

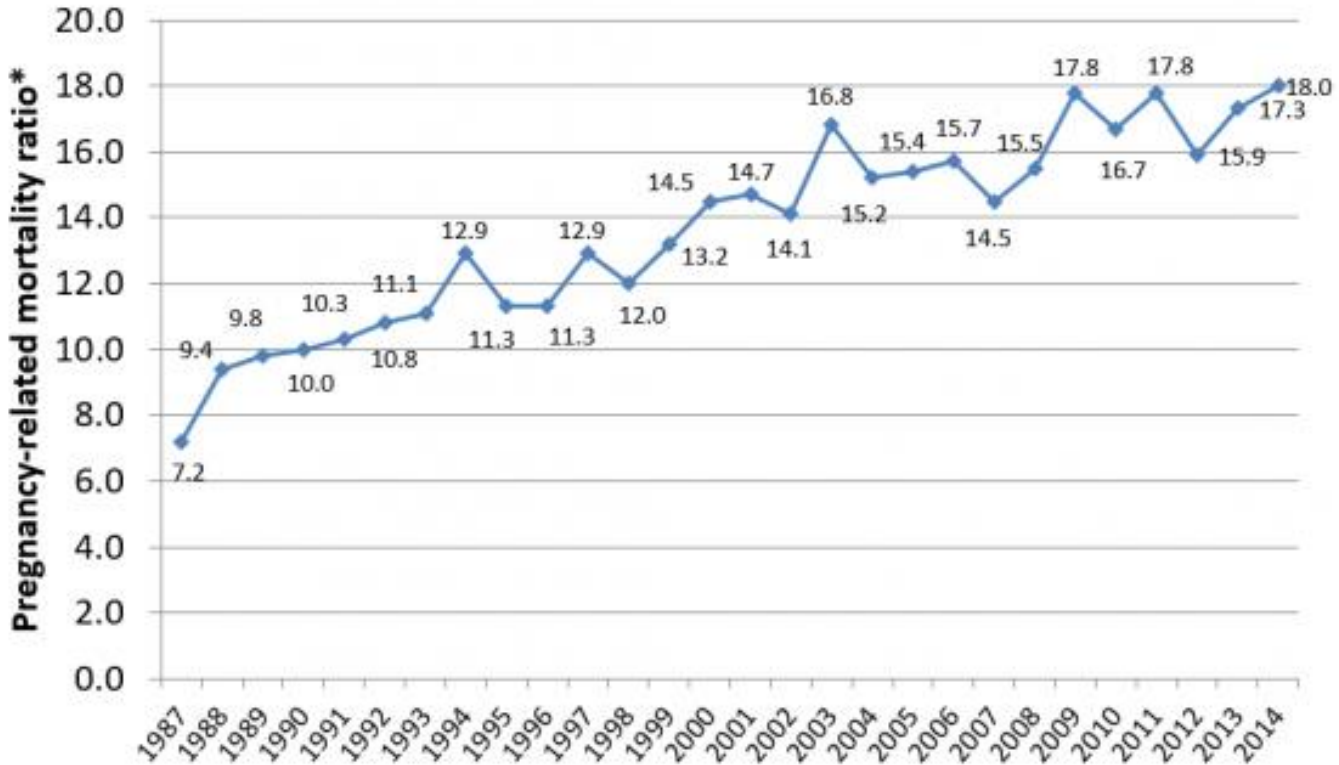
Pennsylvania Maternal Mortality Review Committee

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▶ Maternal Mortality

Maternal mortality has been increasing in the U.S.

**Trends in pregnancy-related mortality
in the United States: 1987–2014**



*Note: Number of pregnancy-related deaths per 100,000 live births per year.

