

# Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

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# Burden of maternal mortality

# Data from three important sources

National Vital Statistics System	Pregnancy Mortality Surveillance System	Maternal Mortality Review Committees
<p>Reports maternal deaths during pregnancy and <u>up to 42 days after delivery</u></p>	<ul style="list-style-type: none"><li>• Defines pregnancy-related death as during pregnancy or <u>within 1 year after pregnancy</u></li><li>• Uses death certificates, linked birth or fetal death certificates, and other information as available</li></ul>	<ul style="list-style-type: none"><li>• Review <u>all deaths that occur during pregnancy or within 1 year, regardless of cause</u></li><li>• Gather data from multiple clinical and non-clinical sources to determine:<ul style="list-style-type: none"><li>• pregnancy-relatedness,</li><li>• underlying cause,</li><li>• preventability,</li><li>• contributing factors and</li><li>• recommendations for action.</li></ul></li></ul>

# Too many mothers die



700

- 700 women die each year in U.S. from pregnancy-related causes
- Includes during pregnancy, labor/delivery, or up to a year after the end of pregnancy

2-3X

- American Indian/Alaskan Native 2 times more likely to die than white women
- Black women 3 times more likely to die than white women

66%

- About 66% of these deaths may be preventable

# Timing of deaths in relation to pregnancy



**31%**

During pregnancy



**36%**

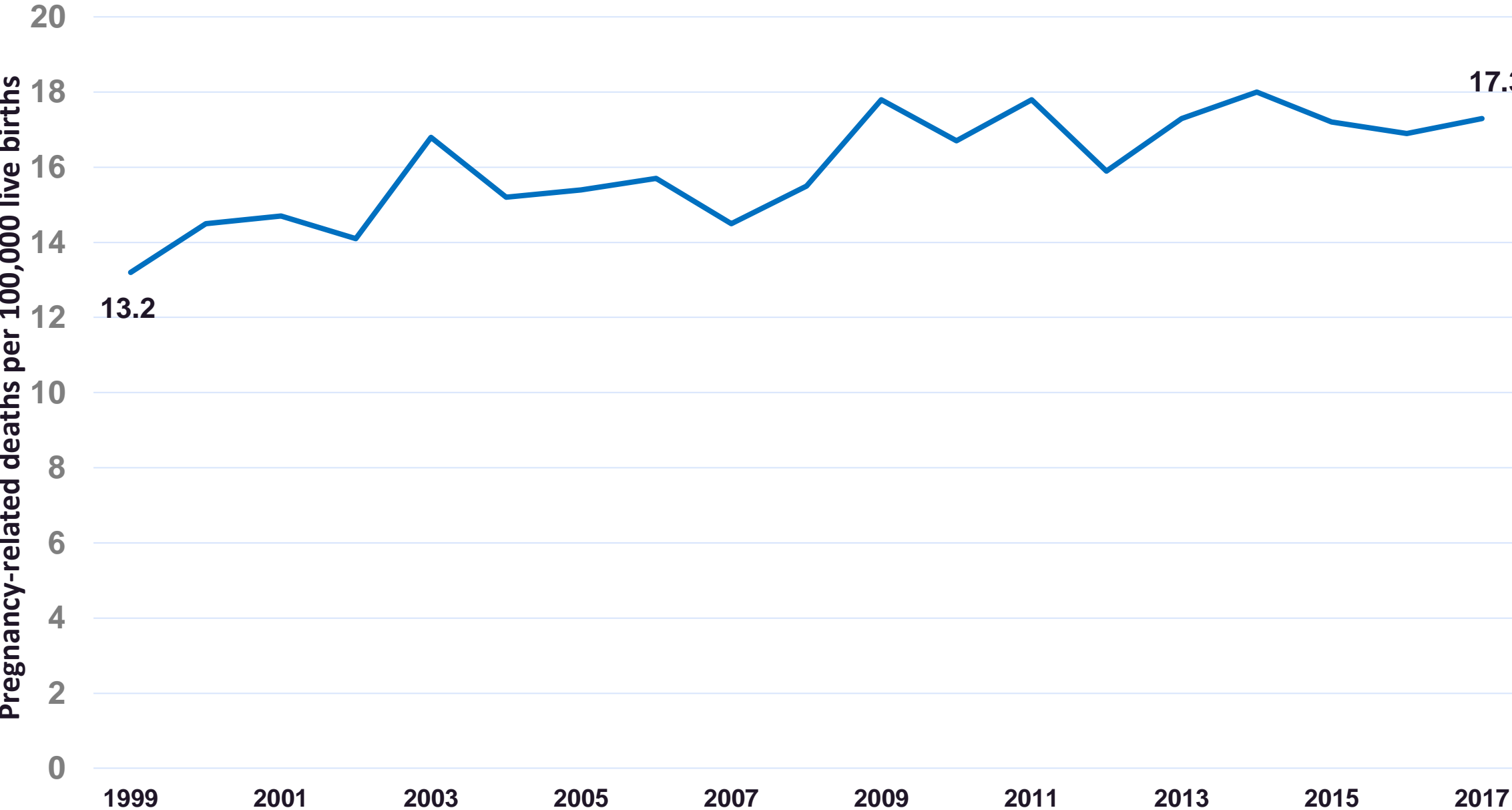
During delivery and  
up to 1 week afterward



