Introduction

Two rising health trends are negatively affecting women’s health across the United States: maternal mortality (death from pregnancy or delivery complications) and severe maternal morbidity (mental and physical health consequences from a pregnancy or delivery).1,2

Research suggests that about half of pregnancy-related deaths are preventable, but in many cases the contributing factors are unknown.3 To address this, maternal mortality review committees (MMRCs) gather information on why pregnancy-related deaths occur and how to prevent them.4 At least forty states have MMRCs, which are convened at the state or jurisdictional level and are mostly established and administered by statute. As the number of states establishing MMRCs grows, some are also beginning to seek a better understanding of maternal morbidity by widen the scope of existing MMRCs or including morbidity reviews in MMRC laws.

Legislative Trends

MATERNAL MORTALITY REVIEW COMMITTEES

In 2019, Arkansas enacted legislation requiring the Arkansas Department of Health to establish a maternal mortality review committee to investigate deaths of women that occur within a year of pregnancy and provide annual policy recommendations to the legislature. Also in 2019, Oklahoma passed a law establishing an MMRC to identify gaps in the provision of healthcare services to pregnant and postpartum women, including poor quality of care, lack of transportation, and lack of financial resources. The committee will provide recommendations to improve systems to help reduce preventable mortality among women.

In 2020, Maryland enacted legislation requiring its MMRCs to include in their meetings women who have experienced near maternal death, high-risk pregnancy, or other challenges, and family members of these women or women who died from complications related to pregnancy or childbirth. The law also requires that specific MMRC stakeholders reflect the racial and ethnic diversity of these populations.

MATERNAL MORTALITY REVIEW COMMITTEE REPORTING

In 2020, Vermont enacted legislation requiring its MMRC to report its findings and recommendations annually to the legislature if the information complies with health privacy laws. It also allows for reciprocal agreements with other states that have MMRCs if privacy and disclosure protections are consistent across the states.

In 2020, Tennessee amended its MMRC’s reporting requirements to be annually instead of every two years. In addition, West Virginia amended its law to require its MMRC to submit an annual report on factors impacting maternal and infant mortality and allowed the panel to submit data to CDC.
INCLUDING MATERNAL MORBIDITY IN REVIEWS IN OREGON

Oregon enacted a law in April 2018 to establish a maternal mortality and morbidity review committee that will also make policy and budget recommendations. Per the legislation, the governor appoints committee members and the state health agency governs committee operation. As with other state MMRCs, the committee is granted access to relevant information (e.g., medical and birth records), its proceedings are confidential, and its members are free from civil and criminal liability related to committee reviews.

Looking Ahead

ASTHO expects states to adopt additional laws aimed at 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.

• Include health equity considerations in the MMRC process.

• Create maternal health advisory councils for interagency coordination and policy recommendations.


