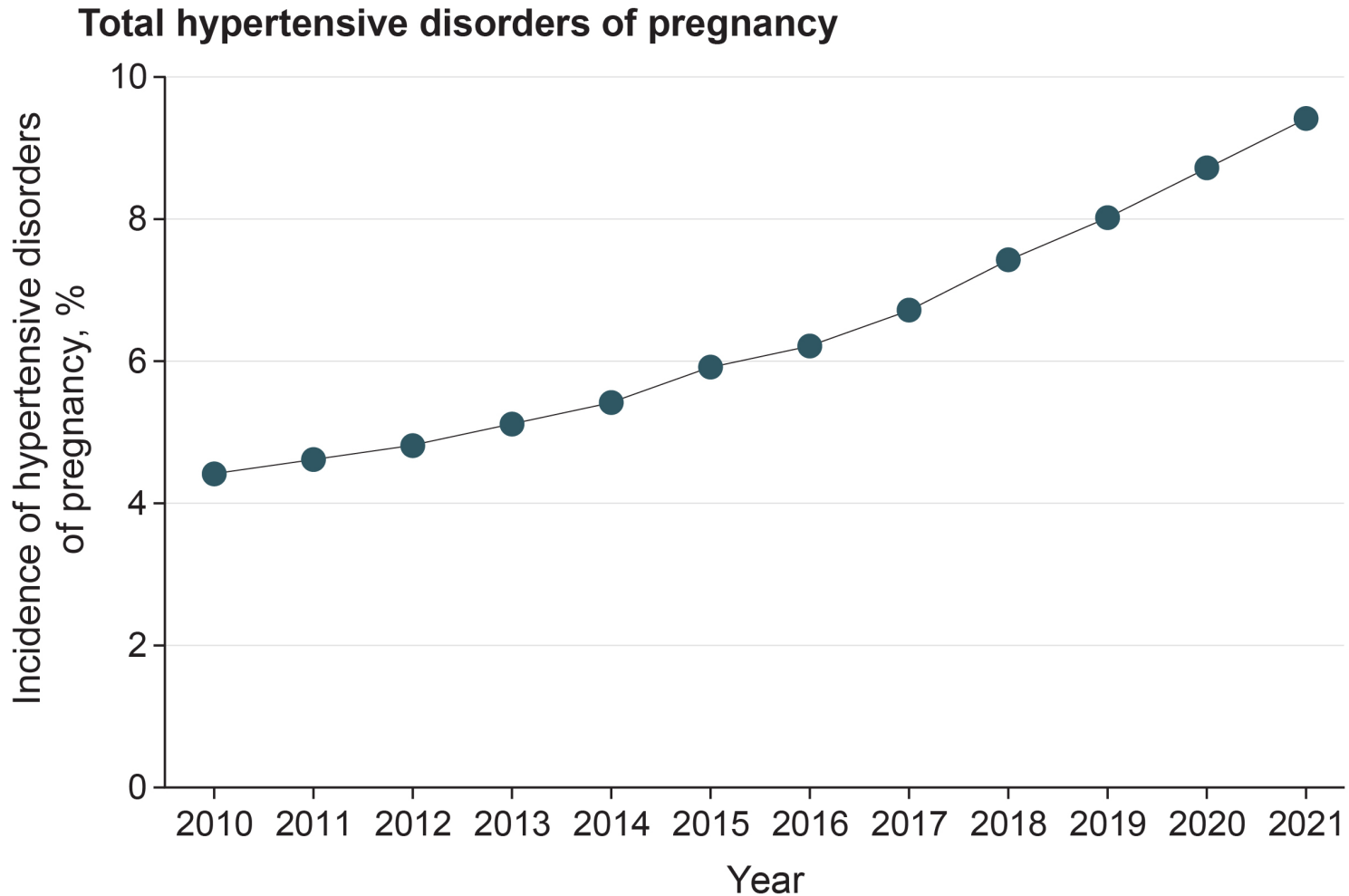


The Case for Hypertension

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*.

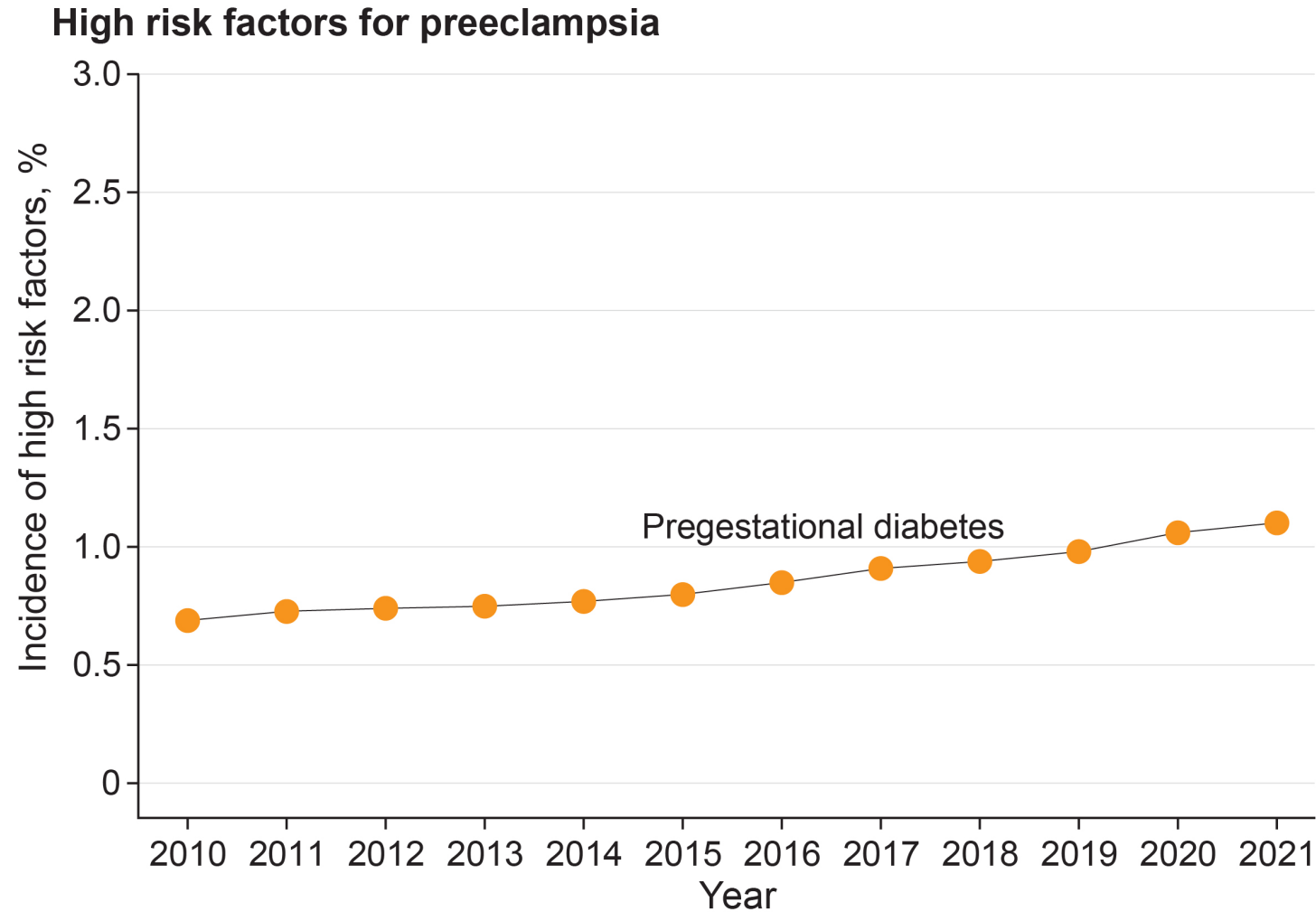
A GENERATIONAL IMPACT

Hypertension in Pregnancy is Increasing in the US.