**33%**

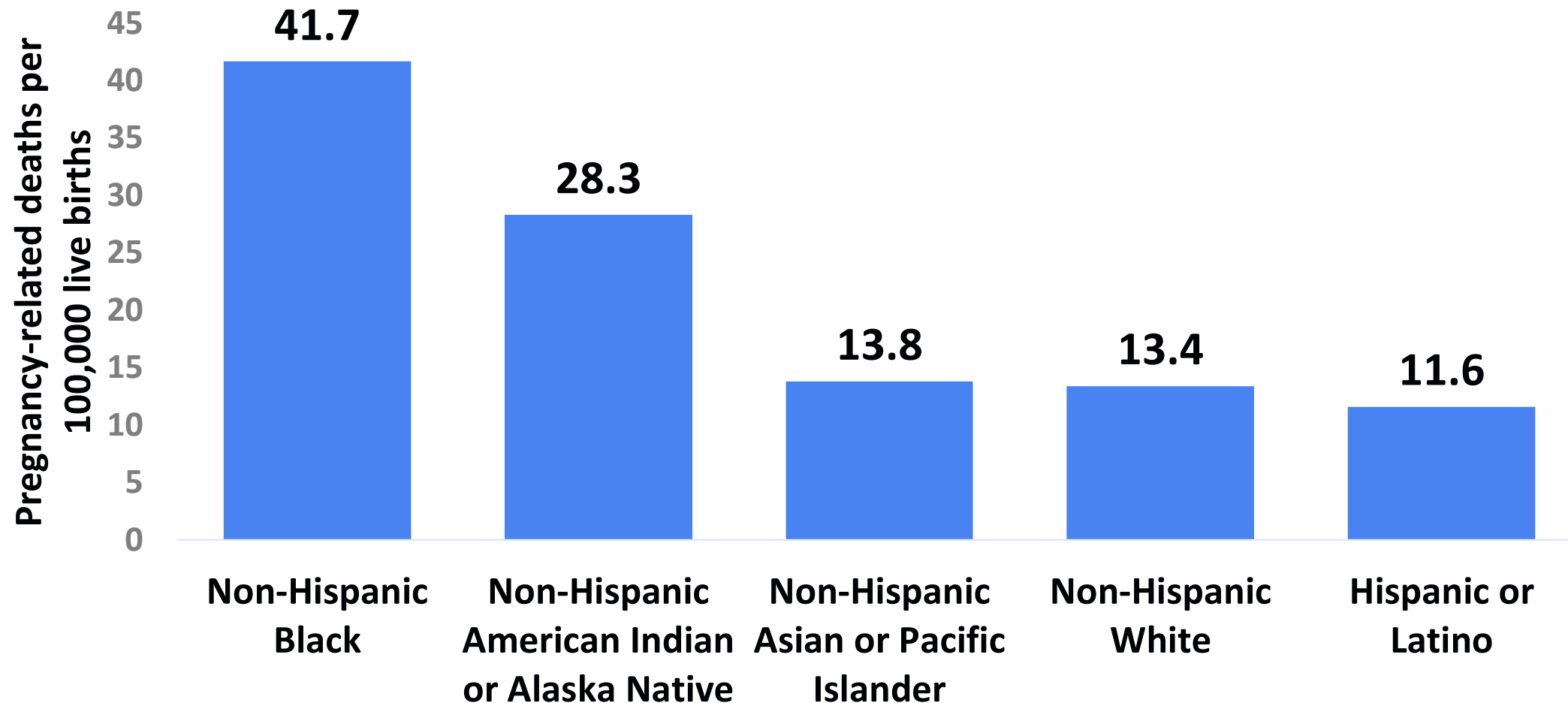
1 week to  
1 year after

# U.S. pregnancy-related mortality ratio, PMSS\* 1999-2017

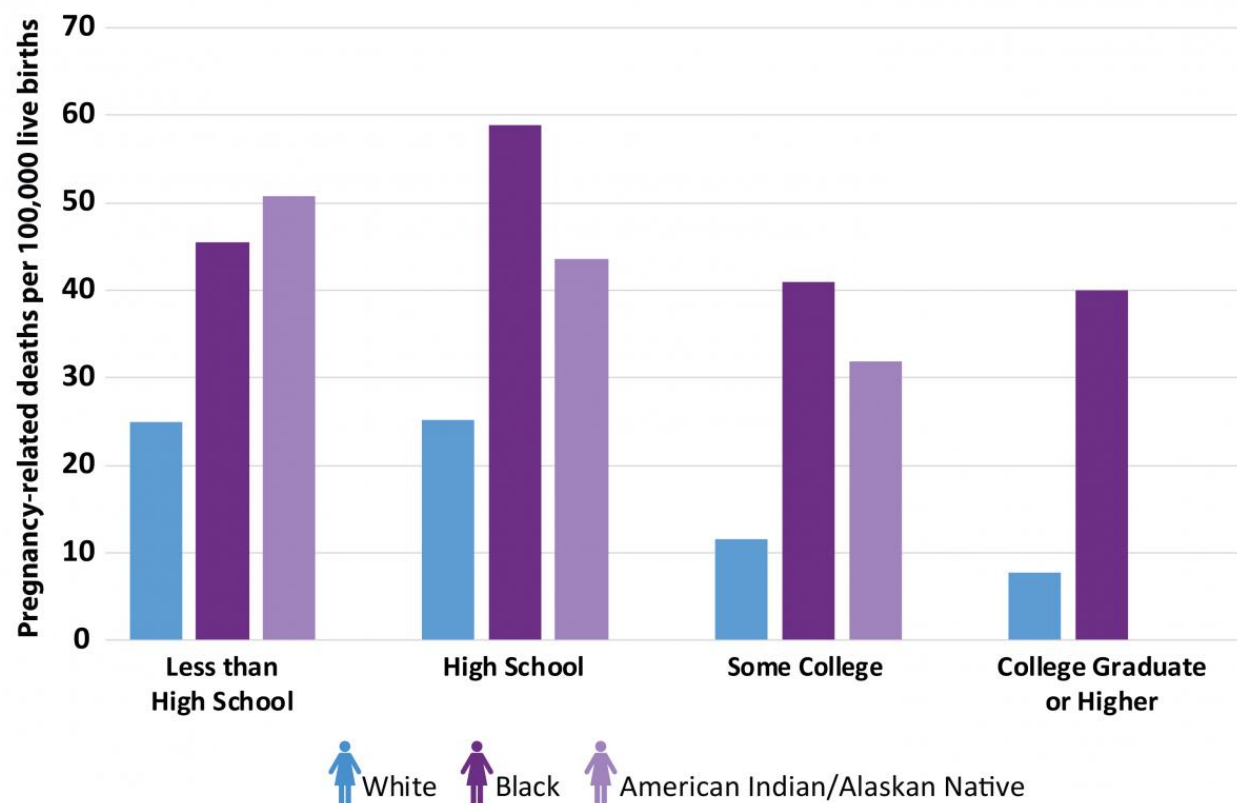


\*CDC Pregnancy Mortality Surveillance System: <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>

# U.S. pregnancy-related mortality ratio by race/ethnicity, PMSS 2014-2017



# U.S. pregnancy-related mortality ratio by race/ethnicity, PMSS 2014-2017



The PRMR for Black women with at least a college degree was 5x as high as white women with a similar education



