 

|  |  |
| --- | --- |
| **Date:** | **ANNUAL MEETING OF DPQC AND MCDRC**September 19, 2023 |
| **Medical Dir.:** |  Garrett Colmorgen, M.D. |
| **Location:** | Hilton Garden Inn, Capital Room, 1706 N. Dupont Highway, Dover, DE 19901 |

**ATTENDANCE:**

|  |  |  |
| --- | --- | --- |
| 🗹 Garrett Colmorgen, Chair | 🗹 Marc Anthony Umobi | 🗹 Philip Schlossman |
| 🗹 Jessica Alvarez, Bayhealth🗹 Bridget Buckaloo, Beebe🗹 Margaret Chou, ACOG🗹 Khaleel Hussani🗹 Cassandra Codes-Johnson | 🗹 Annemarie Puit🗹 Michael Cooksey🗹 Andrea Warfel🗹 Nancy Petit | 🗹 Bridget Buckaloo🗹 Trenee Parker🗹 Kimberly Liprie🗹 Aleks Casper |

**FACILITATOR and DPH Representative:**

|  |  |  |
| --- | --- | --- |
| 🗹 Mawuna Gardesey, DPH |  |  |

**OTHER STAFF ATTENDANCE:**

🗹 JoEllen Kimmey, DPH

|  |  |  |  |
| --- | --- | --- | --- |
| **TOPIC** | **FINDINGS, CONCLUSIONS & RECOMMENDATIONS** | **ACTIONS &****FOLLOW-UP** | **STATUS** |
| I. Call to order and Welcome | The joint meeting of the DPQC and the MCDRC meeting was called to order by Dr. Colmorgen at 3:00p.m. | No further action required | Resolved |
| II. Introductions  | Attendees were introduced.  | No further action required | Resolved |
| III. MCDRC Report | In 2022, the Child Death Review and Sudden Death in the Young in Delaware found that there were 34 cases of CDR, with ten cases being related to bodily force or weapon and 23 cases of SDY, with the majority of 10 being related to unsafe sleep. Black children are overrepresented in the CDR/SDY cohort. While Black children make up 25% of the total population of 0-17-year-olds in Delaware, they make up 58% of the 2022 cohort of CDR/SDY cases. The main causes of postneonatal deaths in 2016-2020:* Congenital malformations
* SIDS—almost half associated with unsafe sleep conditions
* Accidents

In the last 5 years of reviews, 36 out of 60 unsafe sleep cases involved Black children. In an analysis of SDY cases occurring between 2017-2021 (5 year period):* 13/14 infant suffocation cases were BnH infants, that is 93%.

In 2022, 224 cribs were distributed and over 320 people received safe sleep trainings. Other factors related to the unsafe sleep deaths were social determinants of health, housing conditions & stability, caregivers’ schedules & routines and other stressors. In 2022 there were 40 FIMR cases reviewed with 26 fetal deaths, 14 infant deaths and maternal interview acceptance rate 15%. Of the 14 infant deaths, for a second year in a row, congenital anomalies were the #1 underlying COD in FIMR infant cases, outnumbering prematurity.Age at infant death* 43% of infants died in their 1st day of life
* 29% of infants survived beyond 28 days, dying in the post-neonatal period

FIMR goas are to identify and take action to prevent a wide range of local social, economic, public health, education, environmental, and safety factors that contribute to the tragedy of fetal and infant loss.In 2022 there were 11 maternal mortality cases to review, representing deaths occurring between 2018 and 2022. Two cases included a family interview; five of the 11 maternal deaths involved women were Black; 4 were White and 2 were Hispanic.Ten of the 11 women were NCC residents. Per guidance from the CDC, each contributing factor identified in a MMR case should be linked to a specific, actionable recommendation. This recommendation should be documented in the CDC MMRIA database in the format of: who should do what when. MMRC staff worked on drafting recs for each of the contributing factors in 2022 cases. Contributing factors at the patient level were that homicide and IPV victim did not have financial resources to leave her partner. Recommendations at the community level are that communities should communicate services available to individuals experiencing interpersonal violence. More emergency funds should be available to victims of IPV to use to enact a safety plan. Recommendations:With the in-depth, multidisciplinary FIMR process, we are seeing that many cases represent other tiers of morbidity in the maternal outcome pyramid. Starting near the top at tier 2 are the “near misses” or SMM cases. We have been tracking the number of FIMR cases that meet the CDC criteria for SMM. This is particularly important from a public health perspective as for every one maternal death, there are about 100 women who experience a near miss. There is ample evidence of women with multiple medical and psychosocial risk factors requiring complex care and multiple providers. These complex cases often involve hospital admissions during pregnancy, numerous trips to OB triage or the ED and multiple outpatient visits. In this way, FIMR cases represent all the other levels of the pyramid of outcomes below maternal death. The system of care for women with physical health, behavioral health and/or social risk factors is fragmented and complex. FIMR findings demonstrate missed opportunities for care coordination as patients are seen by different providers and across different sites, often to the detriment of patients’ well-being.· The landscape of community-based services is increasing in Delaware and may serve as another model of care coordination. Care coordination may be mediated by nurses, social workers, Medicaid managed care organization case managers, community health workers or peer support specialists. Expected outcomes for women engaged with care coordination include fewer missedappointments, better management of chronic health conditions and decreased patient stress. With respect to maternal morbidity cases, there is the recommendation for respectful maternity care with effective patient communication and shared decision making. Twenty-three percent of FIMR mothers appeared to be dissatisfied with some aspect of their care, and in 15% of cases there was documented poor provider-patient communication. There is recommendation for quality of care: FIMR cases reveal examples of women having difficulty accessing timely obstetric care. Certain rural parts of Delaware have been greatly impacted by the shortage of obstetric providers, leading to longer wait times to get into care and greater distances to travel for care. Covid has greatly impacted the levels and types of staff available in the outpatient and inpatient setting. Loss of nursing, physician and ancillary staff have negatively impacted quality of care and patients’ experiences of care. Five FIMR findings may be linked to staffing shortages and reveal the negative experiences these had on patients during the time of labor and delivery. Nurse midwives and nurses are two types of providers in particular whose impact is seen in FIMR cases. There is recommendation for mental health services as almost half of FIMR mothers had evidence of postpartum depression, anxiety or PTSD and there was the greatest risk the co-occurrence of mental health and SUD. Perinatal mood and anxiety disorders are the most common complication of pregnancy.* Mental health issues are contributory in almost half of Delaware’s pregnancy-associated deaths (46%).
* FIMR cases indicate a high burden of mental health morbidity, particularly due to depression and anxiety: 43% of FIMR mothers have a history of mental illness and 45% experience depression or another mental health morbidity in the postpartum period.
* The need for mental health services exceeds the capacity for specialized mental health providers in Delaware, and so it is important that patients with lower acuity receive care through their established medical providers, either their primary care or obstetric providers. Indeed, many FIMR strengths demonstrate that obstetric providers are screening and treating the common conditions of depression and anxiety.