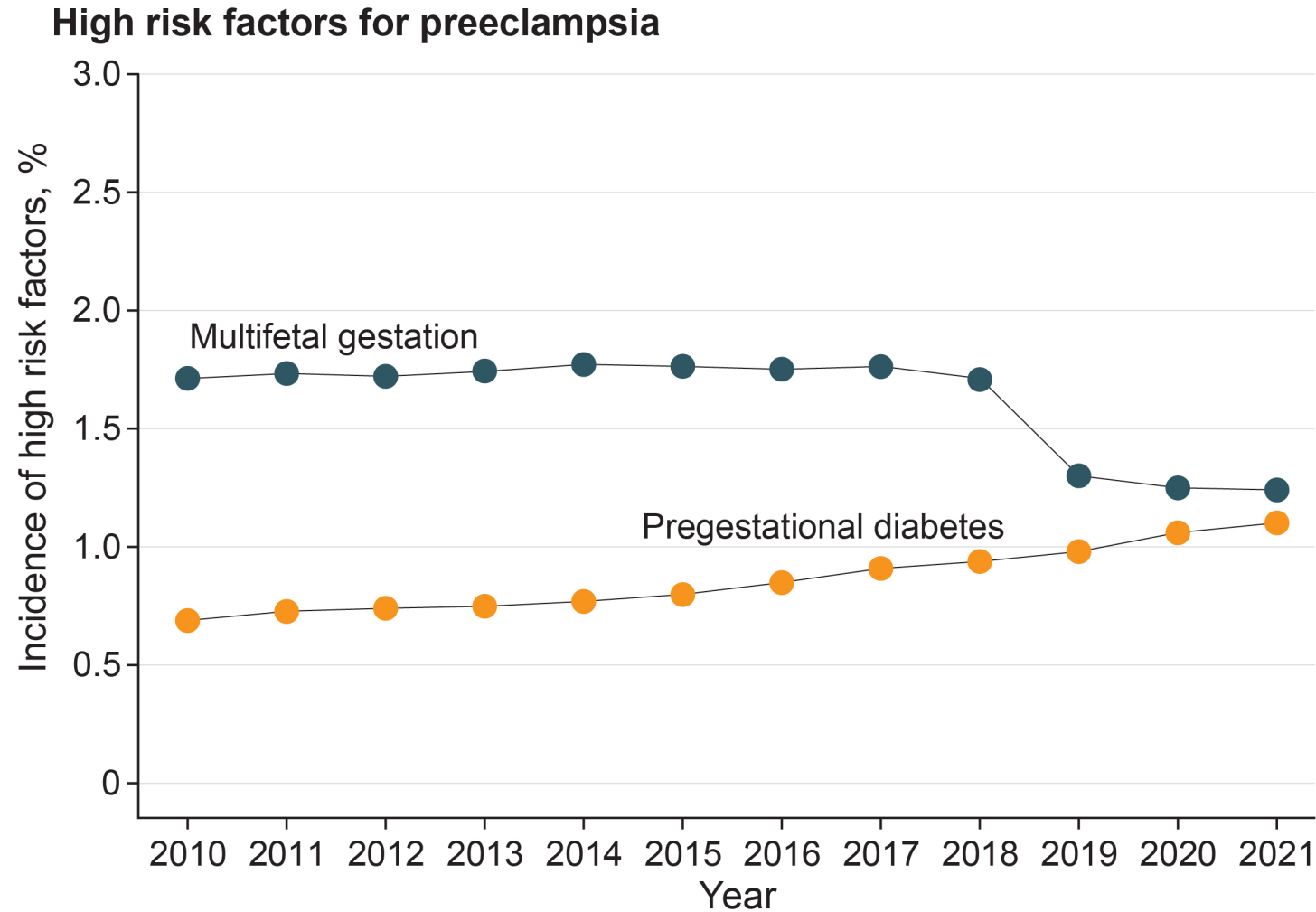
Hypertension in Pregnancy is Increasing in the US

WHY?



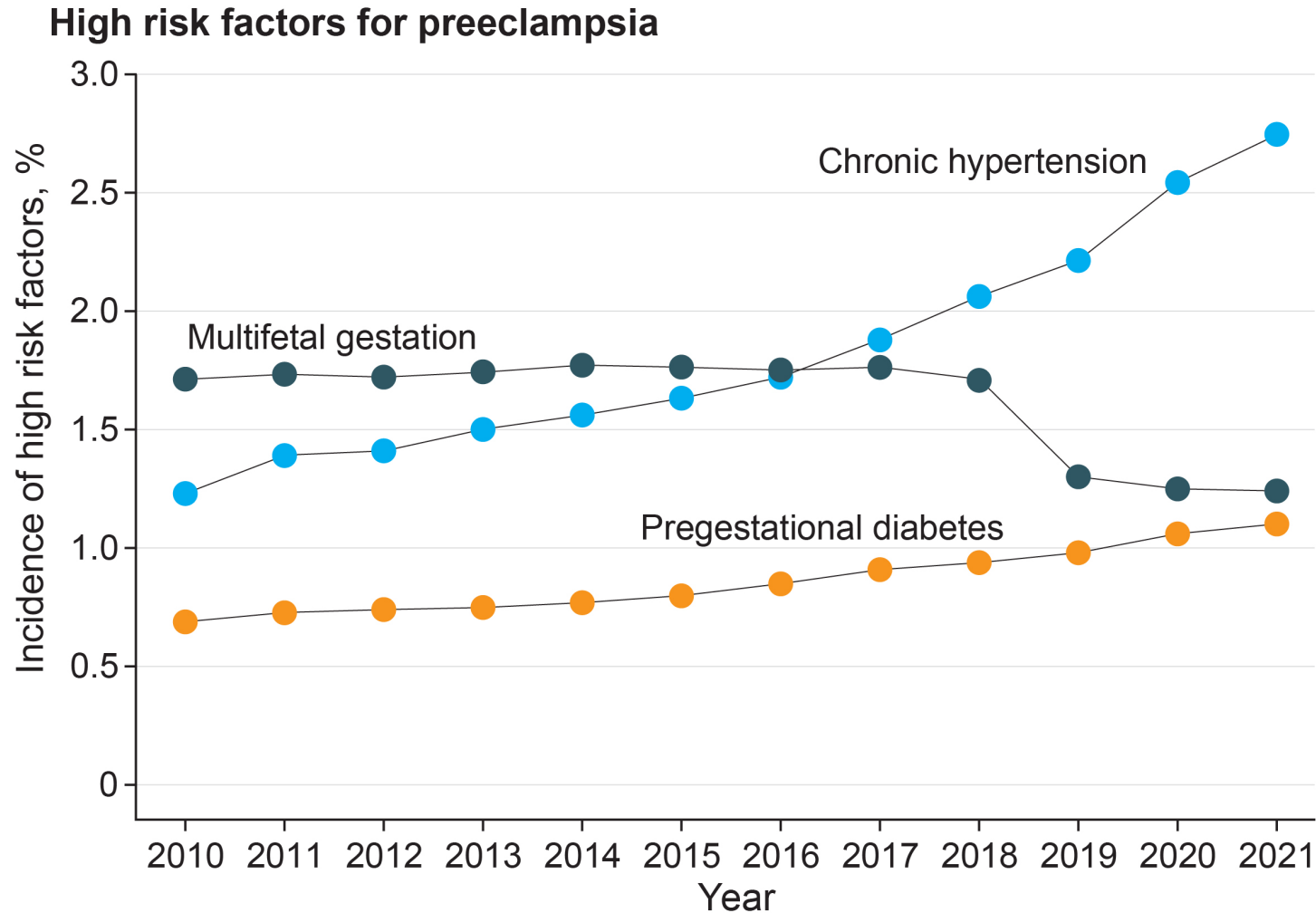
Hypertension in Pregnancy is Increasing in the US

WHY?



Hypertension in Pregnancy is Increasing in the US

WHY?



Maternal and Fetal Complications of Hypertensive Disorders of Pregnancy

Figure 1. Maternal complications of hypertensive disorders of pregnancy



| Short term | | Long term |
|--|---|--|
| <ul style="list-style-type: none"> • Mortality • Myocardial infarction • Stroke • Peripartum cardiomyopathy • Spontaneous coronary artery dissection • Postpartum hemorrhage and placental abruption |  | <ul style="list-style-type: none"> • Hypertension and diabetes mellitus • Hyperlipidemia • Stroke and vascular dementia • Atrial fibrillation and venous thromboembolism • Chronic kidney disease and kidney failure • Cardiovascular diseases |

Figure 2. Fetal complications of hypertensive disorders of pregnancy

| Short term | | Long term |
|---|---|--|
| <ul style="list-style-type: none"> • Small for gestational age • Stillbirth • Preterm delivery |  | <ul style="list-style-type: none"> • Cardiovascular disease • Stroke • Hypertension • Higher body mass index |

A MILLION HEARTS® ACTION GUIDE

Hypertension in Pregnancy
CHANGE PACKAGE

CDC

Act Plan
Study Do



- 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

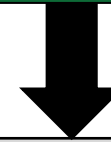
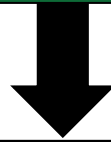
- Identification of a clinical champion
- Standardized treatment protocols
- Patient registries
- Clinician audit and feedback reports
- EHR reminders
- Clinician education and training
- Patient education
- Small tests of change (PDSA cycles)

**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

Management of Chronic Hypertension in Pregnancy

Definition: Hypertension present pre-pregnancy or SBP of ≥ 140 or DBP ≥ 90 prior to 20 weeks' gestation

Antepartum Management

Baseline Evaluation: Labs: CBC, AST, ALT, Cr, urine protein/Cr (UPC) - EKG or echocardiogram

Preeclampsia Prevention: Low dose aspirin (81mg) nightly starting at 12 weeks' gestation, continue until delivery

Hypertension Management

- Nonsevere Hypertension (< 37 weeks GA* (SBP $\geq 140/90$))**
 - End organ disease? → Refer to MFM
 - On medication? → Continue medications as long as compatible with pregnancy; switch to different antihypertensives if not
 - Initiate treatment with long acting antihypertensives (when BP reaches or exceeds 140/90)
 - Titrate antihypertensives as necessary to maintain BP < 140/90
 - *If ≥ 37 weeks GA, recommend against medication up titration.
- Severe Hypertension at any GA (SBP $\geq 160/110$)**
 - Refer to Outpatient Severe HTN Management algorithm on Monday
 - After thorough hospital evaluation including serial BP monitoring, fetal assessment, and lab evaluation, diagnosis of chronic hypertension/exacerbation vs preeclampsia can be made and managed accordingly. Recommend MFM consult as needed.

