Title V Maternal and Child Health Services, Infant Mortality, and Maternal Mortality Reviews

Findings and Recommendations

PA PQC Learning Collaborative

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Maternal Mortality Review Committee

(MMRC)

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Maternal Mortality Review Committee (MMRC)

- PA MMRC established 2018
- Case reviews began in 2019 for deaths that occurred in 2018
  - Review included de-identified summaries of pregnancy-associated deaths in the commonwealth regardless of cause of death and including drug-related deaths, homicides, and suicides by multi-disciplinary committee
  - 85 confirmed maternal deaths were eligible for review, of which 44 were reviewed

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Overview of Data

Table 1: Top Causes of Death for All Maternal Deaths (Excluding Philadelphia County) in 2018 (N=85)		
Cause of Death	**Number of Deaths**	**Overall Percentage**
Accidental Poisoning	43	51%
Other Direct Obstetric Deaths	9	11%
Transportation Accidents	8	9%
Assault	7	8%
Other Pregnancy Related	4	5%
Intentional Self-Harm	4	5%

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Figure 3: Age at Time of Death for All Maternal Deaths (Excluding Philadelphia County) in 2018 (N=85)

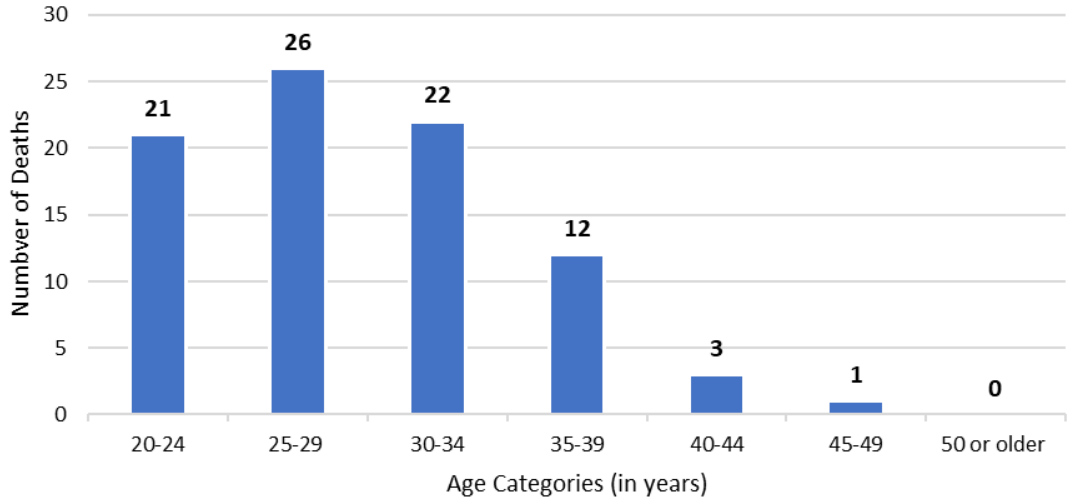
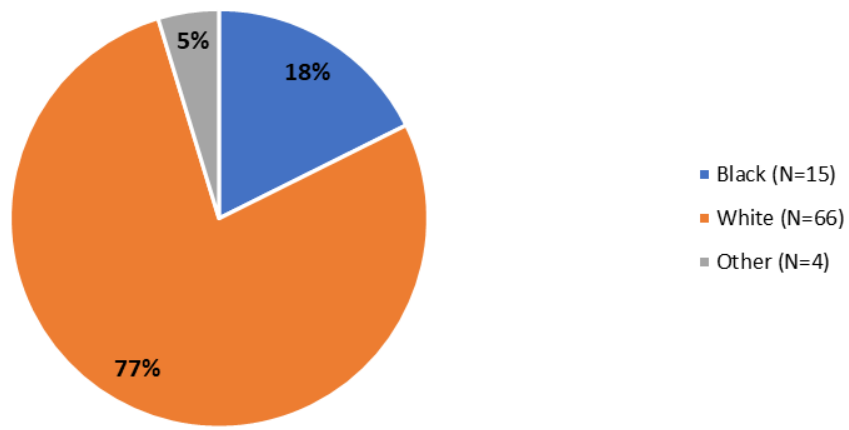


Figure 4: Race for All Maternal Deaths (Excluding Philadelphia County) in 2018 (N=85)



