Pennsylvania Maternal Mortality Review Committee

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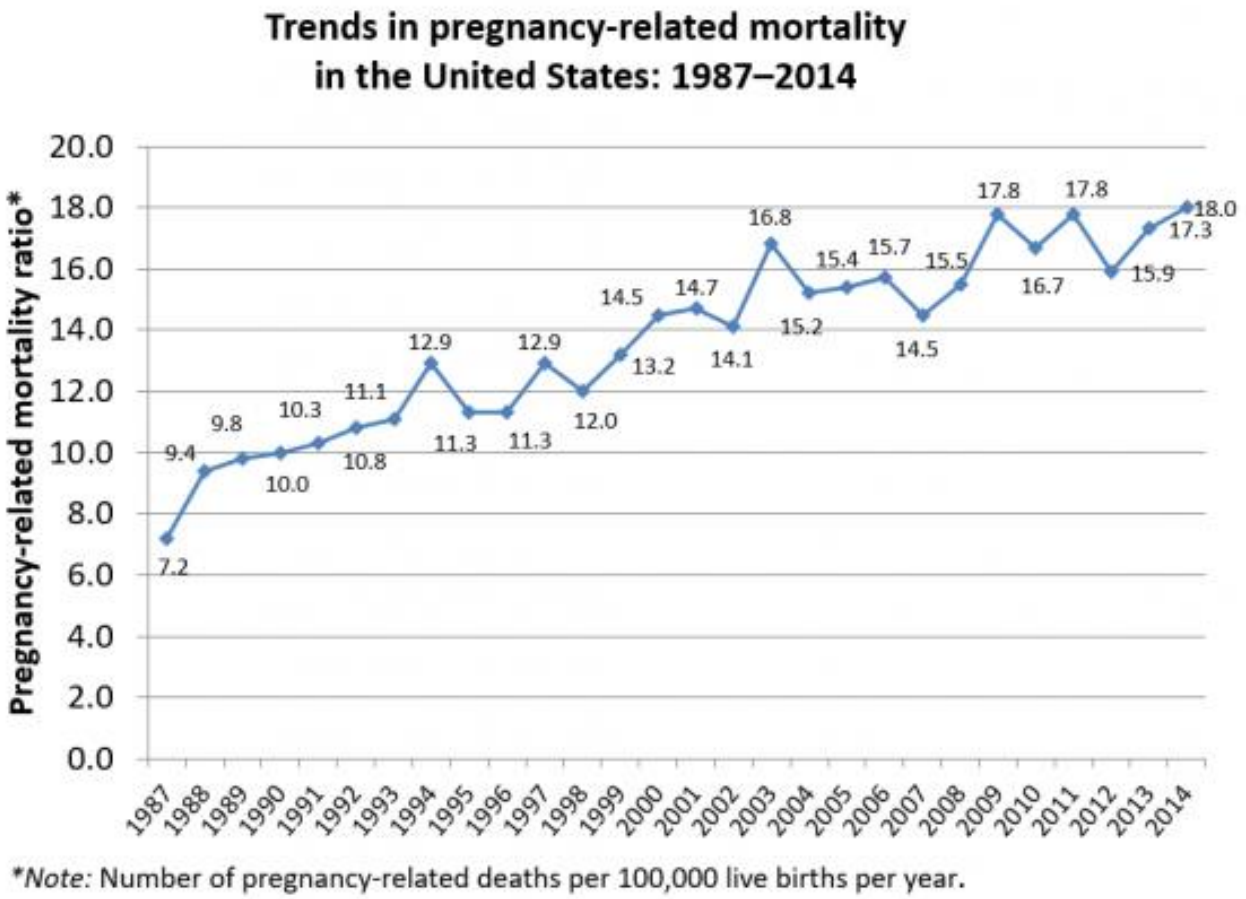
Maternal Mortality

Maternal mortality has been increasing in the U.S.