Duke Unit Management

| Condition | Chronic Hypertension | Gestational Hypertension |
|----------------------------------|---|--|
| Diagnostic criteria | Documented blood pressure $\geq 140/90$ prior to pregnancy or prior to 20 weeks gestation, and does not resolve in the postpartum period (12 weeks) *Of note, there should be at least 2 documented elevated blood pressures ($\geq 140/90$) more than 4 hours apart noted upon chart review to give a diagnosis of cHTN | SBP ≥ 160 or DBP ≥ 110 two occasions 4-6 hours apart postpartum NO history of chronic hypertension NO history of abnormal vision changes |
| Outpatient management | - Baseline labs - Low dose 81mg ASA - baseline ECG - Home BP monitoring - Antenatal testing per Duke guidelines | - Weekly - Home BP - Weekly - Antenatal - Duke GU - If dx pre start LD - Do NOT antihypertensive medications |
| Treatment recommendations | For patients < 20 weeks: Start medications prior BP = 140/90 and no end organ damage For patients ≥ 20 weeks - see Figure 1 *Preferred treatment: - Labetalol 100 mg BID up to 800 mg TID OR - Procardia XL 30 mg daily up to 120 mg daily total dose *Always start with lowest possible dose for management and max out one prior to starting a second agent | Without abnormal onset HTN - Weekly - Home BP - Weekly - Antenatal - Duke GU - If dx pre start LD - Do NOT antihypertensive medications |
| Delivery timing | No meds: 36-39/6 Controlled on meds: 37/0-39/6 | 37/0 week range BP 34/0 week range BP of PEC |

Appendix B: Suspected Preeclampsia Algorithm

New Onset HTN? $\geq 140/90$

- NO → If there is new onset proteinuria or severe features, consider ATYPICAL PREECLAMPSIA and do laboratory assessment
- YES → Assess & address patient/family education needs

BP $\geq 160/110$ Confirmed

- NO → Gestational HTN
- YES → Preeclampsia

Check for Severe Features:

- Persistent Headache
- Visual Changes
- Abdominal Pain
- Pulmonary edema
- Thrombocytopenia (platelets $< 100,000$)
- Elevated LFTs (2x normal)
- Creatinine > 1.2
- Elevated UOI

Management and decision to deliver baby applies equally to Preeclampsia and Gestational Hypertension

- TREAT BP ACCORDINGLY**
- If abnormal labs or symptoms, proceed to delivery

Post-Discharge Evaluation

ELEVATED BP AT HOME, OFFICE, TRIAGE

Postpartum triggers:

- SBP ≥ 160 or DBP ≥ 110 or
- SBP $\geq 140-159$ or DBP $\geq 90-109$ with unremitting headaches, visual disturbances, or epigastric/RUQ pain

Emergency Department treatment (OB/MICU consult as needed)

- AntihTN therapy suggested if persistent SBP ≥ 150 or DBP ≥ 100 on at least two occasions at least 4 hours apart
- Persistent SBP ≥ 160 or DBP ≥ 110 should be treated within 1 hour

Good response to antihTN treatment and asymptomatic → Admit for further observation and management (L&D, ICU, unit with telemetry)

Signs and symptoms of eclampsia, abnormal neurological evaluation, congestive heart failure, renal failure, coagulopathy, poor response to antihypertensive treatment → Recommend emergency consultation for further evaluation (MFM, internal medicine, OB anesthesiology, critical care)

Outpatient Severe Hypertension Evaluation and Management ≥ 20 weeks' gestation

SBPs ≥ 160 or DBPs ≥ 110

- Ensure accurate measurement: Appropriately sized cuff Seated with both feet on ground Arm at level of the heart
- Assess symptoms: Headaches, visual changes, Right upper quadrant or epigastric pain
- Present → Notify provider immediately (during if busy)
- Provider concerned for severe features? → Yes → Hospital evaluation for preeclampsia with severe features
- No → Repeat BP in 15 minutes
- SBP ≥ 180 or DBP ≥ 130 → Notify provider immediately Give 10 mg PO Procardia
- SBP $\geq 160-159$ or DBP $\geq 110-109$ → Hospital evaluation for preeclampsia with severe features
- Prepare patient for admission, possible delivery if ≥ 34 wks. Send to Labor and Delivery for further evaluation. SBP ≥ 160 or DBP ≥ 110 administer second dose of nifedipine 10mg PO.
- If not in clinic 20 min after medication, recheck BP. If SBP ≥ 160 or DBP ≥ 110 administer second dose of nifedipine 10mg PO.
- Recommend transfer to L&D via ambulance. Document recommendation and encourage immediate transfer by personal vehicle.
- Send to L&D

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 | <ul style="list-style-type: none"> 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 |

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 | <ul style="list-style-type: none"> • Asthma • Contraindicated in patients with pre-eclampsia • Avoid extended cardiac • Avoid three times daily dosing due to decreased renal metabolism during pregnancy |
| Nifedipine (extended release) | 30 mg daily | | |
| Methyldopa [†] | 250 mg three times daily | 750 mg per 24 hours | |
| Second-Line Agents | | | |
| Hydralazine | 100 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 |

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:

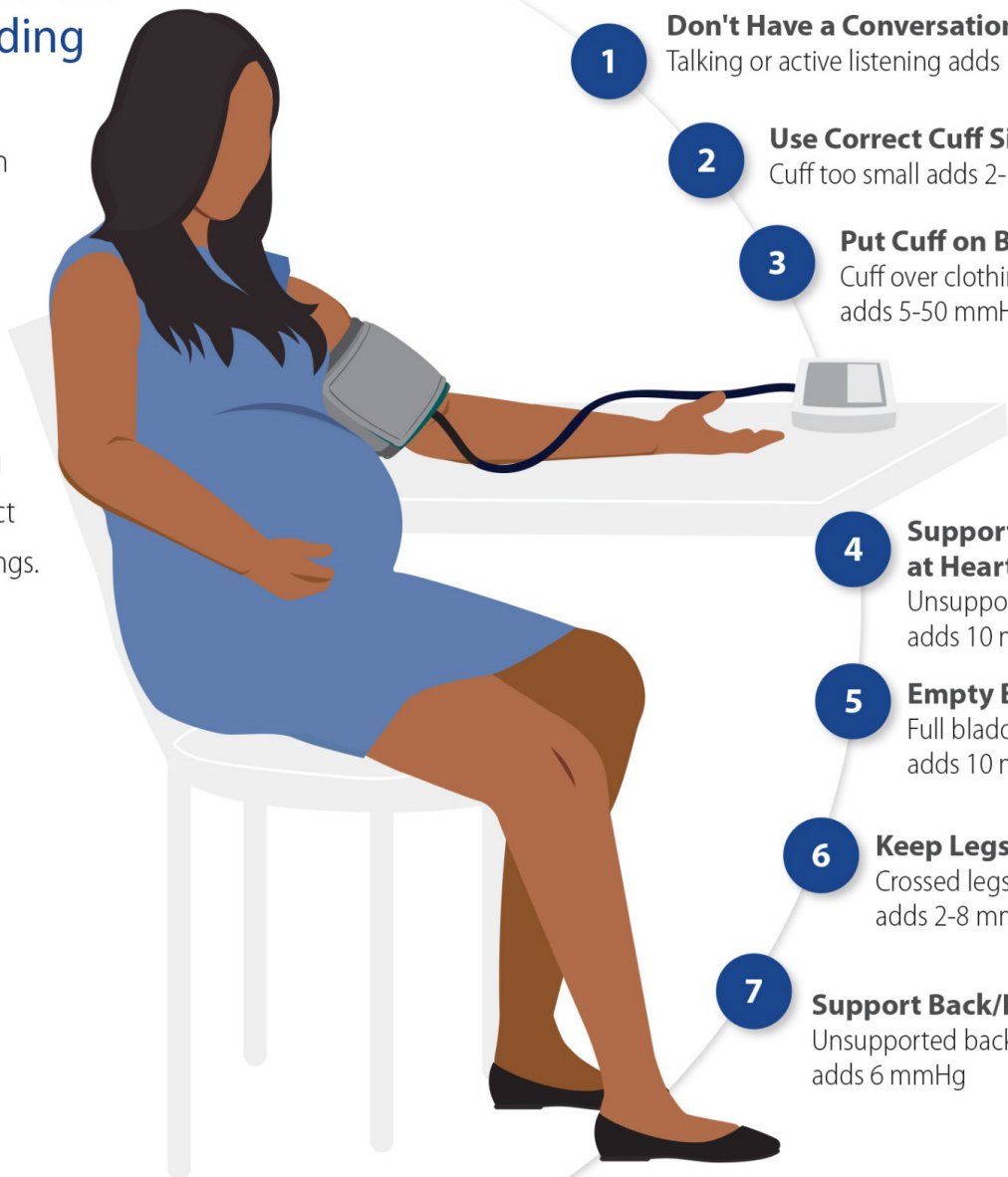
- Started between 12 and 28 weeks of gestation, optimally before 16 weeks
- Daily low-dose (81mg) aspirin until delivery
- **Over \$350M in projected cost savings (vs no aspirin) if guidelines were fully implemented**
- Supported by:
 - American College of Obstetricians and Gynecologists (ACOG)
 - Society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



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!**

This **"7 Simple Tips to Get an Accurate Blood Pressure Reading"** was adapted with permission of the American Medical Association and The Johns Hopkins University. The original copyrighted content can be found at www.ama-assn.org/ama-johns-hopkins-blood-pressure-resources.

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)



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 | | Prior Authorization Required | A4663 | | Source | |
| | Covered | Amount Covered | Covered | Amount covered | | Covered | Amount Covered | | 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 ih-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".

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

YOUR FUTURE HEALTH
If you are diagnosed with preeclampsia during pregnancy, you may be more likely to have health problems in the future when you are not pregnant. These problems may include...



heart attack stroke kidney disease high blood pressure

[Preeclampsia and Pregnancy \(acog.org\)](http://acog.org)

WHAT ARE THE WARNING SIGNS?
When there are symptoms, they may include...



a headache that will not go away

seeing spots, blurry vision, or other changes in eyesight

swelling of face or hands

sudden weight gain

nausea and vomiting in the 2nd half of pregnancy

pain in the upper abdomen or shoulder

shortness of breath

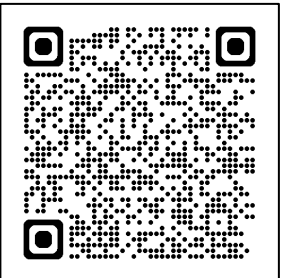
Where Can Medicaid and CHIP Programs Start?