# Jurisdiction-level Maternal Mortality Review

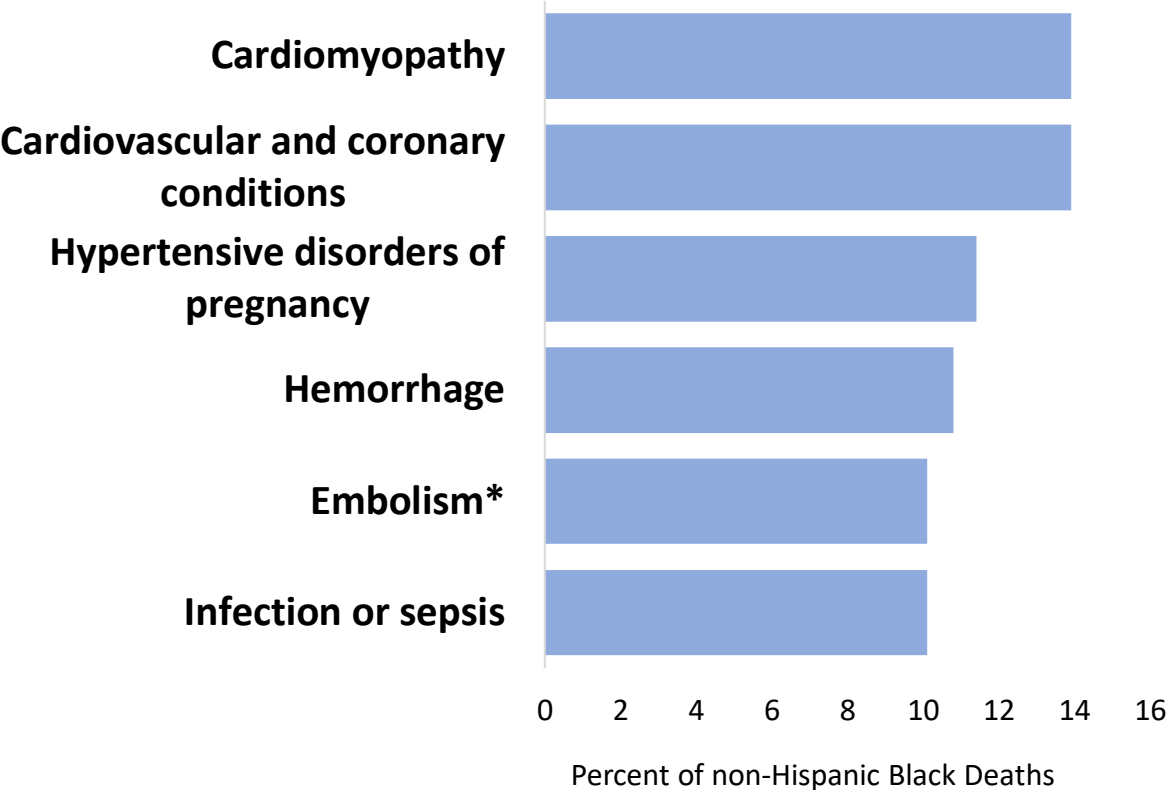
## Committees provide local maternal mortality data



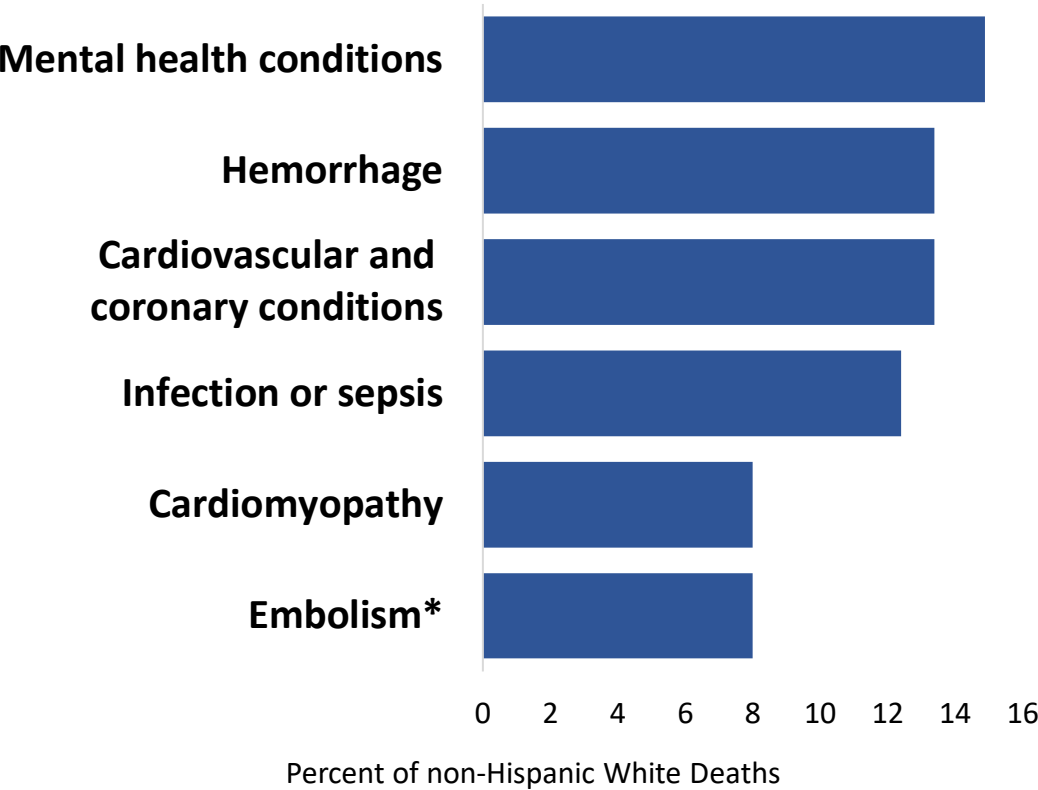
State and Local Maternal Mortality Review Committees (MMRCs)	
Data Source	Death certificates and linked birth or fetal death certificates, medical records, social service records, autopsy, informant interviews, etc.
Time Frame	During pregnancy – 1 year
Source of Classification	Multidisciplinary committees
Terms	Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related
Measure	Pregnancy Related Mortality Ratio - # of Pregnancy Related Deaths per 100,000 live births
Purpose	Understand medical and non-medical contributors to deaths, prioritize interventions that effectively reduce pregnancy-related deaths