Source: Pregnancy Mortality Surveillance System, CDC

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Disparities in Maternal Mortality

- Healthy People 2020 Measure:
  - **11.4** deaths due to complications of pregnancy **within 42 days of a pregnancy** per 100,000 live births
- PA rate is 11.4 (2012-2016)
- However, African American/ black women die at **three times** the rate of white women, 2012-2016:
  - White: **8.7**
  - African American/black: **27.2**

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Definitions

Pregnancy Associated Deaths

Pregnancy-Related Death
The death of a woman during pregnancy or **within one year of pregnancy** due to a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy

Pregnancy-Associated but NOT Related Death
The death of a woman during pregnancy or **within one year of pregnancy** from a cause that is not related to pregnancy

Unable to Determine

Source: St. Pierre A; ZaharatosJ; Goodman D; Callaghan WM. Jan 2018. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths.Obstetrics and Gynecology. 131; 138-142.

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MMRC Summary

- HB 1869/ Act 24 of 2018 created the Maternal Mortality Review Committee (MMRC)

- Purpose: review maternal deaths up to 1 year after pregnancy to identify why women are dying and make recommendations.

- Understand medical and non-medical contributors to deaths and prioritize interventions that effectively reduce maternal deaths

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PA MMRC Members

Membership Required by Act 24:

- The Secretary of Health or a designee
- An obstetrician.
- A maternal-fetal medicine specialist.
- A certified nurse-midwife.
- A registered nurse representing maternal health care.
- A psychiatrist.
- An addiction medicine specialist.
- A social worker or social service provider.
- A medical examiner or coroner responsible for recording deaths.
- An emergency medical services provider.
- A health statistician.
- A representative of the department's Bureau of Family Health programs.
- Three individuals specializing in emergency medicine, family medicine, pathology, anesthesiology, cardiology, critical care or any other relevant medical specialty.
- Additional personnel at the discretion of the secretary

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Mission

The mission of the Pennsylvania Maternal Mortality Review Committee is to:

- Systematically review all maternal deaths;
- Identify root causes of these deaths; and
- Develop strategies to reduce preventable morbidity, mortality and racial disparities related to pregnancy in Pennsylvania.

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Identifying Maternal Deaths

- Pregnancy associated deaths are identified in women of child bearing age, 12- 50 years, via:
  - Pregnancy checkbox
  - Matching of birth and fetal death certificates the year prior with women's death certificate
  - PHC4 discharge data
  - LexisNexis notifications from CDC on maternal deaths identified in the media

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Act 24 Authority for Records

In conducting a review of a maternal death case, the committee may review the following:

- Medical examiner and coroner's reports or postmortem examination records
- Death certificates and birth certificates
- Traffic fatality reports
- Dept. of Human Services records
- Information made available by firefighters or emergency services personnel
- Reports and records made available by the court to the extent permitted by law or court rule
- Medical records from hospitals and other health care providers
- Emergency medical services records
- Reports to animal control
- Any other records necessary to conduct the review
- Law enforcement records and interviews with law enforcement officials as long as the release of the records will not jeopardize an ongoing criminal investigation or proceeding

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Preliminary Data MMRC, 2018 cases for review

- Currently requesting records and reviewing 2018 pregnancy associated deaths.
- First case review meeting was July 24, 2019.
- 20 percent of those cases are Philadelphia residents and are reviewed by the Philadelphia MMRC.

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Case Review and Recommendations

- On average, a review takes 30-45 minutes.
- MMRC meets quarterly to review cases, along with additional meetings as needed.
- Use CDC's MMRIA decision form to review cases during meetings.
- MMRC is required by Act 24 to produce a report every three years that includes aggregate data and recommendations.
- MMRC works with the PA Perinatal Quality Collaborative (PQC) to implement recommendations.

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MMRIA Decision Form

6 Key Questions Answered in Case Review

1. Was the death pregnancy-related?
2. What was the underlying cause of death?
3. Was the death preventable?
4. What factors contributed to the death?
5. What are recommendations that address the contributing factors?
6. What are the expected impacts if those recommendations where acted on?