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

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 \(zoomgov.com\)](https://zoom.us/join/MeetingRegistration)



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:

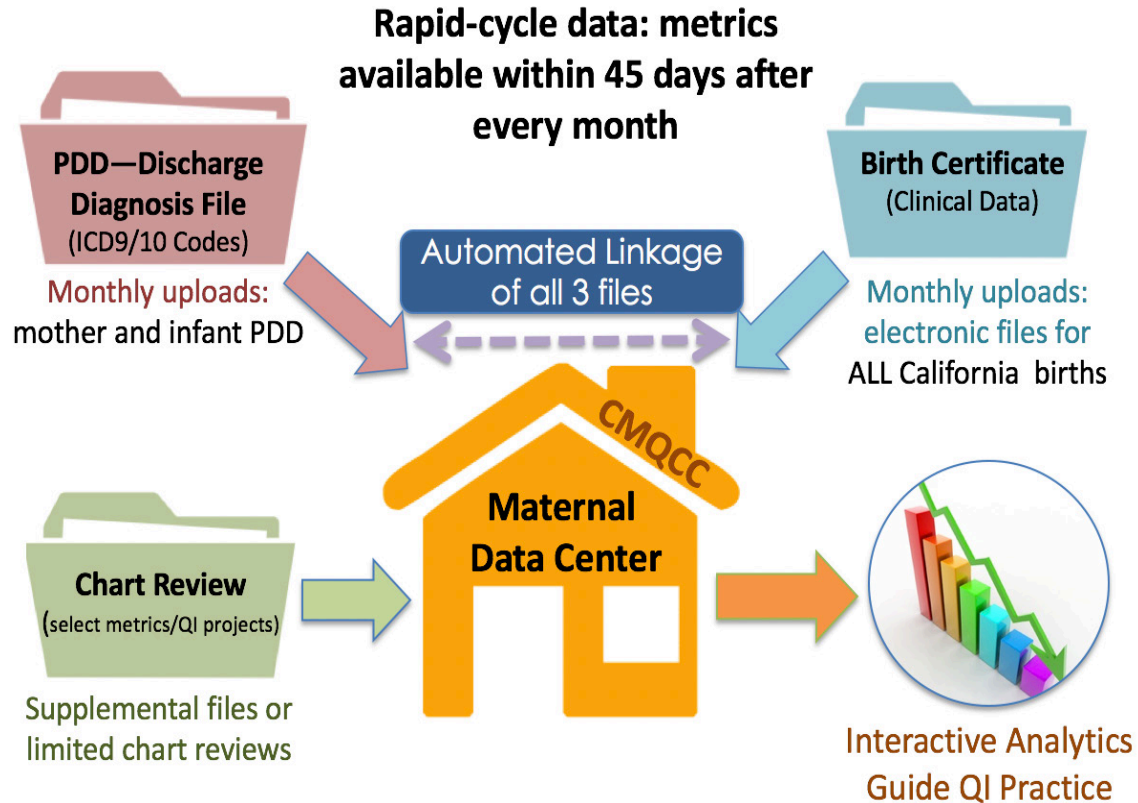
To end preventable morbidity, mortality and racial disparities in maternity care.

- 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



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



*MATERNAL
MORTALITY
CONTEXT*



Racism Alone Is Not Killing Black Mothers. Inaction Is.

Lisa Fitzpatrick Contributor

I write about public health and health innovation for the underserved

Jun 16, 2022, 01:00pm EDT

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

HEALTH | LIFE

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

Image: Axelle/Bauer-Griffin/FilmMagic.

By Jenn Barthole | April 11, 2022

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



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

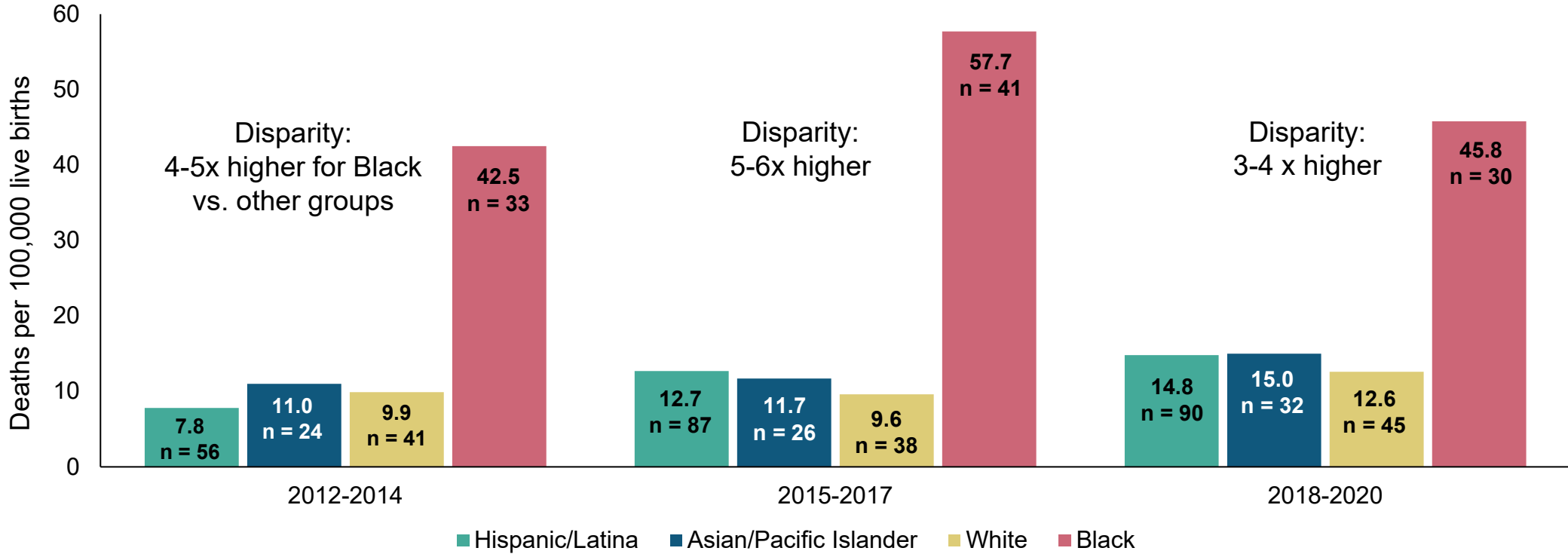
Allyson Felix wants to raise awareness of health disparities Black moms face, so she is sharing the harrowing details of her own near-death experience

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



Pregnancy-Related Mortality Ratio by Race and Ethnicity

California 2012-2020

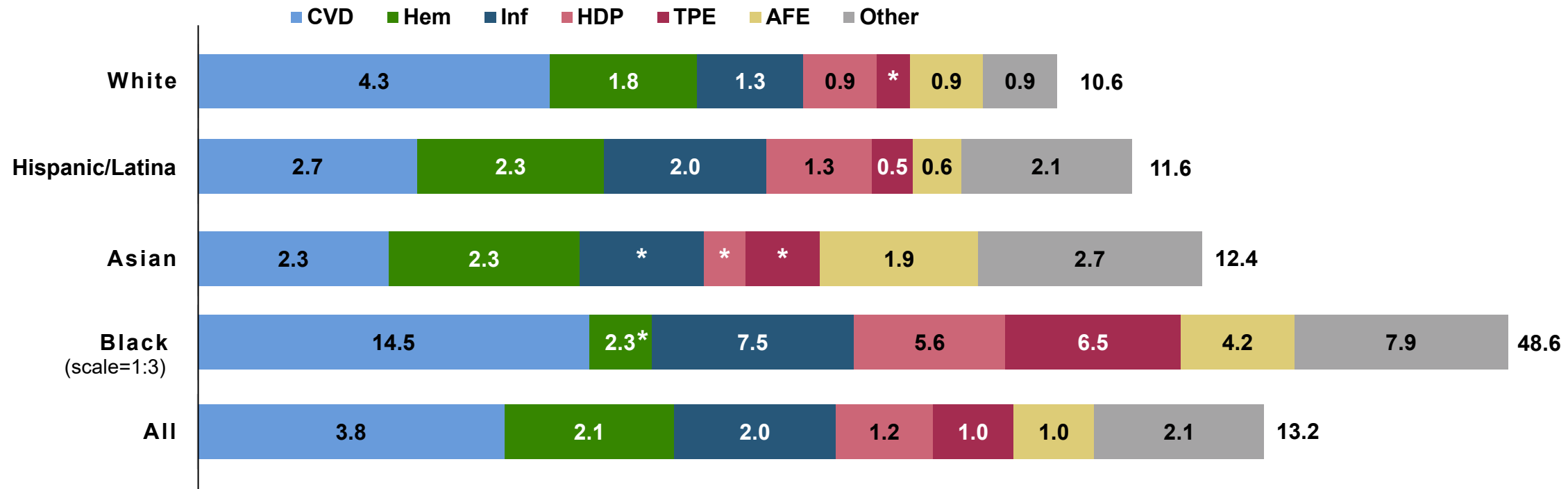


Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births. Pregnancy-related deaths include deaths within a year of pregnancy from causes related to or aggravated by the pregnancy or its management, as determined by expert committee review.



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.