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**

▶ Maternal Drug Use

Maternal Hospital Stays, 2016-2017¹

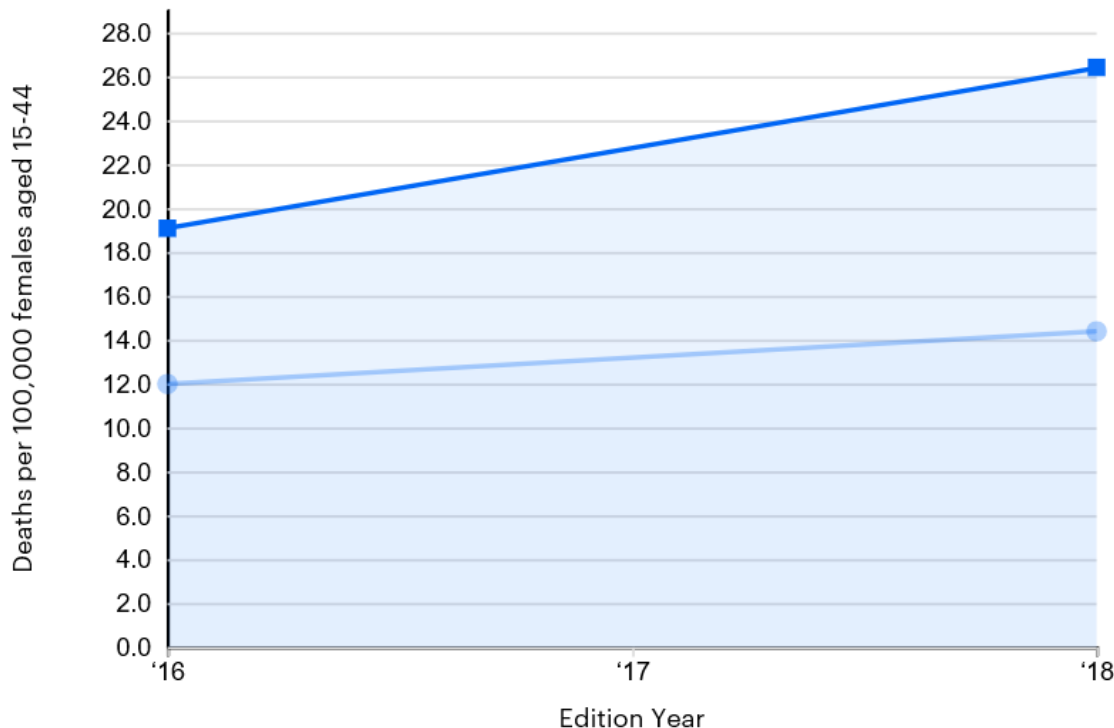
- Substance use (such as opioids, cannabis, cocaine, alcohol, etc.) was present in **1 of every 25 maternal hospital stays** (delivery, as well as other maternal hospital stays)
 - **49 percent involved an opioid**
- Hospital stays with opioid use also had significantly higher rates of co-occurring conditions. Most common co-occurring conditions were **tobacco use (67.3%)** and **mental health disorder (40.0%)**

1. PHC4 Maternal Hospital Stays Involving Substance Use and Opioids
http://www.phc4.org/reports/researchbriefs/opioids/121118/docs/researchbrief_opioids121118.pdf

Drug Deaths, Females aged 15-44

Drug Deaths of Women in Pennsylvania¹

- Age-adjusted number of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined) per 100,000 females aged 15 to 44
- Source: CDC WONDER Online Database, Underlying Cause of Death, Multiple Cause of Death files, 2014-2016



PA: 26.4 (Rank: 46th)