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Mock Panel

www.reviewtoaction.org

WELCOME

Have you ever wondered what happens during a maternal mortality review committee meeting? Maybe you are in the early phases of assembling a committee in your local jurisdiction, and you aren't quite sure who should be involved or how to describe the process to potential committee members. Or maybe you have been invited to serve on a review committee, but you don't know what to expect when you arrive.

This interactive website was designed to offer people a peek inside a review committee

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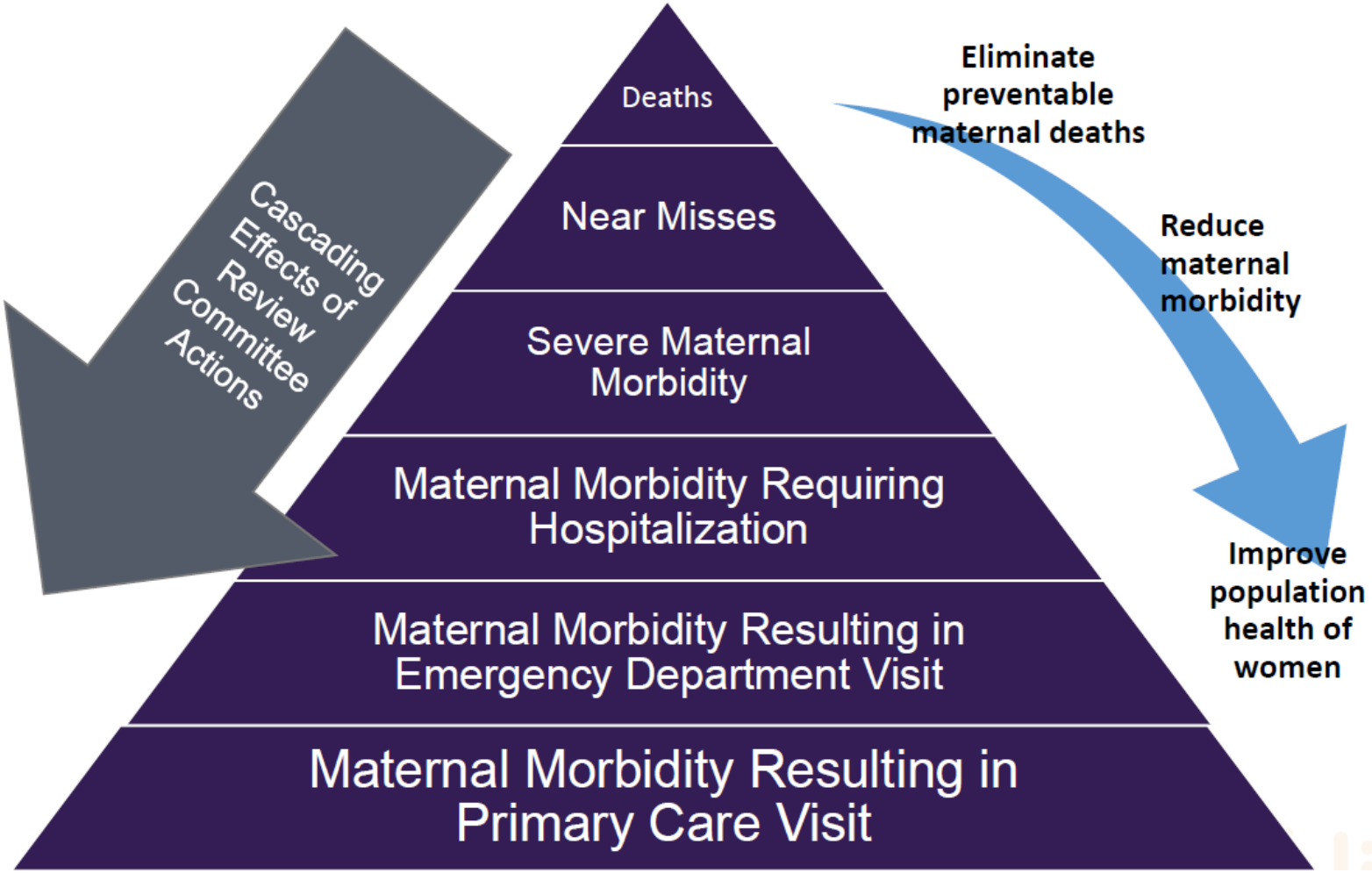
Cascading Effects of MMRC