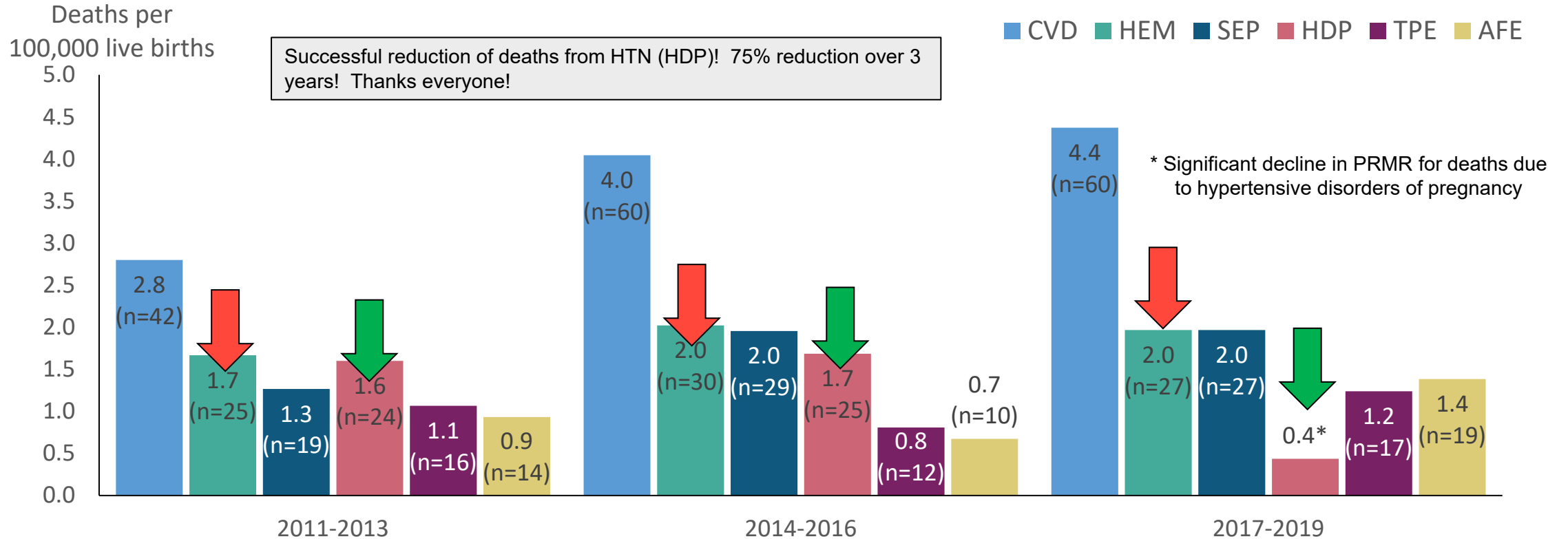
Abbreviations: CVD = Cardiovascular disease; Hem = Hemorrhage; Inf= Sepsis or infection; HDP= Hypertensive disorder of pregnancy; TPE = Thrombotic pulmonary embolism; AFE = Amniotic fluid embolism. PRMRs of American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple-race and other races 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*



QI INITIATIVES

STATE MATERNAL HEALTH
INNOVATION PROGRAM

PERINATAL EQUITY

CARDIOVASCULAR DISEASE

EARLY ELECTIVE DELIVERIES

**HYPERTENSIVE DISORDERS OF
PREGNANCY**

Collaboratives

Data tools

LOW DOSE ASPIRIN TO PREVENT
PREECLAMPSIA

MOTHER & BABY SUBSTANCE
EXPOSURE

OBSTETRIC HEMORRHAGE

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!*

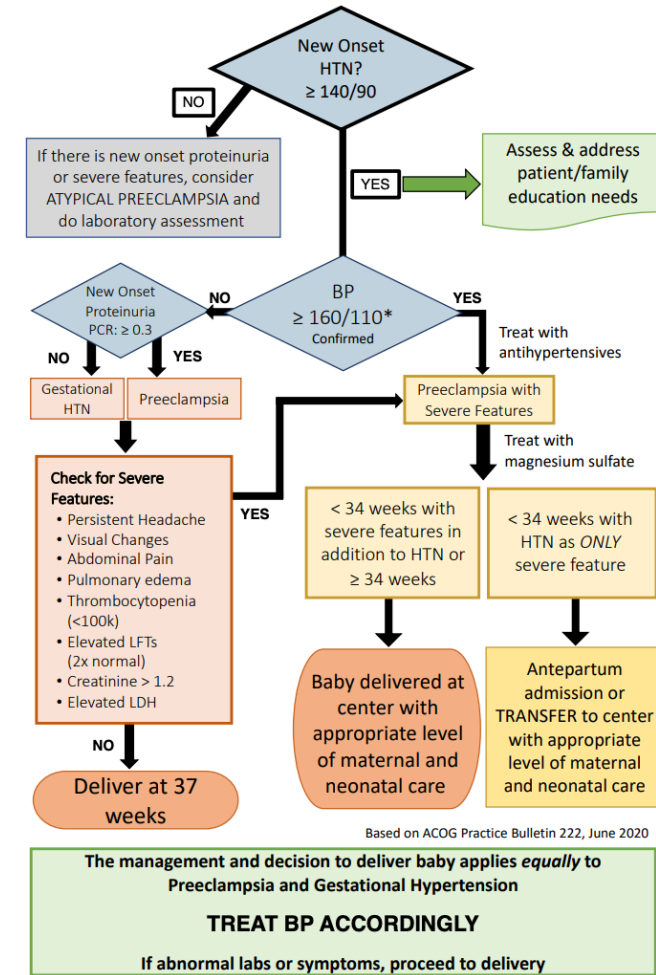
CMQCC member hospitals are also encouraged to monitor their hypertension and preeclampsia metrics in our [Maternal Data Center](#).

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



Based on ACOG Practice Bulletin 222, June 2020

*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?



Tell us if you
ARE PREGNANT or
HAVE BEEN PREGNANT
within the past 6 weeks



Come to the front of the line if you have:

- ▶ Persistent headache
- ▶ Visual change (floaters, spots)
- ▶ History of preeclampsia
- ▶ Shortness of breath
- ▶ History of high blood pressure
- ▶ Chest pain
- ▶ Heavy bleeding
- ▶ Weakness
- ▶ Severe abdominal pain
- ▶ Confusion
- ▶ Seizures
- ▶ Fevers or chills
- ▶ Swelling in hands or face

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

3

Early appointment

Within 72 hours

Can use remote patient monitoring or leverage technology

2

Symptom Education


Headaches, blurry vision, RUQ pain

Rapid onset swelling, chest pain, shortness of breath

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

ARE YOU PREGNANT AND AT RISK FOR PREECLAMPSIA?

All pregnancies are at risk and the best defense is to ensure patients understand how to prevent and appropriately respond to the warning signs of preeclampsia. Help us educate patients by taking this survey. Eligible participants who complete the survey will receive \$15.

SURVEY LINK:
<https://bit.ly/cmqqcpreeclampsia>

Who can participate?

- Currently pregnant
- Living in California
- Older than 18 years
- Can read in English or Spanish



QUESTIONS RELAED TO THE STUDY??
Contact: Susan Perez, PhD, MPH
(916) 827-1213 sperez@stanford.edu

CMQCC
California Maternal
Quality Care Collaborative



Participant's rights questions, contact 1-866-680-2906
Protocol Director: Elliott Main, MD

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



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



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

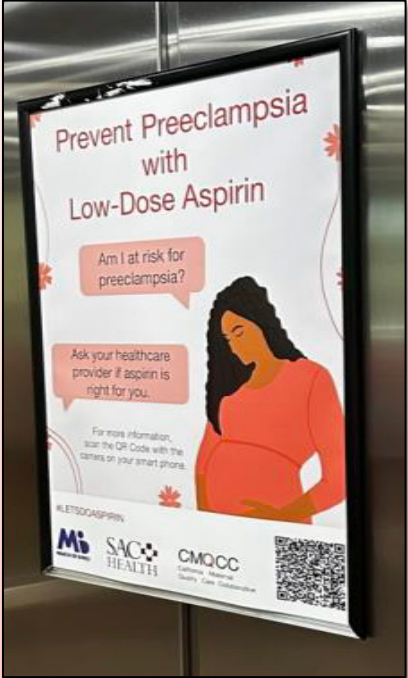
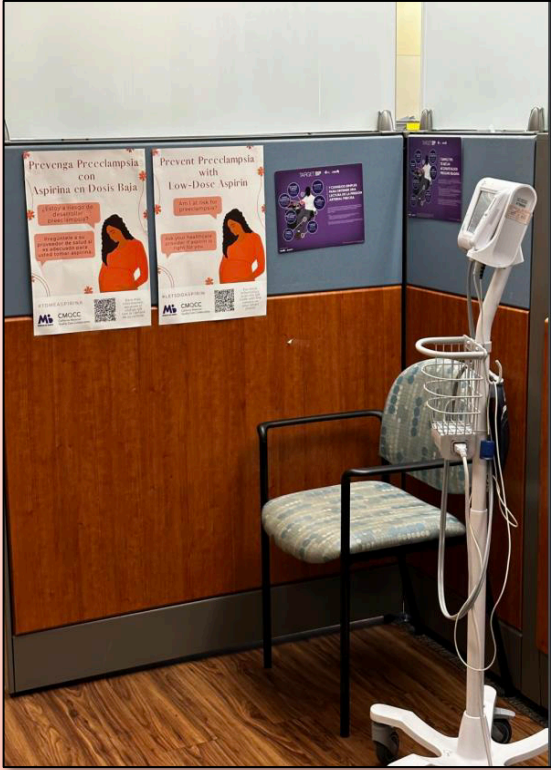
Should I do Aspirin...
TO KEEP ME AND MY BABY SAFE?

| 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



Education & Resources – Webinars

Low-Dose Aspirin (LDA)
Campaign Webinar Series:

Discussing Risk Respectfully

Attention physicians, nurses, midwives, community birth workers and other maternal care providers! You're invited to learn about the promotion of LDA to prevent preeclampsia and subsequent preterm birth for California's women and birthing people. During this webinar, our expert panel will present best practices for respectful, compassionate discussion about risk factors for the development of preeclampsia with patients, tips for essential patient education, and tools available in the Maternal Data Center (MDC) for tracking patient LDA usage. Learn how you can join in California's #LetsDoAspirin campaign, funded by the March of Dimes. **Webinar objectives can be found on the registration page.**

Webinar Speakers:



Amanda P. Williams, MD, MPH, FACOG
Clinical Innovation Advisor, CMQCC



Melinda Kent, MSN-Ed, RNC-OB, C-EFM, C-ONQS
Clinical Lead, CMQCC



Lindsay du Plessis, DrPH, MPH
Community Engagement Lead, CMQCC



Emily McCormick, MPH, RNC-MNN, C-ONQS, IBCLC
Senior Content Expert, Maternal Data Center, CMQCC

Continuing education contact hours are available for registered nurses through the California Board of Registered Nurses, Provider #3104, Mid-Coastal CA Perinatal Outreach Program for real-time attendance of 50 or more minutes plus completion of an evaluation.