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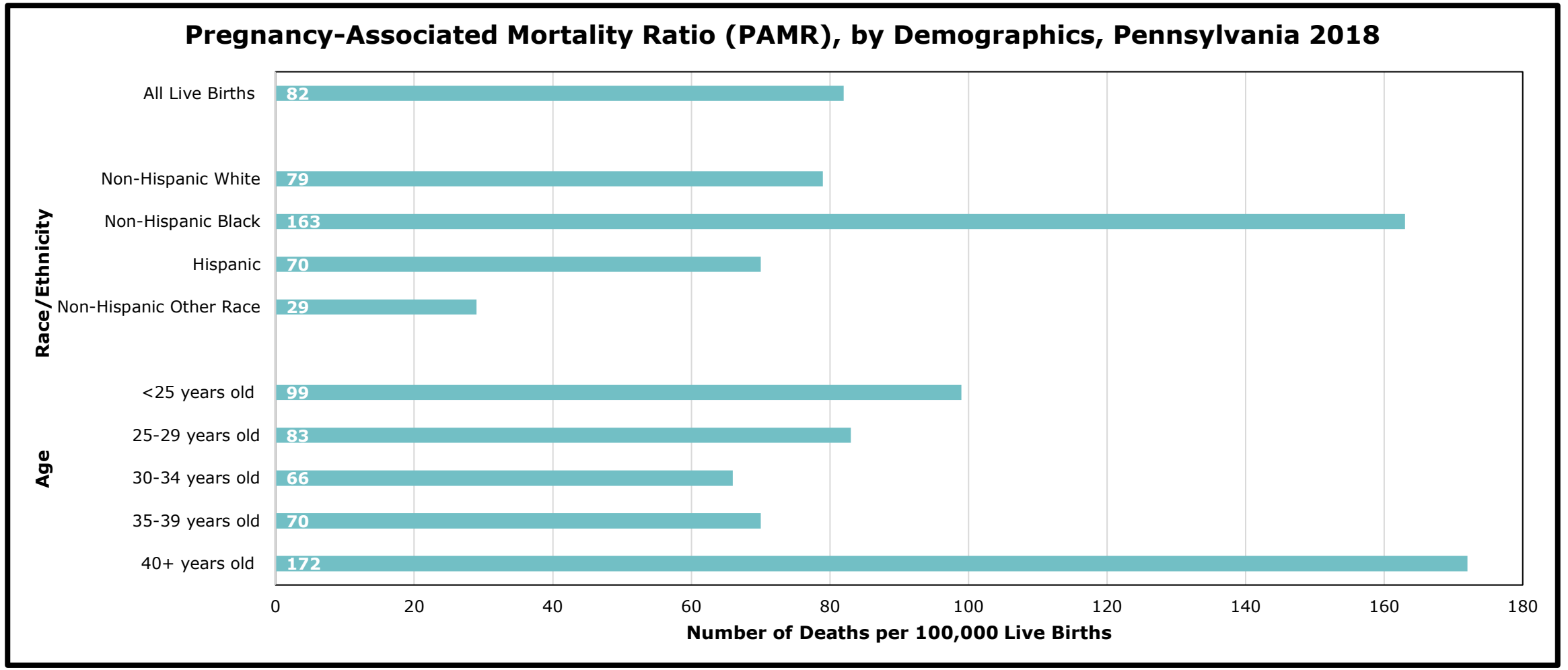
Pregnancy-Associated Mortality Ratio (PAMR)



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Overview of Data

Figure 5: Pregnancy-Relatedness Status Determination for the 2018 Maternal Deaths Reviewed by PA MMRC (N=44)