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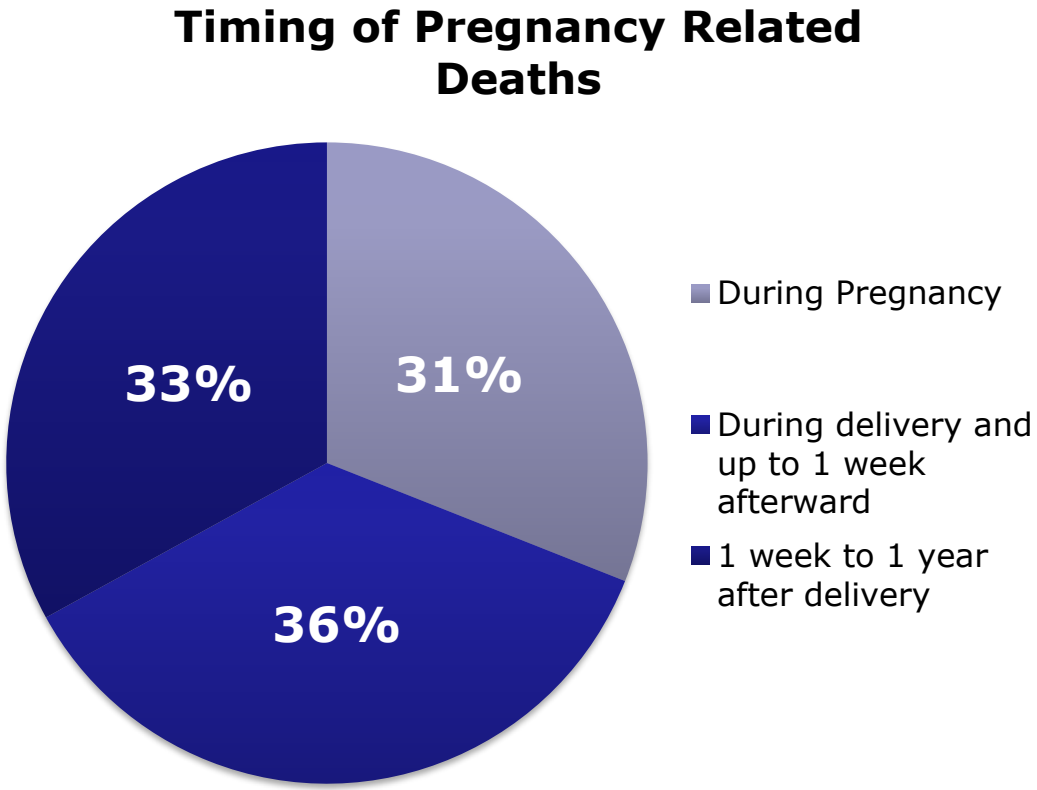
Source: Power of MMRCs, www.reviewtoaction.org

National Data – Pregnancy Related Deaths

700 women die from pregnancy-related complications each year in the United States.

3 in 5

pregnancy related deaths could be prevented.