# Leading causes vary by race-ethnicity: 14 MMRCs

Non-Hispanic Black



Non-Hispanic White



Data Source: <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html>

Notes: \* Embolism – thrombotic pulmonary and other embolisms

# Review to Action

Staff present each *selected case* to the MMRC using the case narrative

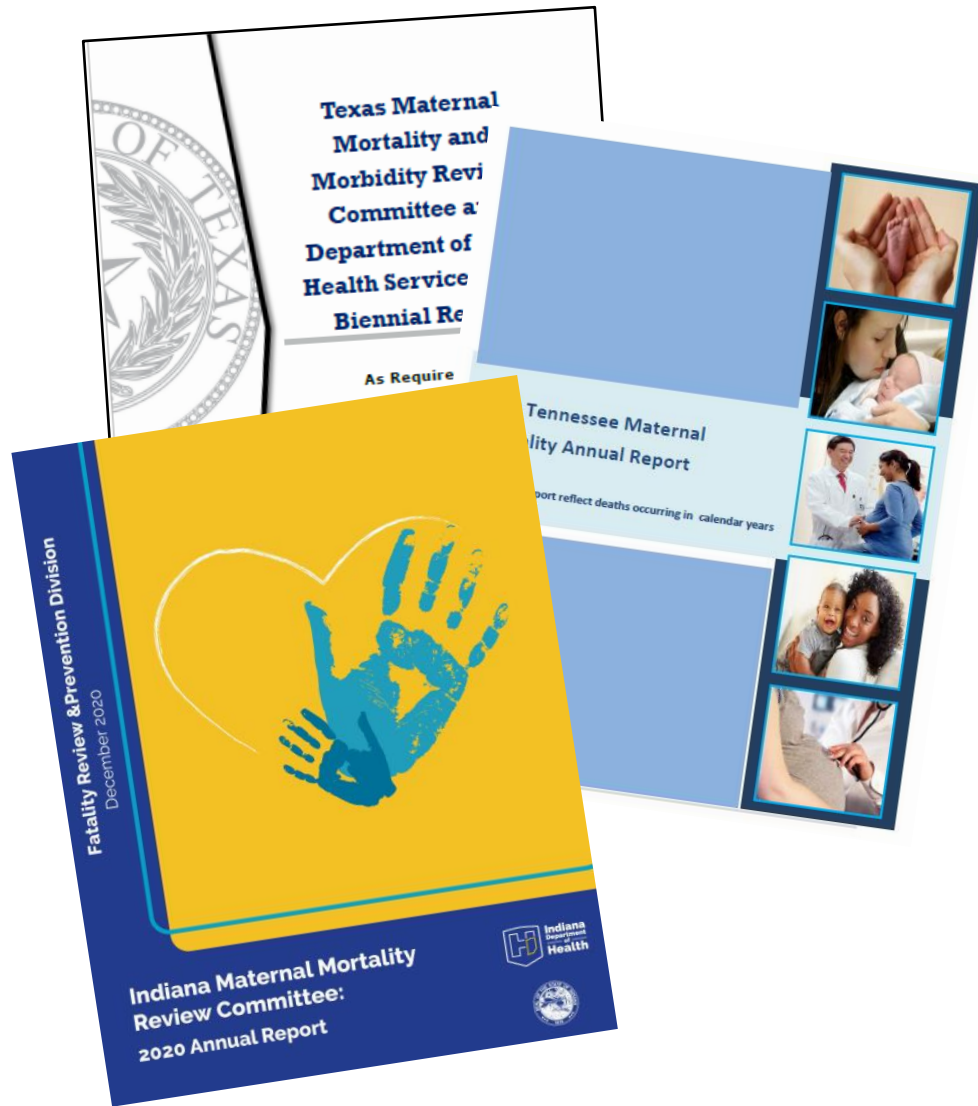
MMRC discusses and makes key decisions about each death