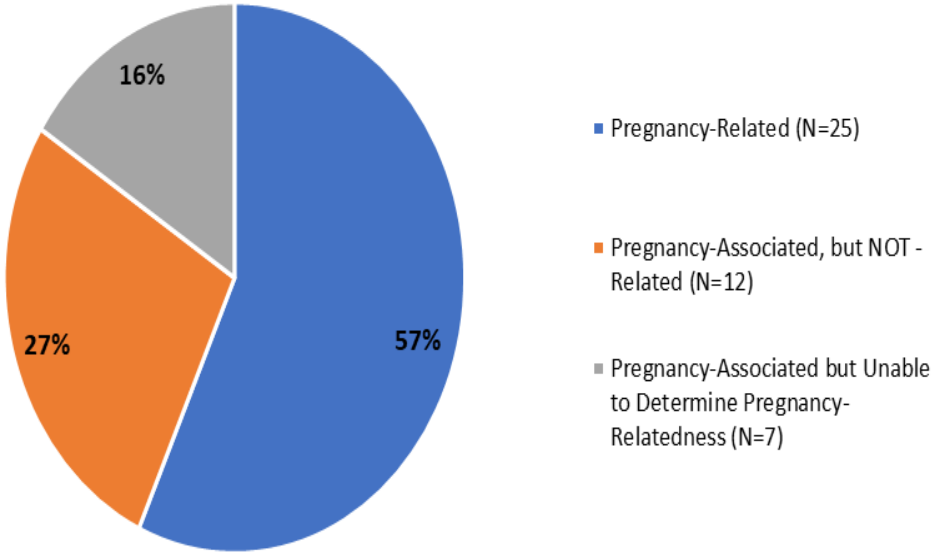
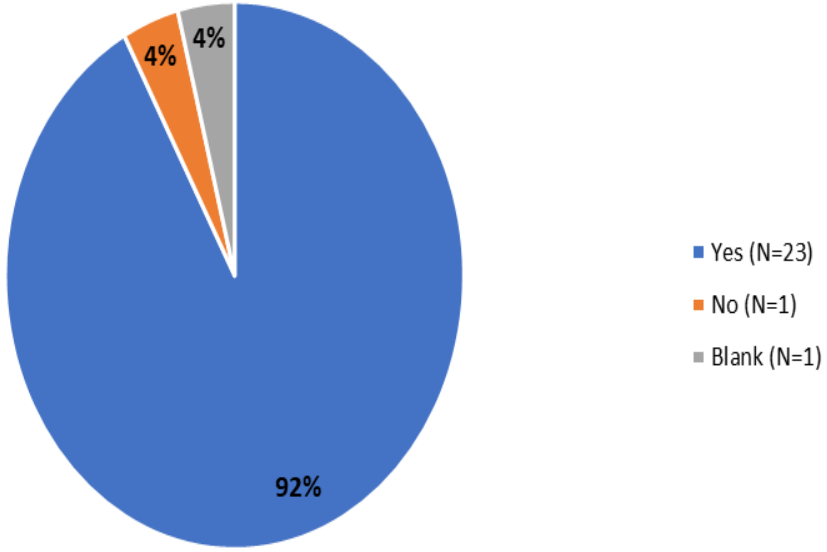


Figure 6: Preventability Determination for the 2018 Pregnancy-Related Maternal Deaths Reviewed by PA MMRC (N=25)



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Recommendations:

- 135 recommendations were documented through the case review process and categorized by Committee members into overarching themes with specific recommendations to improve maternal health outcomes
- Full recommendations can be viewed in Pennsylvania Maternal Mortality Review:

  2021 Report

https://www.health.pa.gov/topics/Documents/Programs/2021%20MMRC%20Legislative%20Report.pdf

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Recommendations:

Recommendations to build infrastructure to:

- Identify and support pregnant and postpartum individuals with mental health concerns
- Identify and support pregnant and postpartum individuals who use substances
- Provide more comprehensive medical care for all pregnant and postpartum individuals
- Identify and support pregnant and postpartum individuals with a history of intimate partner violence

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MMRC Moving Forward

- Committee opted to skip to 2020 case reviews in order to have more timely evaluation of data
- Committee membership was updated at beginning of 2022 to assure statewide representation and acquisition of members as per legislative requirements
- 37 cases reviewed throughout 6 meetings
  - 30 cases were reviewed by full committee
  - 7 cases were internally reviewed

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Child Death Review

Infant Fatalities 2016-2020

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Infant Mortality Reviews in PA

Child Death Review

- Act 87 of 2008
- Reviews resident deaths children birth through age 21 years
- No identified group to refine and implement prevention strategies
- Parent/Family interview permissible but not done

Fetal and Infant Mortality Review

- No statutory requirement
- Reviews resident fetal and infant deaths
- Two-tiered review model
  - Review Team- Process information
  - Community Action Team- Refine and implement prevention strategies
- Parent/Family interview