For more information about CMQCC, please visit cmqcc.org



Thursday
December 7, 2023



12:00 to 1:00 P.M.
Pacific Time



Virtual
Zoom

Register online today!
Scan the QR code
or use the link below.

SCAN ME

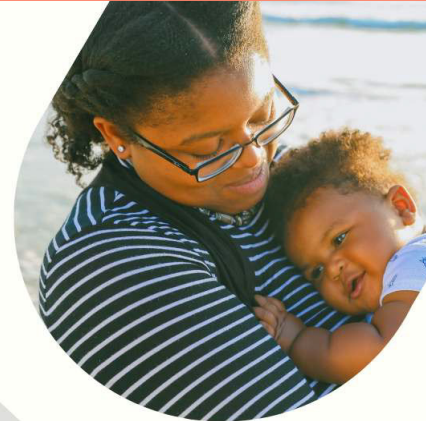


<https://tinyurl.com/LDADecember7>



Low-Dose Aspirin (LDA) to Prevent Preeclampsia

Community-to-Community Webinar



Featured Speakers



Mary Lankford
Public Health Nurse
Black Infant Health



Jessica Wade
Maternal & Infant Health
Manager, March of Dimes

CMQCC
California Maternal
Quality Care Collaborative



Community organizations are a trusted resource and key to centering the needs of birthing people as well as bridge the connection between hospital, clinic and community. Join us to learn more about the LDA Pilot Campaign.

Thursday,
June 29th
11:00am

Scan to Register



Low-Dose Aspirin (LDA)
Campaign Webinar Series:

Preventing Pre-Term Birth and Preeclampsia: How Can Pharmacists Help?

Attention pharmacists, pharmacy technicians, physicians, nurses, midwives, community birth workers and other maternal care providers! You're invited to learn about the role of pharmacists in the promotion of LDA to prevent preeclampsia and subsequent preterm birth for California's women and birthing people. During this webinar, our expert panel will present how pharmacists play a crucial role in promoting LDA for expectant mothers and birthing people, how clinicians can work together with pharmacists to make sure all medications are safe, and the role of pharmacists in supporting mothers and birthing people's adherence through patient education and intervention techniques. Learn how you can join in California's #LetsDoAspirin campaign, funded by the March of Dimes. **Webinar objectives can be found on the registration page.**

Webinar Speakers:



Joice Huang, PharmD, MBA
Dr. Huang received her PharmD and MBA from the University of Maryland. She currently leads a team of health outcomes researchers at a pharmaceutical company. Her interest in maternal fetal health began in 2010 while studying sVEGF/PlGF as biomarkers of preeclampsia. She is now a mother of two and an advocate for improved access and outcomes for all expectant mothers.



Gina Ahmadyar, PharmD, MS
Ahmadyar is a registered pharmacist in the state of California. She currently works in the pharmaceutical industry as a manager of Health Economics and Outcomes Research and is passionate about causes related to women's health and underserved medicine.

As stated on the BRN's website (<https://www.brn.ca.gov/licenses/ce-renewal.shtml>), acceptable CE courses must be taken through a CE provider recognized by the Board of Registered Nursing. Our Board accepts CE courses that are provided by recognized providers.

California State Board of Pharmacy (BTP) | (916) 518-3100 | FAX (916) 574-8614 | www.pharmacy.ca.gov
Be Aware and Take Care: Talk to your Pharmacist!

For more information about CMQCC, please visit cmqcc.org



Tuesday
January 16, 2024



1:00 to 2:00 p.m.
Pacific Time



Virtual
Zoom

Register online today!
Scan the QR code
or use the link below.

SCAN ME



<https://tinyurl.com/LDAJanuary16>



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

Preeclampsia Screener
 Depression Screen
 Vital Signs
 Anthropometr

Accordion
 Expanded
 View All

Routine Prenatal fr...
7/19/2023
1500

Vitals

Height (inches):

Weight before pregnancy (lbs):

High Risk Factors

| | |
|-------------------------------------|----------------------|
| Preeclampsia in previous pregnancy? | <input type="text"/> |
| Multiples in current pregnancy? | <input type="text"/> |
| Hypertension? | <input type="text"/> |
| Diabetes Mellitus (type 1 or 2)? | <input type="text"/> |
| Kidney disease? | <input type="text"/> |
| Autoimmune disorder? | <input type="text"/> |
| Antiphospholipid syndrome? | <input type="text"/> |

Moderate Risk Factors

| | |
|---|----------------------|
| Did your mother or sister have preeclampsia ("tox...) | <input type="text"/> |
| Are you 35 years or older? | <input type="text"/> |
| Did you weigh less than 5-1/2 pounds (2.5 kg) at ... | <input type="text"/> |
| Are you of African or Afro-Caribbean ancestry? | <input type="text"/> |
| Are you taking low-dose aspirin (81 mg daily)? | <input type="text"/> |
| In the last six months, has it been difficult for you ... | <input type="text"/> |
| Is this a pregnancy from in vitro fertilization? | <input type="text"/> |
| Will this be your first child? | <input type="text"/> |

Risk Scores:

| | |
|-----------------------------|----------------------|
| High Risk Score (0-7): | <input type="text"/> |
| Moderate Risk Score (0-11): | <input type="text"/> |
| BMI: | <input type="text"/> |

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.

The screenshot displays the MDC interface for Alpha Medical Center, covering the period of August to October 2020. The interface includes a navigation bar with options for Admin, Support, What's New, and Search, along with user information (Hi, Emily) and account management links (CMQCC Accounts, Logout). The main content area is divided into several sections:

- Favorite Measures:** A table listing 15 key clinical quality measures with their current percentages.
- Clinical Quality Measures:** A section listing 121 measures, with a filter to view them by name, reporting organization, or topic.
- Live Births:** Summary statistics for October 2020 and 2020 Year-to-Date, showing a decrease in both.
- Equity: Race & Ethnicity Reports & Tools:** A section providing links to various equity-related reports and a PDF download button.
- Patient Safety Watch:** A section listing safety-related tools and standards.

| Measure | Percentage |
|--|------------|
| Anemia on Admission | 25.0% |
| Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current) | 18.2% |
| Chorioamnionitis Among Maternal Cases | 4.0% |
| Early Elective Delivery (PC-01) | 20.0% |
| Hemorrhage Frequency | 7.3% |
| Hypertension Frequency | 11.1% |
| QBL Cumulative Value | 100.0% |
| SMM Excluding Transfusion-Only Cases | 1.0% |

| Measure | Percentage |
|--|------------|
| Early Elective Delivery (PC-01) | 20.0% |
| Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current) | 18.2% |
| Cesareans after Labor Induction: NTSV Cases | 32.0% |

| Period | Count | Change |
|-------------------------------|-------|----------------------------|
| October 2020 Live Births | 265 | ↓ 8.9% (from 291 in 2019) |
| 2020 Year-to-Date Live Births | 2743 | ↓ 0.4% (from 2753 in 2019) |



THANK YOU!