Enter key decisions into MMRIA

Analyze data, identify key issues and recommendation themes

**Prioritize recommendations for action, and disseminate findings**

# Data to action examples



- In 2020, 14 state MMRCs published a state report using their MMRC data
- IL, TN, and WA MMRC findings were used to support the extension of Medicaid coverage from 2-months to 1-year postpartum
- In response to a prioritized MMRC recommendation, the Utah Department of Health launched the [Utah Maternal Mental Health Resource Network](#)

# Equipping MMRCs to understand community context

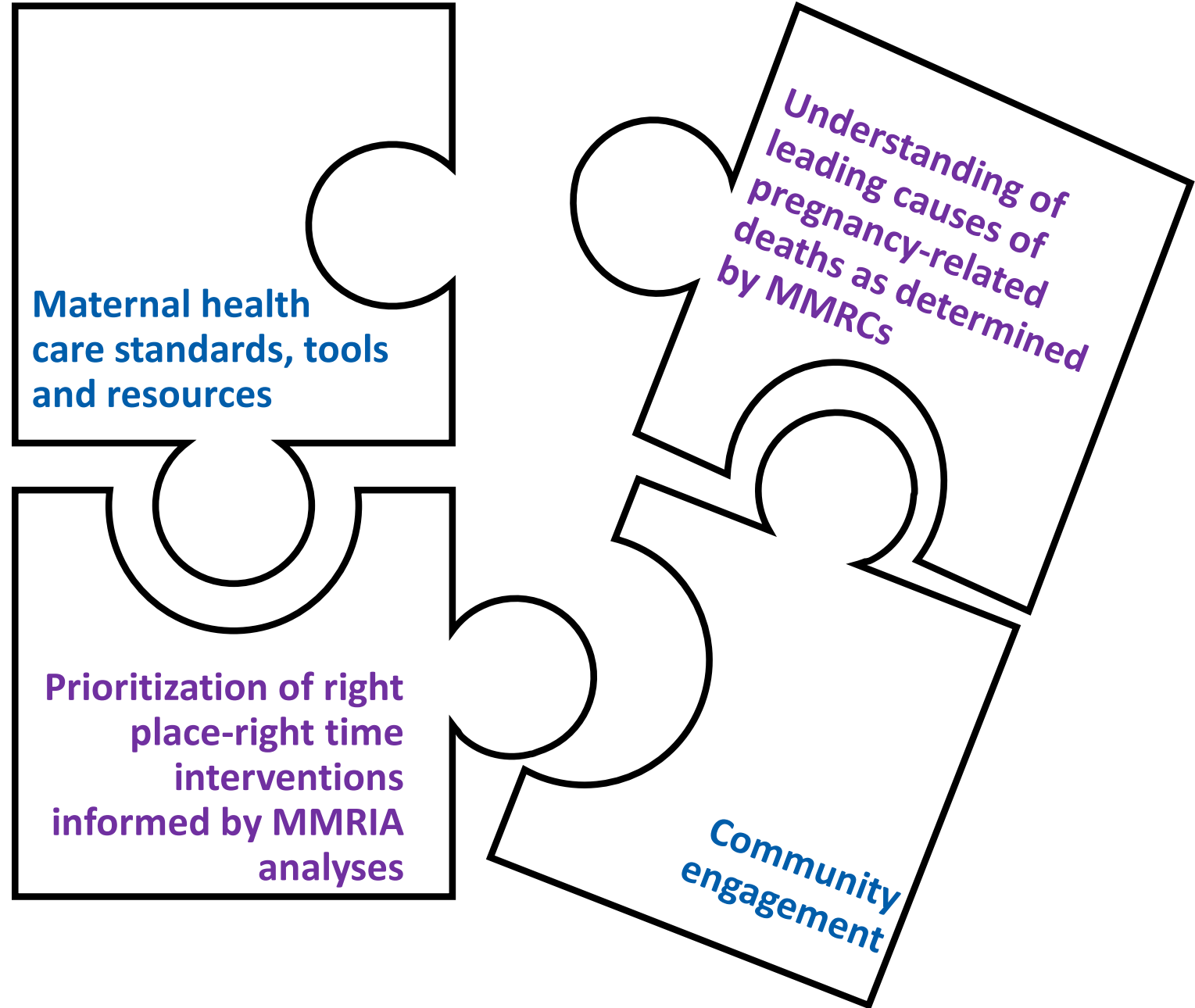


*An MMRC cannot limit its focus to medical drivers alone—doing so will only get to about 50% of the reductions we want to achieve in maternal mortality.*