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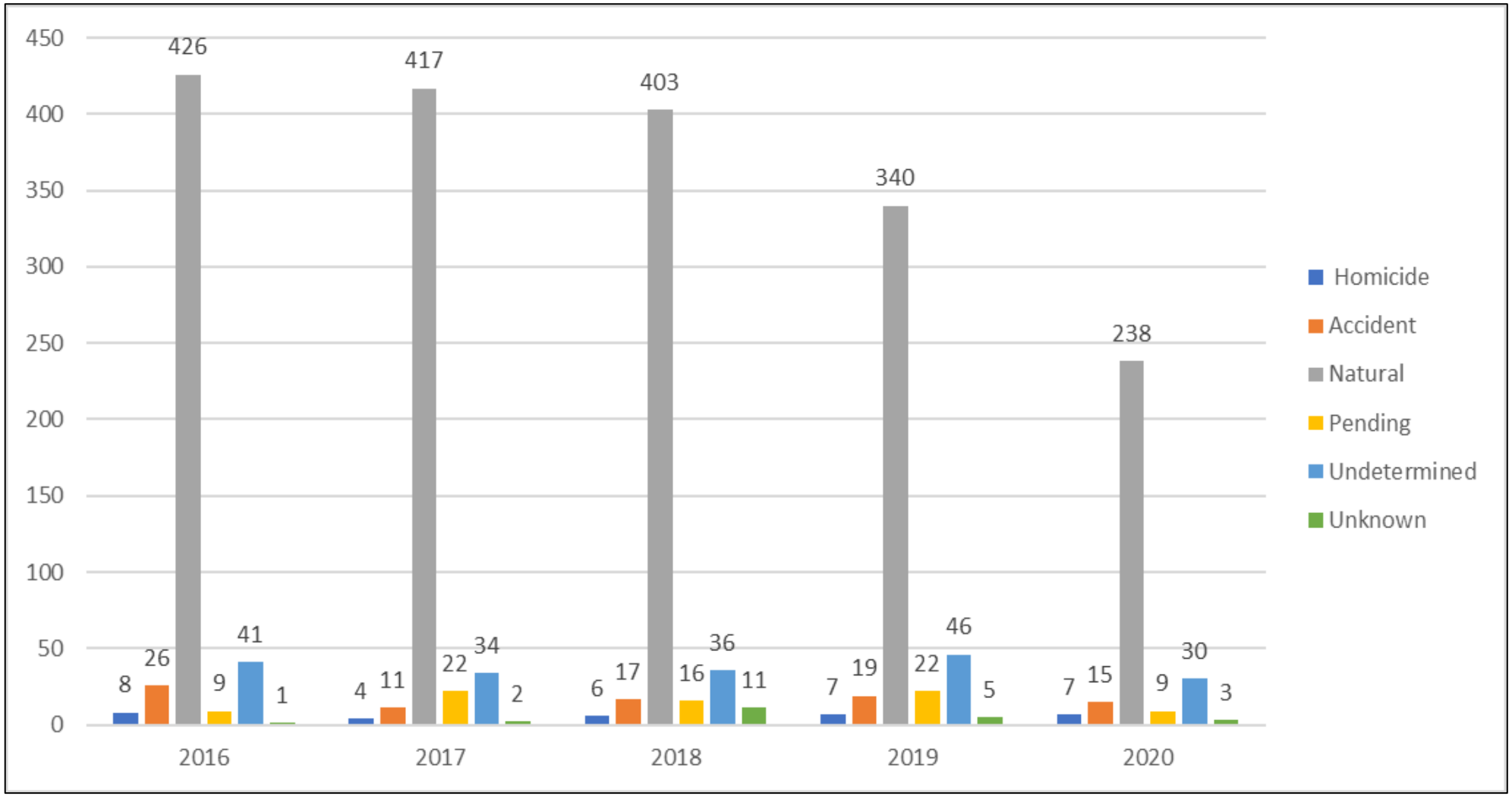
Reviewed Infant Deaths by Manner 2016-2020



