MATERNAL MORTALITY AND MORBIDITY: PREVENTING A CRISIS

LEGISLATIVE OVERVIEW SERIES: 2020 PUBLIC HEALTH SPOTLIGHT

Introduction

Two alarming health trends are increasingly affecting women across the United States: maternal mortality, which is death resulting from pregnancy or delivery complications, and severe maternal morbidity, characterized as short- or long-term mental or physical health consequences resulting from pregnancy or delivery.[1,2]

Research suggests that about half of pregnancy-related deaths are preventable. Maternal mortality review committees (MMRCs) effectively gather information on why pregnancy-related deaths occur and how to best prevent them.[3] At least 40 states now have MMRCs, most of which are established and administered by statute. In 2019 alone, 13 states enacted legislation to establish or modify an MMRC. As more states establish MMRCs, some are seeking a better understanding of maternal morbidity by widening the scope of existing MMRCs or including morbidity reviews in MMRC laws.

BY THE NUMBERS

MATERNAL MORTALITY AND MORBIDITY

7.2 to 16.9
Increase in number of deaths per 100,000 live births between 1987-2016.

665
Number of pregnancy-related deaths in 2016.

50,000+
Number of women affected by severe maternal morbidity in 2014.

200%
Rate by which severe maternal morbidity increased from 1993-2014.

Legislative Trends

MATERNAL MORTALITY REVIEW COMMITTEES

In 2016, Washington state passed a law establishing a maternal mortality review panel. The law directs the secretary of health to appoint panel members and authorizes the panel to access health documentation related to maternal mortality, including medical records. The information collected by the panel is excluded from state disclosure laws and panel members are exempt from testifying in any civil or criminal action related to the information under review. In 2019, the law was amended to require hospitals and licensed birth centers to provide information on maternal deaths to local coroners that the panel could later use.

In 2019, Arkansas enacted legislation requiring the department of health services to establish a MMRC. The committee investigates deaths of women that occur within 12 months post-pregnancy and provides annual policy recommendations to the legislature. In 2019, Oklahoma passed a law making MMRCs responsible for identifying gaps in the provision of healthcare services to pregnant and post-partum women, including poor quality of care, lack of transportation, and lack of financial resources. The law directs committees to recommend improvements to the systems to help reduce preventable mortality among women.

INCLUSION OF MATERNAL MORBIDITY IN REVIEWS
In 2013, Texas created the Texas Maternal Mortality and Morbidity Task Force to study not only pregnancy-related deaths, but also state trends, rates, and disparities in severe maternal morbidity cases. The task force is administered by the state health agency and appointed by the commissioner of health. As with MMRCs in other states, the Texas task force is authorized to access various types of information related to maternal mortality and morbidity; the committee's proceedings remain confidential, and its members are granted immunity from any civil or criminal liability related to their work.

In April 2018, Oregon enacted a law establishing a maternal mortality and morbidity review committee that would also make policy and budget recommendations. The governor appoints committee members and the state health agency governs committee operation.

Looking Ahead

ASTHO expects states to adopt additional laws with the goal of reducing and preventing maternal mortality and morbidity. In addition to establishing or expanding MMRCs, future state legislation may:

- Expand the type of information available for review by MMRCs.
- Improve screening and treatment for postpartum depression and substance use.
- Create maternal health advisory councils for interagency coordination and policy recommendations.

WHAT DO REVIEW COMMITTEES HAVE IN COMMON?

- Oversight by state health agency.
- Access to health documentation and medical records.
- Exclusion of reviewed documentation from open records laws.
- Proceedings protected from criminal and civil liability.

1. U.S. Centers for Disease Control and Prevention (CDC). "Severe Maternal Morbidity in the United States." Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html. Accessed March 10, 2020.
2. CDC. "Pregnancy-related Deaths." Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm. Accessed March 10, 2020.
3. Review to Action. "What Makes Maternal Mortality Review Unique?" Available at: https://reviewtoaction.org/learn/what-makes-maternal-mortality-review-unique. Accessed March 10, 2020.

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