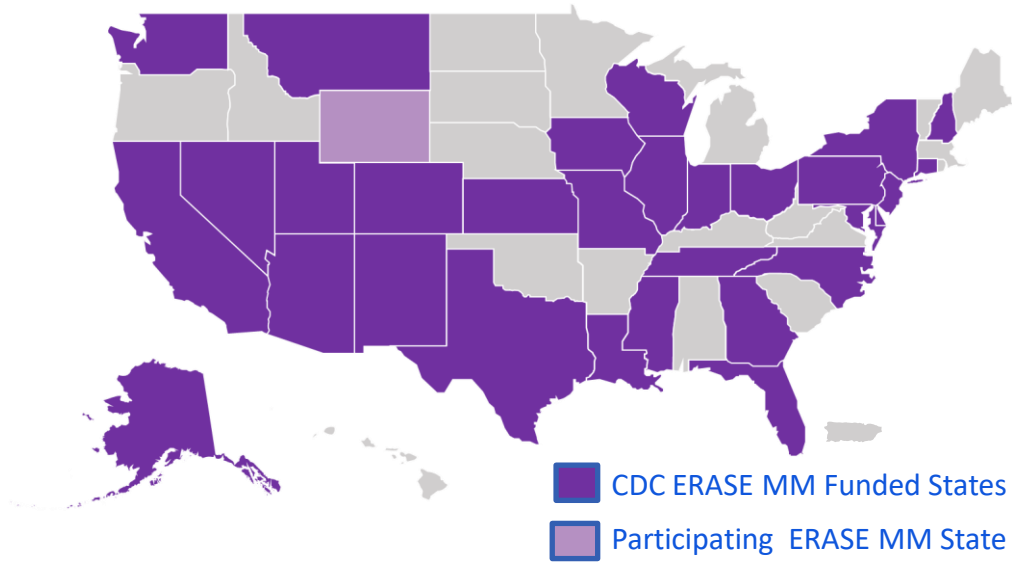
*Include and integrate members who represent community and who understand health policy drivers. It is important that all members be trained in and sensitized to societal, ecological, and historical contexts.*



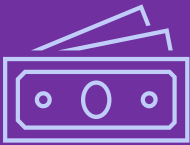

*Training and technical assistance on implementing the Community Vital Signs Web Portal and Recommendations Reference and understanding trauma are important tools.*