Patients with higher acuity mental health issues may need specialized psychiatric or behavioral health services. There is capacity in the state to offer specialized care for perinatal mood and anxiety disorders. Patients in need of specialty care should be identified as soon as possible and have help accessing these services. There is also the recommendation to address the social determinants of health as hospitals should screen women for and document social risk factors as well as a medical home. Patients who are at high risk for medical and/or social complications could be given high priority for case management services while admitted, helping engage the patient and identify her most pressing needs and opportunities to help. In the MMR review 6 cases involved trauma history; 6 cases involved issues with access to care and 2 cases involved unstable housing. For the future, the formation of a community action team will be a critical component to address and prevent these situations. | On-going | On-going |
| V. DPQC – Review of accomplishments (OB and Peds sections) over past year | The DPQC has been working on 4 Initiatives with two Teams: OB & Peds Team which meet monthly. The DPQC has the following initiatives:1.Low Dose ASA therapy- OB Team:Recommendation Statement from the US Preventive Services Task Force (USPSTF) and Practice Advisory from the American College of Obstetricians & Gynecologists (ACOG) and Society for Maternal-Fetal Medicine (SMFM) recommend daily prophylactic low-dose aspirin for patients with any high-risk factor or with > 1 moderate-risk factor. TheACOG/SMFM Advisory adds that low-dose aspirin should optimally be started between 12 and 16 weeks of gestation. To implement these measures in Delaware the following has been accomplished:* A Screening tool was shared with OB providers with instructions for use
* Data is being collected by each center on a quarterly basis- 20 random charts
* Birth hospitals were asked to add a screening question to their L&D assessment: “Have you taken Low Dose ASA at any time during your pregnancy?” YES or NO
* IF YES- Document on Medication list
* Further query into risk factors, were patients eligible and not started on ASA?
* Hospitals use data to make improvements in screening.
* Barrier: This is an outpatient initiative- hospitals do not have a lot of purview over private practices that are not employed by the hospitals.

2.OBH Bundle- OB TeamOB Hemorrhage which is an AIM Bundle with the following implemented in Delaware:Key Elements:* + Hemorrhage Cart
	+ Medications readily available
	+ Rapid Response/MTP
	+ Staged based OBH protocols/order sets/Checklists
	+ Cumulative blood loss assessment/Quantitative blood loss assessment
	+ Simulation
	+ Debrief after events
	+ Data collection

Technical assistance was provided- CCHS OBERT team. 3.Severe Hypertension Bundle- OB TeamAnother AIM Bundle, Severe Hypertension, with the following implemented in Delaware:Key Elements:* + Antihypertensive Medication kits readily available
	+ Severe Hypertension protocols/order sets/provider notification
	+ Simulation training
	+ Debrief after events
	+ Postpartum follow up
	+ Data collection- Time to treat- Administer antihypertensive within 60 minutes of identification of persistent severe HTN

Technical assistance was provided- CCHS OBERT team.Quality Metric: Time to Treat – process metric* AIM Metric for Severe Hypertension:
	+ Denominator:
		- Birthing patients with acute-onset severe hypertension that persists for 15 minutes or more, including those with preeclampsia, gestational hypertension or chronic hypertension.
	+ Numerator:
		- Among the denominator, birthing patients who were treated within 1 hour with IV Labetalol, IV Hydralazine, or PO Nifedipine. The 1 hour is measured from the **FIRST** severe range BP reading, assuming confirmation of persistent elevation through a second reading*.*

4.NOWS- Peds TeamThe Peds team is working on initiatives to bring Eat, Sleep, Console to every birthing institution in Delaware to address Neonatal Opiate Withdrawal Syndrome. Since April 2023, the rates of NOWS has declined from 11 to 2, 1 and 1 for May, June and July respectively.Data on each of these initiatives was shared and discussed.  | No further action required.  | Resolved |
| VI. Agreement on Date for next joint meeting |  There being no further business before the Cooperative, the chair adjourned the meeting at 4:00pm. | No further action required | Resolved |

*Minutes prepared by J. Kimmey, DPH*

**Upcoming Annual Meeting of the DPQC and MCDRC:**

TBD ~ 2024