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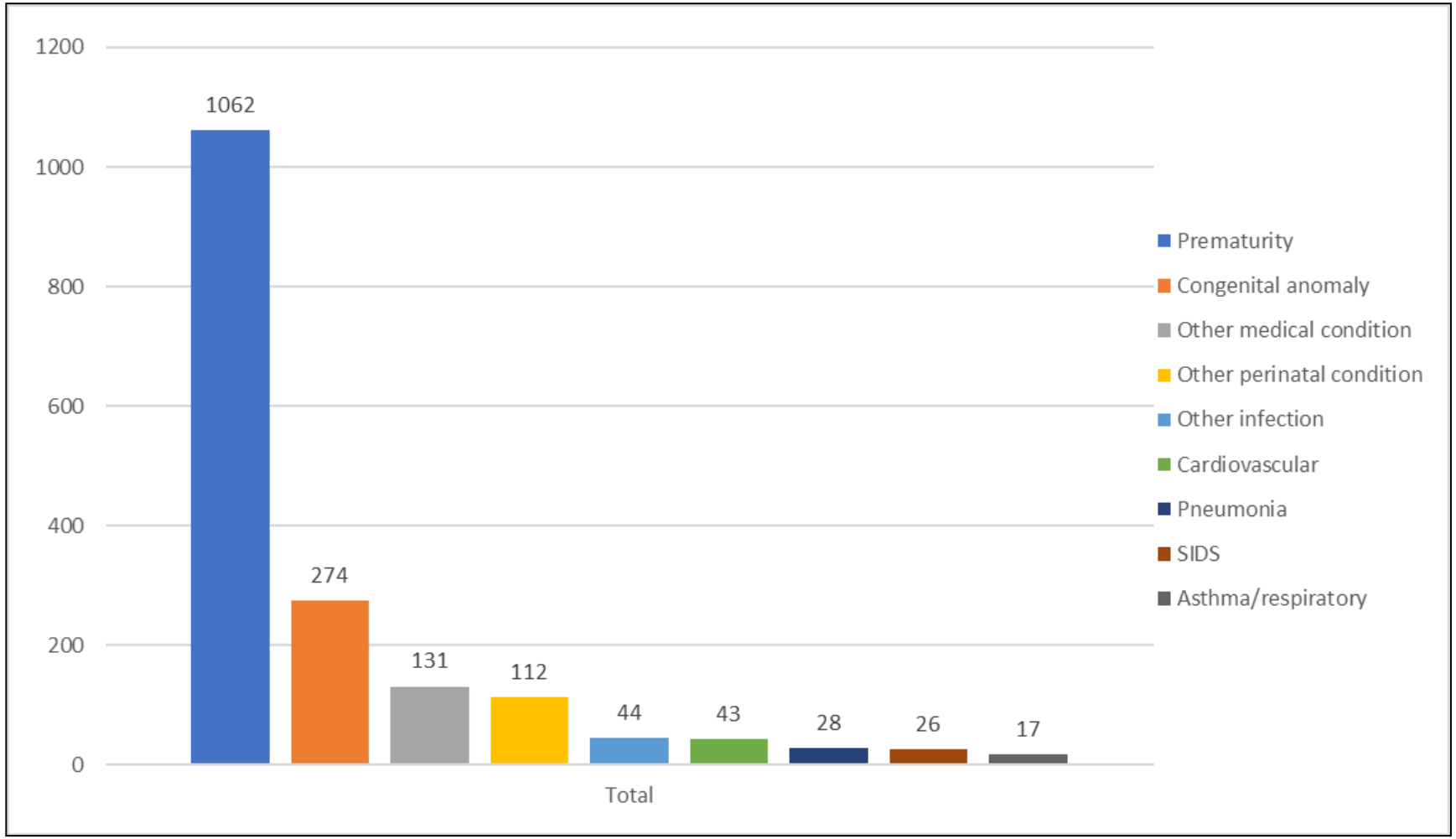
Reviewed Natural Infant Deaths by Cause 2016-2020