# Data informing action

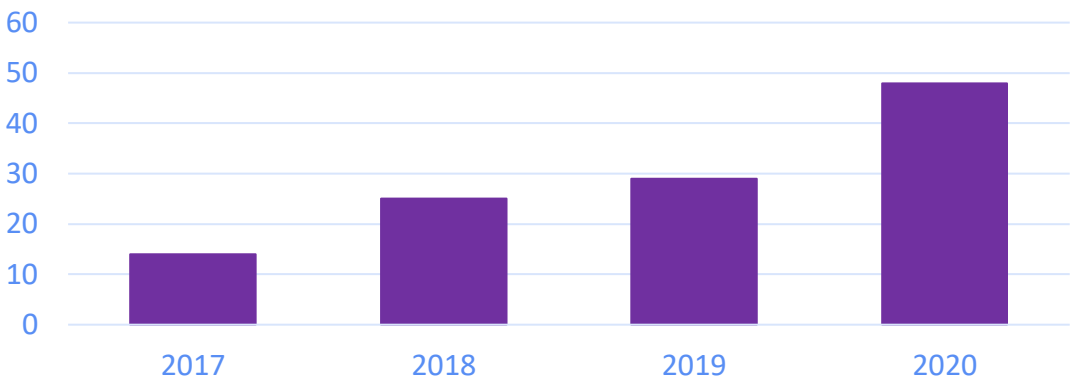


# Investing in Maternal Mortality Review: Enhancing Reviews and Surveillance to Eliminate Maternal Mortality



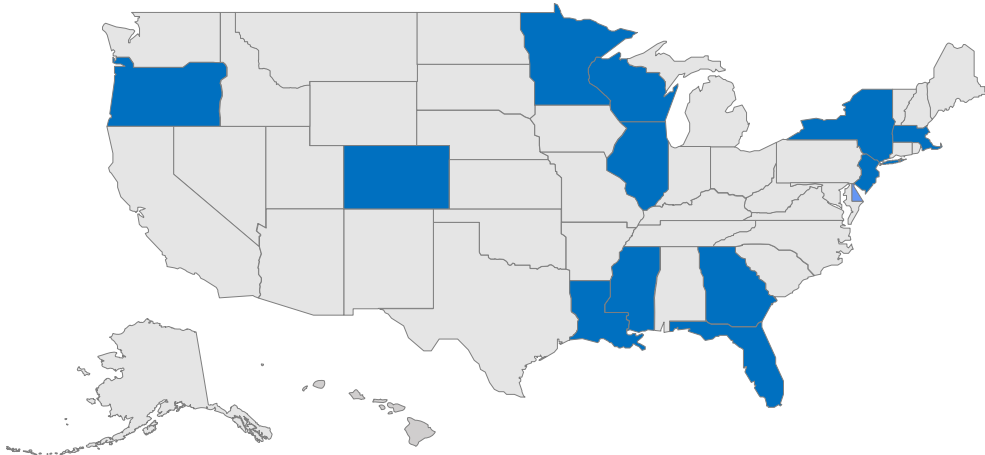
-  Standardized Data System
-  Technical Assistance, Job Aids, Tools, and Training
-  Funding (31 States in FY 21)
-  Innovation

Jurisdictions Using MMRIA

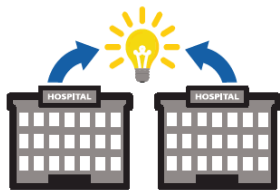




# Building the Infrastructure for Equity: Perinatal Quality Collaboratives (PQCs) Close Gaps in Care



**CDC Funds 13 PQCs and a National Network of PQCs**



**Collaborative Learning**

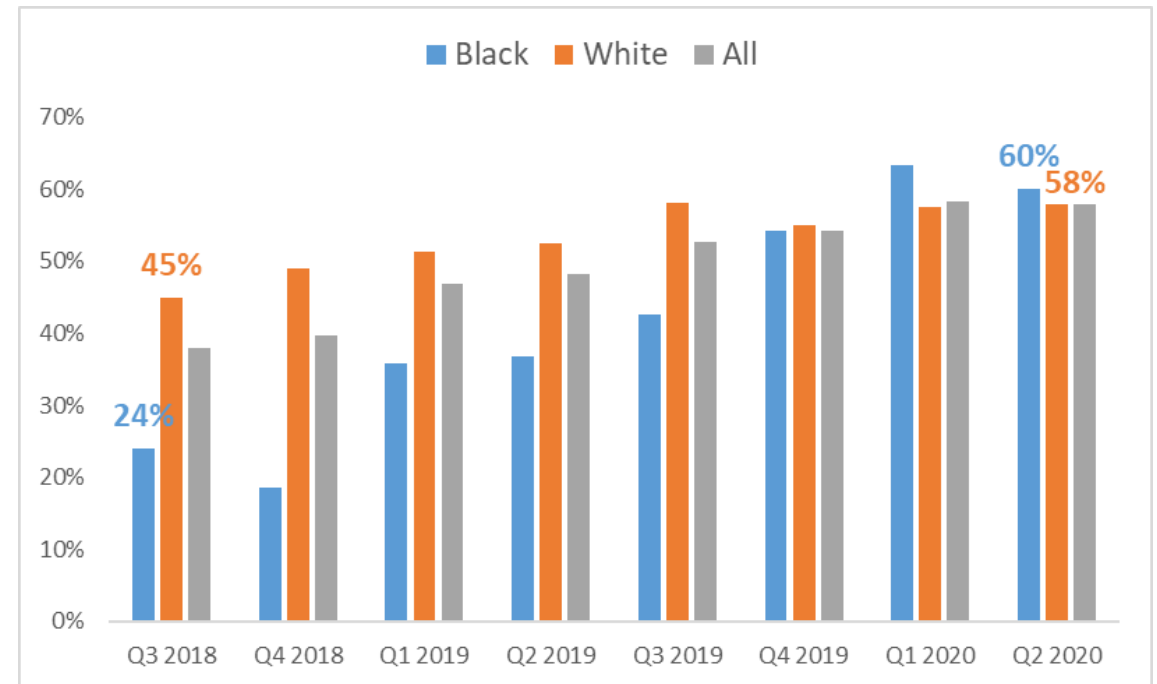


**Rapid Response Data**



**Quality Improvement Science Support**

**Comparison of percent of patients with OUD receiving MAT by delivery discharge by race**



**In Illinois, at baseline, Black patients with OUD were less likely to be on MAT. Across the initiative, improvements in MAT rates were seen for all patients with the greatest improvement for Black patients.**





**Help prevent  
pregnancy-related  
deaths.**

**HEAR**

**HEAR HER CONCERNS**

# Thank you!

For more information, visit  
[www.cdc.gov/erasemm](https://www.cdc.gov/erasemm) or  
contact: [erasemm@cdc.gov](mailto:erasemm@cdc.gov)



The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.