State Spotlight – Oklahoma

Carrie Edwards and Amy Allen, Oklahoma Health Care Authority

PERINATAL CARDIOMYOPATHY CARE MANAGEMENT

Presented by State of Oklahoma Medicaid

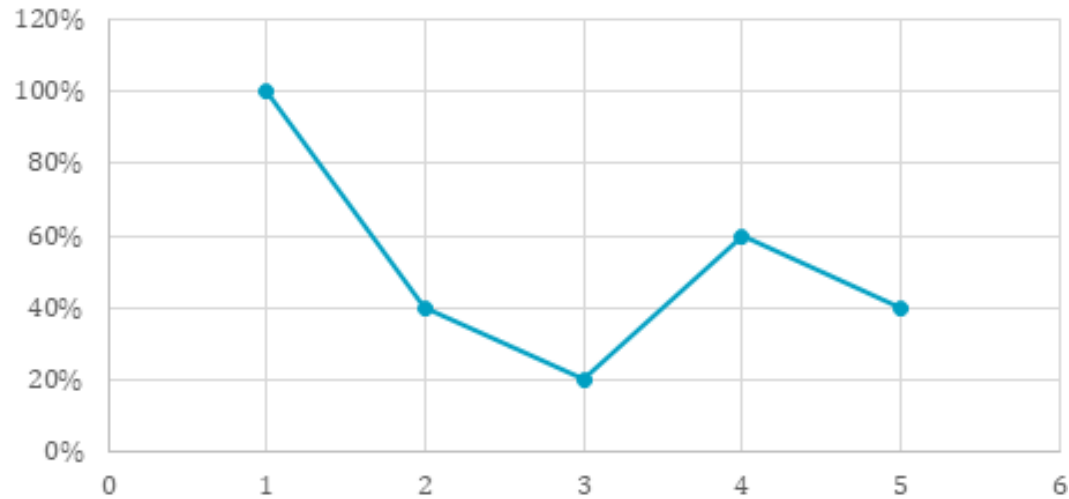
Amy Allen | RN, CCM

Carrie Edwards | BSN, RN, CCP

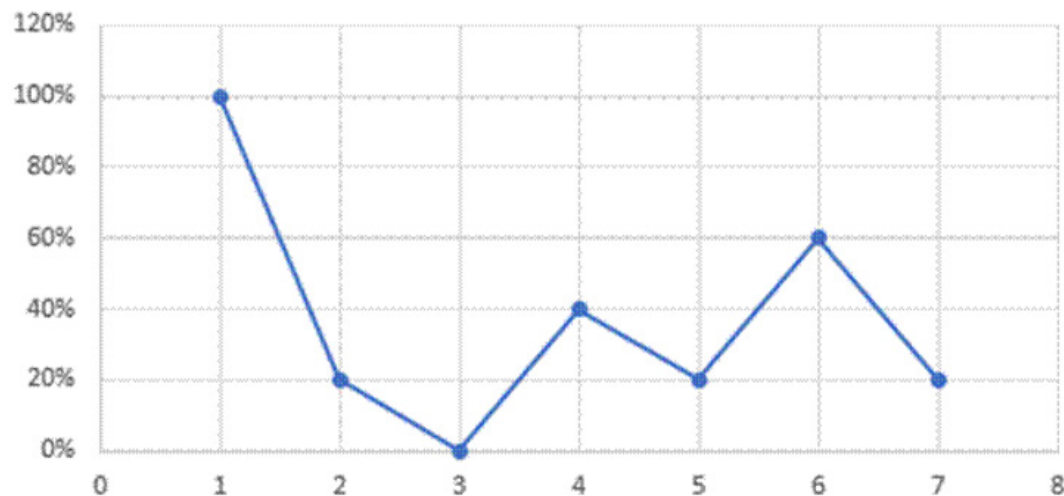


HOW IT STARTED

PDSA Cycle 1 CHT/DM Afric.Amer Case Management



PDSA Cycle 2 CHT/DM Afric.Amer Case Management in HCSI



- 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

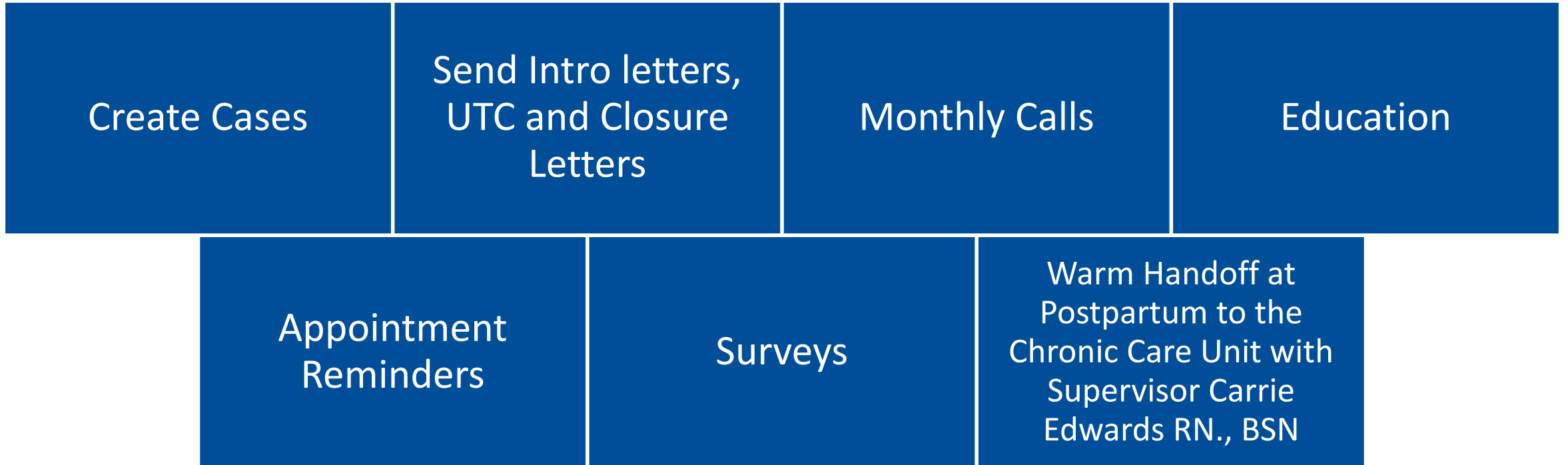
NOW WHAT?

- 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

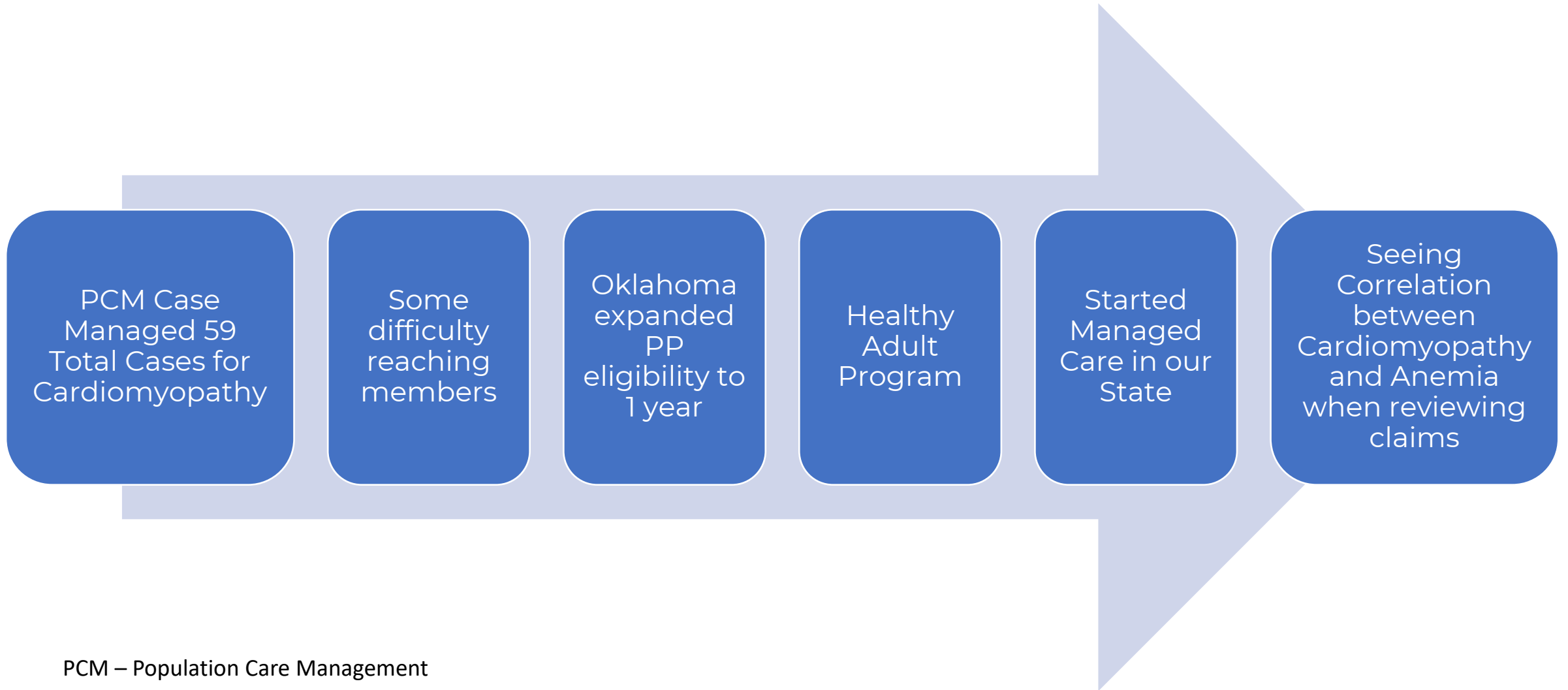


- 30,000 births with SoonerCare.
- 1.5% develop cardiomyopathy
- This is also in the vein of chronic care
- Cases found that met criteria:
 - 92 cases 2022
 - 67 cases 2023
 - 104 cases so far from 1/2023 to 4/2024