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Source: Pregnancy Related Deaths, CDC Vital Signs, May 7, 2019

National Data – Pregnancy Related Deaths

Leading Causes of Pregnancy Related Deaths by Time of Death

- **Overall:** Heart disease and stroke caused more than one in three deaths.
- **At Delivery:** Obstetric emergencies, like severe bleeding and amniotic fluid embolism (when amniotic fluid enters a mother's bloodstream) were most common.
- **Week after delivery:** severe bleeding, high blood pressure, and infection were most common.
- **One week to one year after delivery:** Cardiomyopathy (weakened heart muscle) was the leading cause of deaths

Source: Pregnancy Related Deaths, CDC Vital Signs, May 7, 2019

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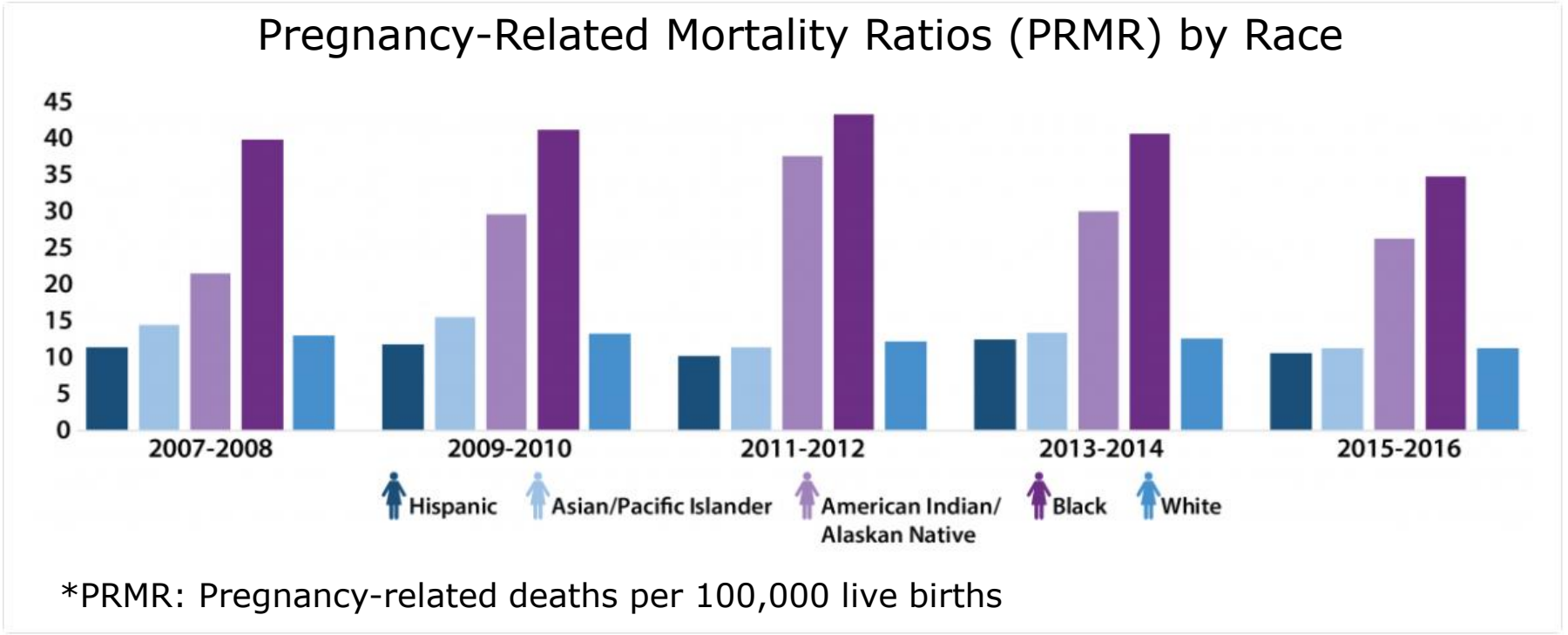
National Data - Racial Disparities

Nationally, American Indian/Alaska Native and Black women are **two to three times** more likely to die from a pregnancy-related cause than white women. These inequities persist over time.



