

# MATERNAL MORTALITY PREVENTION IN COLORADO



## CDPHE EFFORTS TO ADDRESS MATERNAL MORTALITY

The department has implemented the following programs and strategies to reduce stigma surrounding maternal mental health and to reduce substance use:

## MATERNAL HEALTH AND WELLNESS DATA

A recently developed online survey called Health eMoms asks new moms about their experiences with stress, mental and emotional health, substance use, and other topics starting shortly after they give birth and continuing up until their child's 3rd birthday.

## MATERNAL MENTAL HEALTH AWARENESS

Depression is one of the most common complications of pregnancy. CDPHE's Maternal Wellness & Early Childhood team launched a bilingual public awareness campaign in 2016 to reduce the stigma associated with maternal mental health and increase the number of women seeking treatment for pregnancy-related depression and anxiety. The team also helps health care providers and other community partners to address maternal mental health and works closely with the Colorado chapter of Postpartum Support International (PSI) to provide a quick path for women to find available resources.

**1 IN 9**  
**COLORADO WOMEN EXPERIENCE THE SIGNS AND SYMPTOMS OF DEPRESSION**

## MEDICAID REIMBURSEMENT FOR DEPRESSION SCREENINGS

In the spring of 2017, the legislature approved increasing Medicaid reimbursement for maternal depression screening from 1 to 3 times per year. This has resulted in twice the number of screenings of women on Medicaid.

Regular screening and education can increase awareness and identification of pregnancy-related depression and anxiety. It can also increase the number of women seeking treatment.

## DEPRESSION SCREENINGS FOR WOMEN ON MEDICAID

2017  
1 IN 3



2015  
1 IN 7



## MATERNAL SUBSTANCE USE

CDPHE's Opioid Overdose Prevention Program promotes best practice opioid prescribing guidelines and engages in provider education efforts to prevent misuse, abuse and overdose. The program's main activities related to maternal wellness include:

- Making the Colorado Prescription Drug Monitoring Program (PDMP) system easier to use in order to increase the number of prescribers who regularly consult the PDMP before prescribing opioids.
- Linking maternal mortality data to the PDMP to enrich the data available for case review.
- Expanding access to medication-assisted treatment for pregnant and postpartum women.
- Increasing access to care in high-need areas by working with programs that offer loan repayment for substance use providers.

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**COLORADO**  
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Maternal mortality is increasing in Colorado and the Maternal Mortality Prevention Program at the Colorado Department of Public Health & Environment plays a vital role in understanding trends and informing on how to prevent such tragedies. A maternal death is a death that happens during pregnancy or up to one year after pregnancy, regardless of the cause. Maternal deaths represent the most extreme and rarest negative maternal outcome. A multidisciplinary committee reviews each death comprehensively to understand the causes, identify prevention opportunities and improve maternal health outcomes.

The Maternal Mortality Prevention Program identifies maternal deaths in Colorado and collects and reviews medical, coroner and police records from each death. The program also convenes a Maternal Mortality Review Committee to review the case summaries without any identifying information to protect privacy and confidentiality. The department has had an active and dedicated committee of volunteer professionals since 1993. The committee includes experts from obstetrics/gynecology, maternal-fetal medicine, nursing, midwifery, anesthesiology, forensic pathology, psychology, psychiatry, behavioral health and public health.

In reviewing each case, the committee:

- Determines whether the death was related to the pregnancy.
- Determines the underlying cause of death.
- Discusses whether the death could have been prevented and, if so, how.
- Identifies factors that might have contributed to the death.
- Identifies potential opportunities to prevent future deaths.

### NEARLY 80% OF MATERNAL DEATHS ARE PREVENTABLE

Each case of a maternal death is complex and tragic. To determine whether a death was preventable, the committee considers whether there was at least some chance of changing the outcome. It looks at any factors that could have contributed to the death, including looking at the patient, health care provider team, and facilities where care was delivered, as well as factors at the community and systems levels.

The Maternal Mortality Prevention Program then uses this information to identify and implement public health and clinical interventions that can prevent future deaths and improve the well-being of the pregnant and postpartum population. Additionally, the program reports on data to help decision-makers understand who is most affected by these tragedies and where to prioritize resources.

*CDPHE acknowledges that social, economic, and environmental inequities result in adverse health outcomes and have a greater impact than individual choices. Reducing health disparities through systems change can help improve opportunities for all Coloradans.*

## MATERNAL DEATHS IN COLORADO

**145**

Deaths, 2008 - 2013

**15 - 40**

Deaths each year with an increase in recent years

### LEADING CAUSES:

- Injuries, including motor vehicle crashes and homicides.
- Mental health conditions, including suicide and substance overdose.
- Cancer.
- Cardiovascular conditions.
- Infection.



Motor vehicle crashes and homicide deaths **DECREASING.**



Deaths due to mental health conditions **INCREASING.**

People who died were significantly more likely to :

- have a HS education or less.
- have incomes less than \$15,000.
- live in rural areas.
- be unmarried.
- be obese.
- obtain delayed or inadequate prenatal care.
- have preterm or low birth weight infants.
- have 4+ children.
- be black.
- be on WIC.

Average age: 27.3 years.