WORKING WITH MEMBERS WITH CARDIOMYOPATHY



DISCOVERY AND FACTORS IN PCM



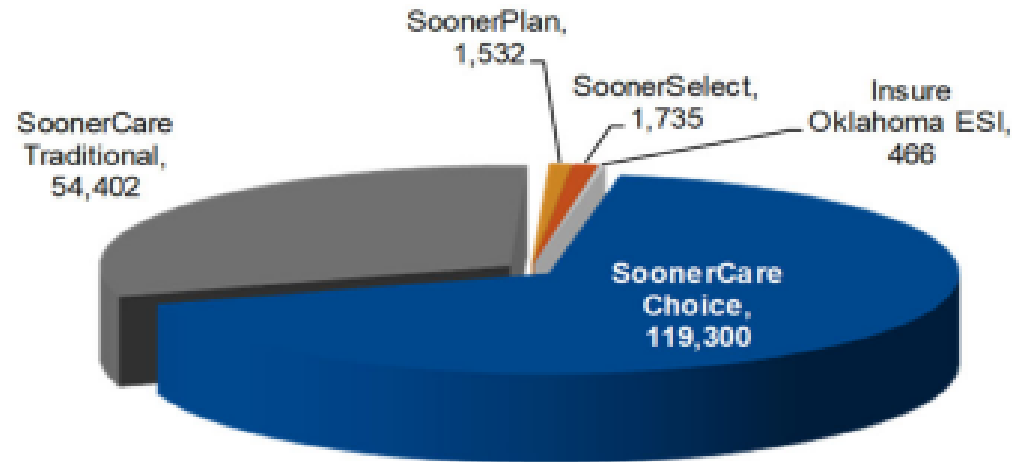
PCM – Population Care Management

SOONERCARE NATIVE POPULATION

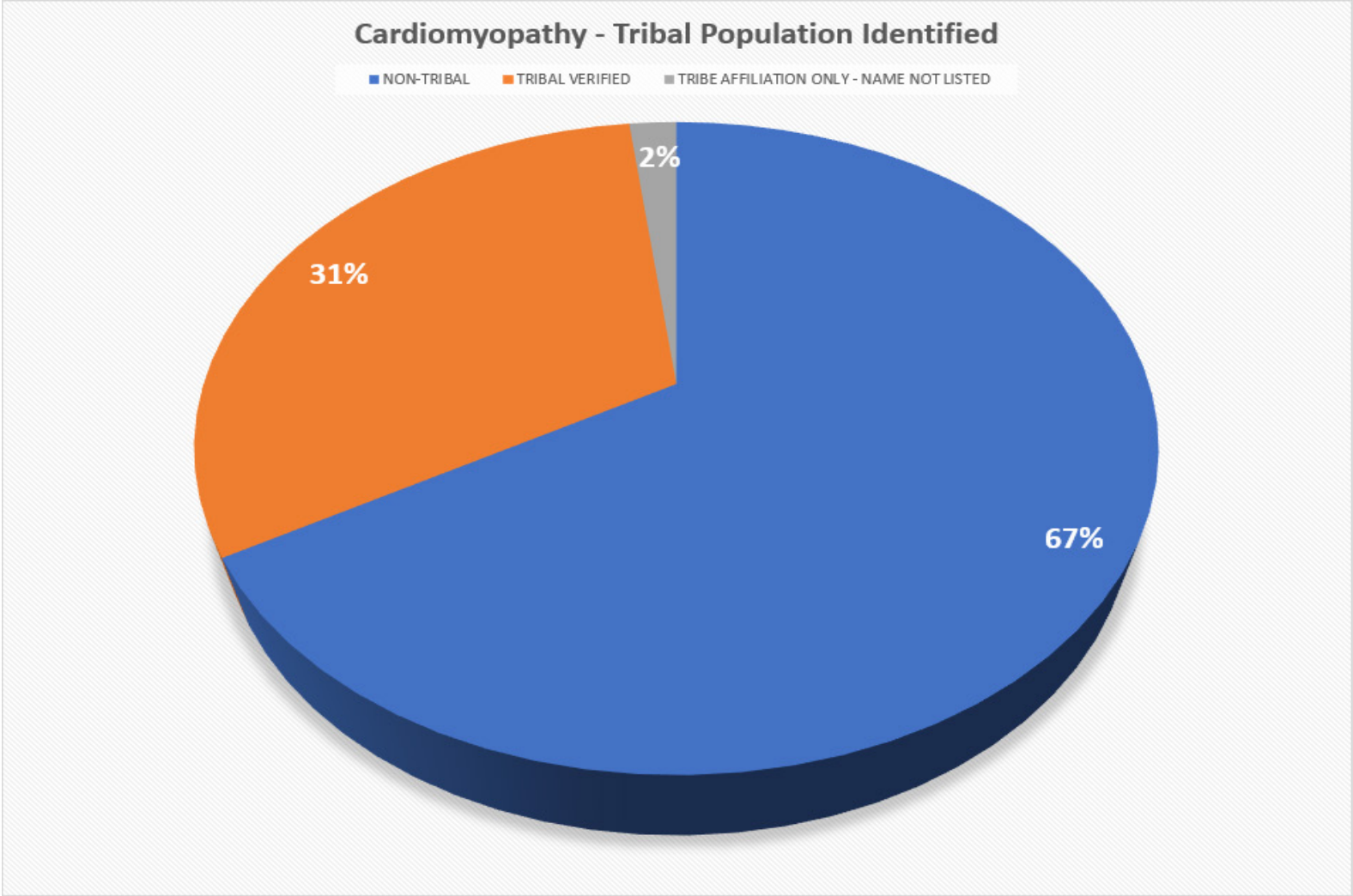
AMERICAN INDIAN FAST FACTS • MAY 2024

| 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

15 lost eligibility upon referral to Chronic Care Management

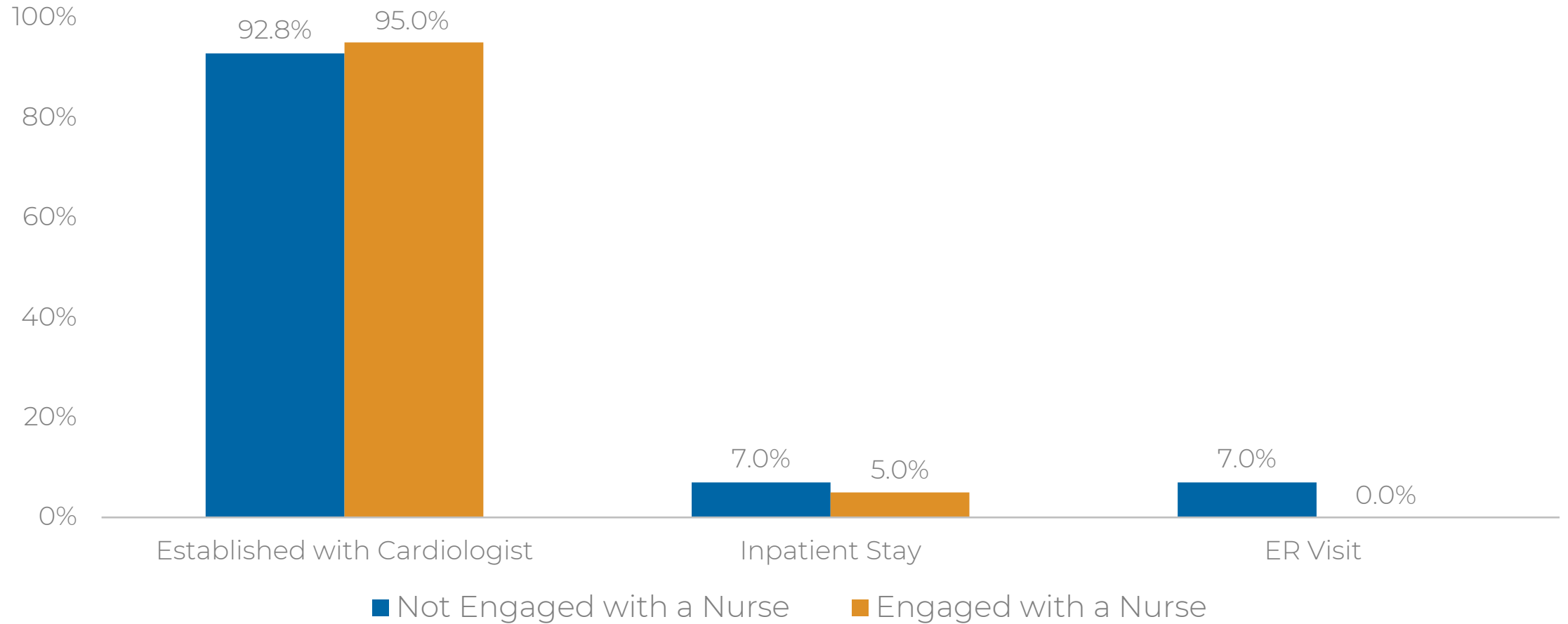
12 referred to SoonerSelect (managed care)

14 additional received warm hand-off to SoonerSelect

28 referred to externally contracted care management partners

45 followed by Chronic Care Management

CARE MANAGEMENT OUTCOMES



KAREN'S STORY

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



-Susan, NCM

- 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

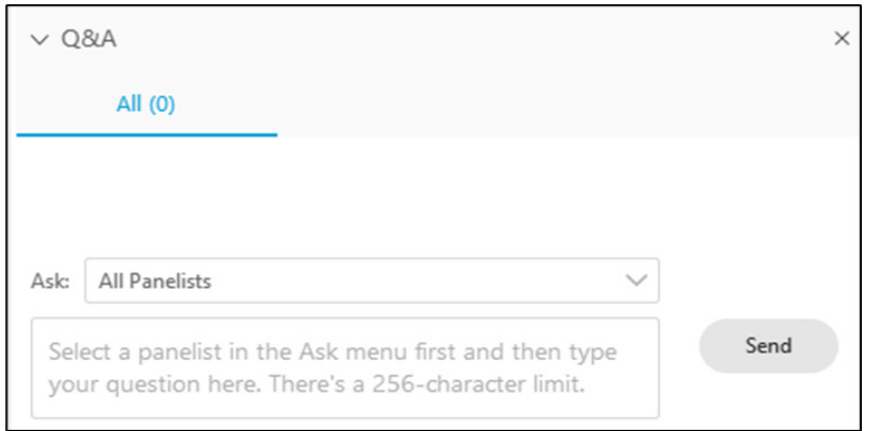


Questions and Discussion

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



The screenshot shows a Q&A interface with a dropdown menu set to 'All Panelists' and a text box for entering a question. Two red arrows point from the text in the list to the 'All Panelists' dropdown and the text box.

Q&A

All (0)

Ask: All Panelists

Select a panelist in the Ask menu first and then type your question here. There's a 256-character limit.

Send

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)

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!

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***

Maternal Health Resources

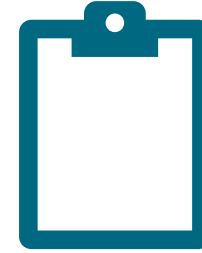
Visit the [2024 Medicaid & CHIP Beneficiaries at a Glance: Maternal Health Infographic](#) on Medicaid.gov for a snapshot of maternal health demographics, health outcomes, risk factors, and more.

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



Thank you for participating!

- Please **complete the survey** as you exit the webinar.



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