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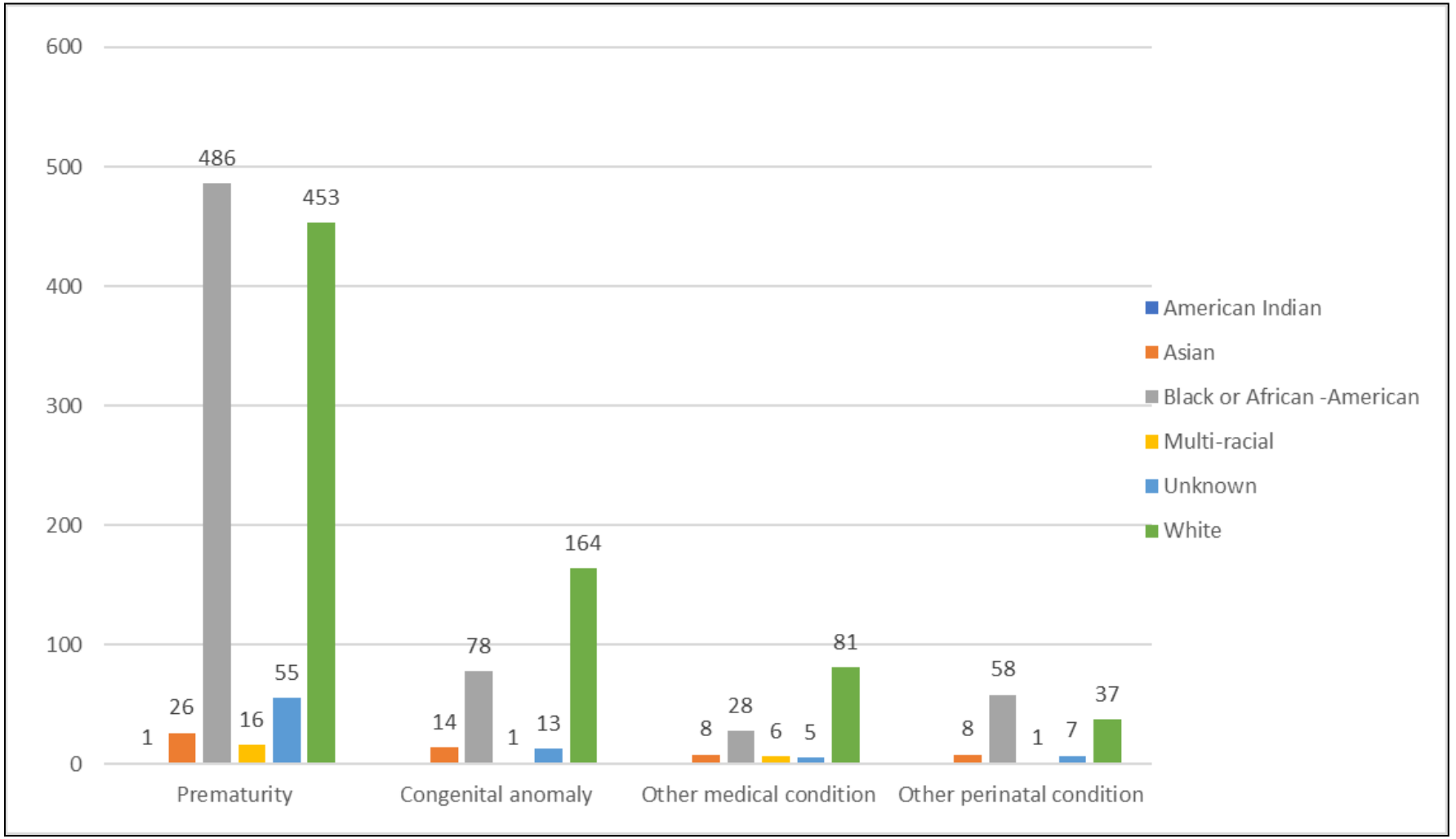
Reviewed Causes of Natural Infant Deaths by Race 2016-2020



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Local CDR Team Identified Risk Factors 2016-2020

- Not using a safe sleep place
- Co-sleeping
- Birthing parent tobacco use
- Lack of prenatal care
- Caregiver substance misuse

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Local CDR Team Recommendations(2016-2020)

- Safe sleep education
  - Falling asleep while breast feeding
  - Education at post natal/pediatric visits
  - Couch/chair/adult bed dangers
- Education on early prenatal care
- Postnatal birth control education
- Confidential sources for information on pregnancy

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Title V Maternal and Child Health Services Block Grant Priorities and Measures

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Title V Priorities and Performance Measures

Priorities

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity.
2. Reduce rates of infant mortality (all causes), especially where there is inequity.
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs.
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system.
5. Reduce rates of child mortality and injury, especially where there is inequity.
6. Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development.
7. Support and effect change at the organizational and system level by supporting and promoting policies, programs and actions that advance health equity, address the social, environmental and economic determinants of health and deconstruct institutionalized systems of oppression.

Maternal and Infant Health National and State Performance Measures

- NPM1: Percent of women, ages 18 through 44, with a preventive medical visit in the last year
- NPM4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM5: A) Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, and C) Percent of infants placed to sleep without soft objects or loose bedding
- SPM1: Percent of newborns with on time report out for out of range screens
- SPM3: Percent of hospitals making referrals to Early Intervention
- SPM4: Percent of eligible infants with a Plan of Safe Care
- SPM6: Rate of mortality disparity between black and white infants
- SPM8: Rate of maternal mortality disparity between black and white persons

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Title V Resources

- PA DOH Title V Webpage
- Title V Executive Summary Fact Sheet
- Title V Women/Maternal Health Fact Sheet
- Title V Perinatal/Infant Health Fact Sheet

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