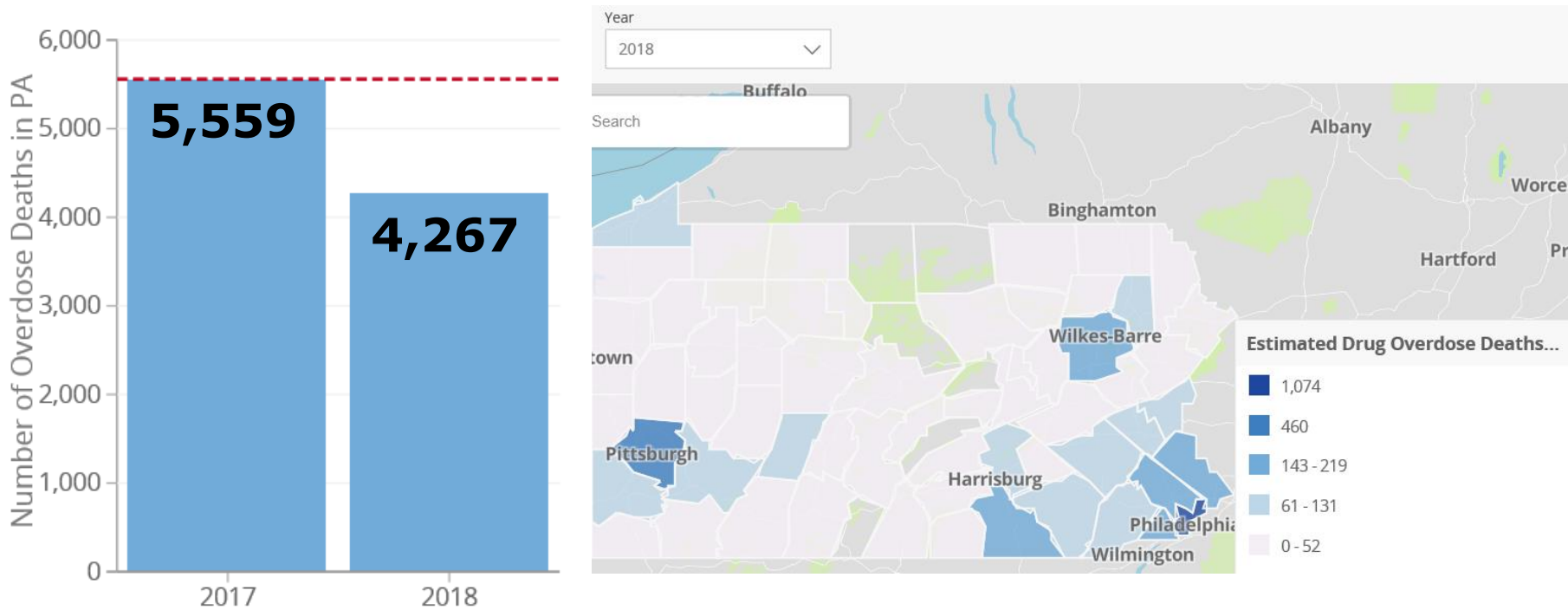
United States: 14.4



1. Americas Health Rankings https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/drug_deaths_women_mch/state/PA

Overdose Deaths in Pa.

Pa. is making progress and preliminary data is showing a decline in drug overdose deaths...



...but there is still more work to do.



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

MMRC Summary

- HB 1869/ Act 24 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

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

Co- Chairs of MMRC

Amanda Flicker, MD, FACOG- Ob/Gyn,
Lehigh Valley Health Network

Stacy Beck, MD- Ob/Gyn,
UPMC, University of Pittsburgh,
Magee Women's Hospital

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.

Scope

Order cases are reviewed:

1. Pa. residents who die in Pa.
2. Pa. residents who die outside of Pa.
3. Non-Pa. residents who die in Pa. and are not already reviewed by another state's MMRC

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

▶ 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
- 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
- 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

Medical Records

- Requests have been made to Pa. hospitals to identify a point of contact for MMRC records requests
- MMRC will request complete records including:
 - Autopsy report
 - Prenatal care record
 - Medical transport records
 - Discharge summaries
 - ER visits/hospital medical records/Labor and Delivery Records
 - Other medical office visits
 - Nursing flow sheets and notes
 - Physician orders/progress notes
 - Social work notes
 - Labs and diagnostic studies

Records requests:
Jessica Beaty, MPH, BSN, RN
jebeaty@pa.gov

Preliminary Data MMRC, 2018 cases for review

- Currently requesting records to review 2018 pregnancy associated deaths (~110 cases)
- 20 percent of those cases are Philadelphia residents and are reviewed by the Philadelphia MMRC
- *Preliminary* leading causes of pregnancy associated death in 2018:
 1. Accidental Poisoning (X40 to X49)
 2. Other Direct Obstetric Deaths (010 to 092)

▶ Case Review

- On average, a review takes 30 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

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 were acted on?