*PRMR: Pregnancy-related deaths per 100,000 live births

Source: Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016, CDC, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion

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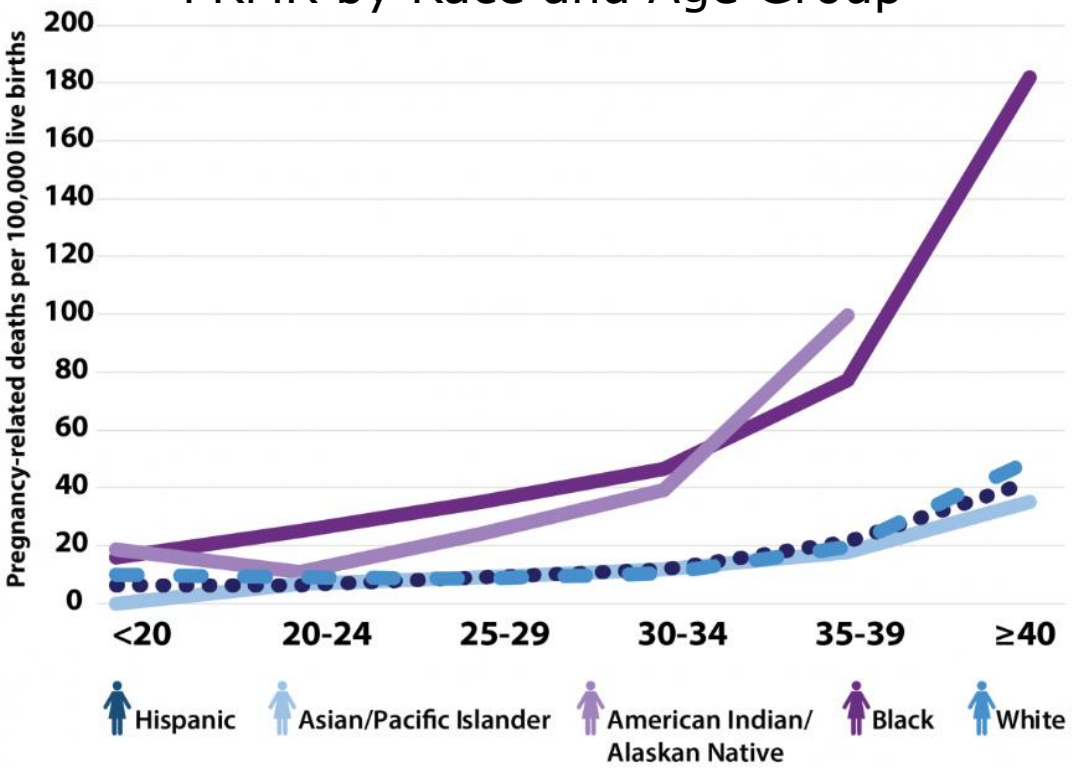
National Data - Racial Disparities

Inequities Increase with Age

PRMR by Race and Age Group



The disparity ratio between black women and white women by age:

- 1.5 for <20 age group
- 4.3 for 30-34 age group

*PRMR: Pregnancy-related deaths per 100,000 live births

Source: Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016, CDC, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion

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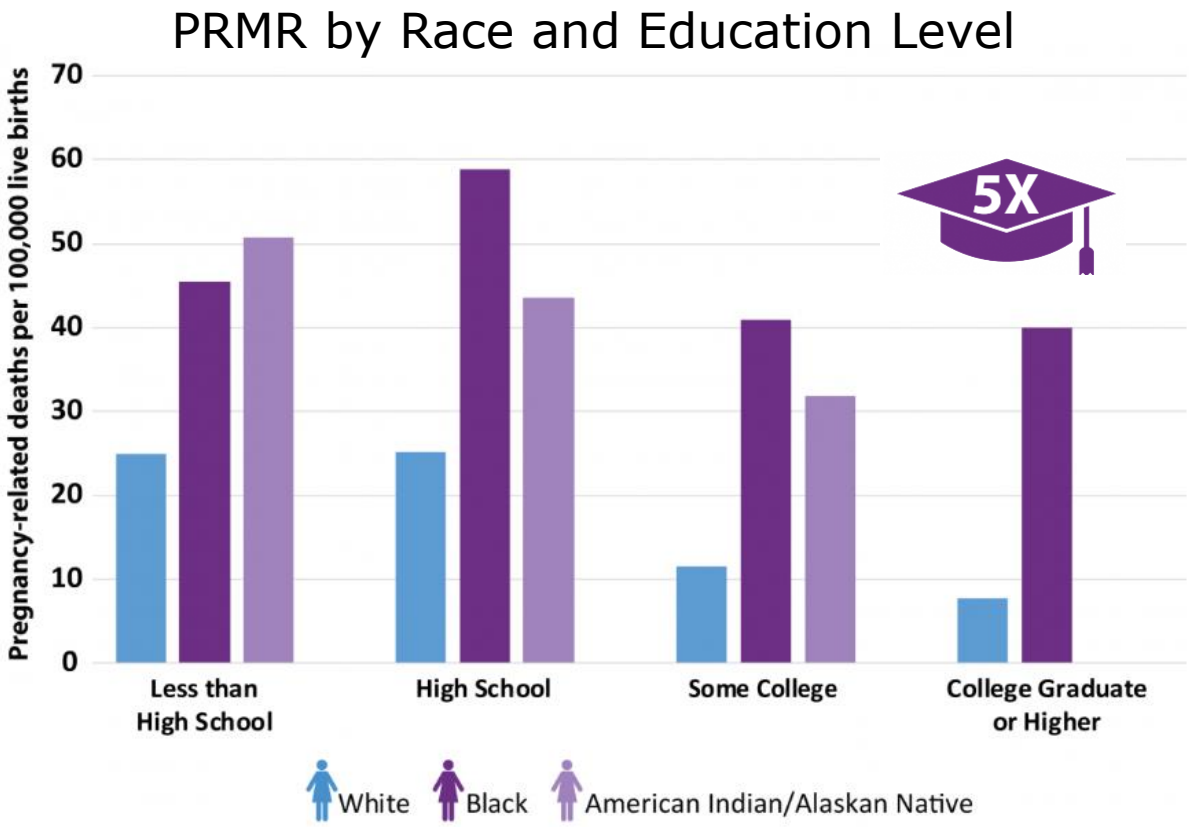
National Data - Racial Disparities

Inequities by Education Level



The PRMR for black women with **at least a college degree was five times higher** than white women with a similar education.

*PRMR: Pregnancy-related deaths per 100,000 live births

Source: Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016, CDC, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion

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*2018 data coming this Fall

More info at Health.PA.gov

Health > All Health Topics > Healthy Living > Maternal Mortality

Maternal Mortality

Maternal mortality is devastating for families and communities worldwide. In Pennsylvania specifically, a large disparity exists between white and African American women for maternal mortality. Unfortunately, mortality is just the tip of the iceberg: for every woman who dies, there are more women who just barely survive. Because of this, Governor Wolf has made maternal and child health a priority for the state of Pennsylvania.

What is Maternal Mortality?

Maternal mortality is a death of a woman during pregnancy, or up to one year following the end of the pregnancy, regardless of the outcome of the pregnancy. Maternal mortality applies in cases of livebirth, stillbirth, abortion and miscarriage. When describing maternal mortality, deaths are divided into the following categories:

Pregnancy Associated Deaths: the death of a woman during pregnancy, or up to one year following the end of the pregnancy, regardless of the outcome of the pregnancy.

Resources

CDC Vital Signs Report on Maternal Mortality

Maternal Mortality in Philadelphia 2010-2012

Maternal Mortality Terminology

PA Perinatal Quality Collaborative

Review to Action

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Questions?

For more information go to:

Health.PA.gov

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