Mock Panel

www.reviewtoaction.org

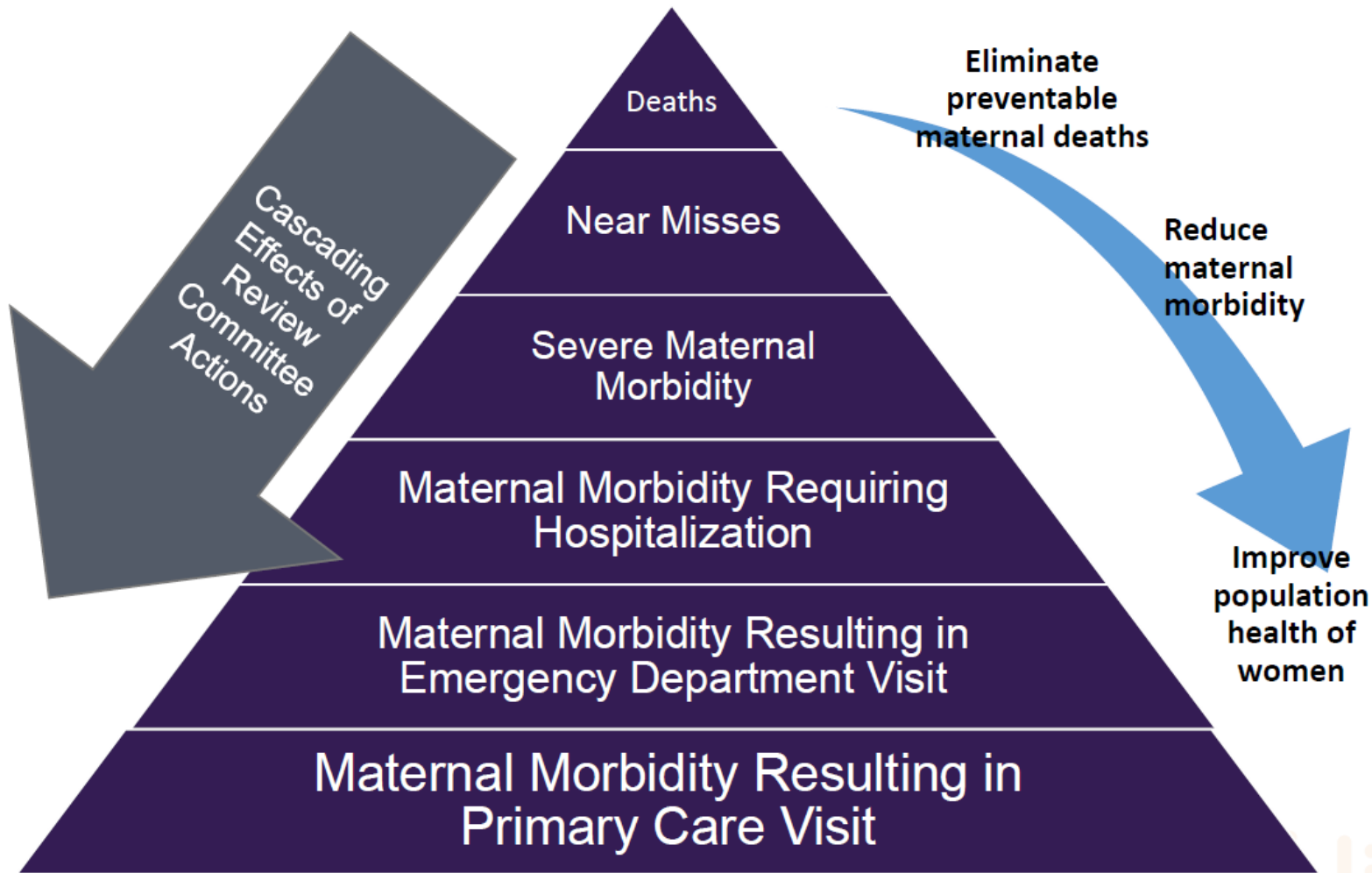
WELCOME

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



Cascading Effects of MMRC



Funding MMRC

- Currently Title V Block Grant Funding provides for one nursing services consultant to facilitate MMRC
- The department is applying for CDC Grant, in partnership with Philadelphia MMRC, to fund additional personnel, education and collaboration efforts.

THANK YOU

Thank you to our PA MMRC and
Philadelphia MMRC Members

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