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Maternity Care in Crisis

1/11/2019

American Women Are Dying From Childbirth at a Higher Rate Than in Any Other Developed Country

By Tahra Johnson

Kira and Charles Johnson were excited to welcome a second son into their family. Langston was to be delivered, like his older brother, by cesarean section on April 12, 2016. The Johnsons knew what to expect and were prepared for Kira's recovery. Or so they thought. While Kira was still in the hospital, Charles noticed blood in her catheter. He alerted the medical staff immediately, but hours went by before Kira could get a CT scan. By the time she went into surgery, it was too late.

Kira died 11 hours after delivering her baby.

Like hundreds of other American women that year, Kira died due to a delayed response to complications from pregnancy delivery. "Seven-hundred mothers die every year, and over 50,000 others experience dangerous complications that could have killed them—making the U.S. the most dangerous place in the developed world to give birth," Stacey D. Stewart, president of the March of Dimes, told the U.S. Energy and Commerce Subcommittee on Health in September last year. In fact, an American woman is three times more likely to die from childbirth than a Canadian woman and six times more likel than a Scandinavian woman. Kazakhstan and Libya have better rates than the U.S.

"This situation is completely unacceptable," Stewart said.

Uptick in Maternal Deaths

The national maternal mortality rate more than doubled between 1987 and 2012 and now sits at 20.7 deaths per 100,000 live births, according to the Centers for Disease Control and Prevention. The average maternal mortality rates for each state from 2011 to 2015 varied from 4.5 to 47 deaths per 100,000 live births.

Any time a woman dies while pregnant or within one year of the end of a pregnancy from any cause related to the pregnancy or its management, the CDC considers it a pregnancy-related death. The agency does not include deaths from accidental or incidental causes, such as dying in a car wreck while pregnant.

Different recording practices used over the years, however, make it hard to draw definitive conclusions on maternal death

rates. According to a 2017 article in the journal Obstetrics & Gynecology, the current coding rules can negatively affect da quality. If the "pregnancy or post-partum within 42 days" box is checked, for example, the record is coded as a maternal death, regardless of what is written in the cause-of-death section. In some states, better information is available because maternal mortality review committees examine death records and decide whether the cause was pregnancy-related.

A 2018 report from nine review committees shows that most deaths are preventable, especially those involving delayed emergency care, as in Kira Johnson's case, or a lack of protocols for responding to labor and delivery complications.

Severe Maternal Morbidity

Deaths are not the only concern. For every maternal death in the United States, as many as 70 to 100 women experience severe maternal morbidity, or "near misses." Morbidity includes unexpected events during labor and delivery, like uncontrolled bleeding or serious infections.

After U.S. tennis star Serena Williams opened up about her near-death experience after delivering her baby girl, the issue received national attention. Williams developed a blood clot in her lungs. "I just remember getting up and I couldn't breath I couldn't take a deep breath," she recalled in her HBO docuseries "Being Serena." Williams had experienced a similar incident about five years earlier and knew to ask the medical staff for a CT scan with dye. She received the scan and endured three subsequent surgeries.

"I'm not someone who takes their health for granted," Williams said. "With as many issues and scares as I've had, I think I've learned pretty well how to listen to my body."

Aiming for Answers

So, why are mortality and morbidity rates increasing in the United States while they're decreasing almost everywhere else? The reasons are unclear. Increases in maternal age, pre-pregnancy obesity, poverty, untreated pre-existing chronic medical conditions, the high number of cesarean deliveries and a lack of access to health care, especially in rural areas, all could be factors contributing to the upswing in maternal deaths in the U.S.

With support from the Maternal and Child Health Bureau in the federal Health Resource Services Administration, at least 13 states and more than 667 hospitals are working with the Alliance for Innovation on Maternal Health, known as AIM, to put in place a set of effective, proven practices. The program works directly with practitioners in health care facilities, including hospitals, who perform 1,780,000 births a year, or 45 percent of the annual U.S. total.

Want to Know More?

The Review to Action website offers state profiles, contacts, examples of state statutes and other resources to help maternal mortality review committees. You can also get the Maternal Mortality Review Information Application, aka MMRIA or "Maria." The app is provided free of cost to review committees for their own use in collecting and analyzing data on maternal deaths and opportunities for action.

Among the program's tools are "maternal safety bundles"—one- to two-page briefs divided into bulleted sections with reminders for staff on how to prevent, recognize, respond to and report on a variety of conditions. When performed collectively and reliably, the strategies work. Safety bundles cover such topics as:

- Early-warning signs of complications.
- Hemorrhage.
- Hypertension.
- Vaginal births.
- Racial disparities.
- Basic postpartum care.
- Care for opioid-dependent women.

The American College of Obstetricians and Gynecologists reports that Illinois reduced severe maternal morbidity by about 22 percent and morbidity due to hypertension by nearly 20 percent through the AIM initiative. Oklahoma reduced severe maternal morbidity by roughly 20 percent in its participating hospitals.

A Better Review Process

About half the states have established a comprehensive maternal mortality review committee to examine deaths and identify areas for improvement. The committees typically include public health workers, obstetricians and gynecologists, maternal-fetal medicine experts, nurses, midwives, forensic pathologists, and those in the mental and behavioral health fields. Some include social workers or patient advocates.

Despite recent national attention, a few states created these committees more than 15 years ago. Maryland's review program, which was established in 2000, is required by statute to:

- Identify maternal death cases.
- Review medical records and other relevant data.
- Determine preventability of death.
- Develop recommendations to prevent maternal deaths.
- Disseminate findings and recommendations to policymakers, health care providers, health care facilities and the public.

Georgia's legislature created a review committee through legislation sponsored by Senator Renee Unterman (R). It convened for the first time in 2012.

"Unfortunately, Georgia was ranked high in maternal and infant mortality. We were ranked five years in a row as the best state to do business in. How can we be ranked that way and not be doing well for our moms and babies?" she asks.

Georgia's law provides legal protections for committee members and the review process, ensures confidentiality and gives the committee the authority to collect data for case review. The state also piloted programs to improve access to care in rural areas. The Centering Pregnancy program puts pregnant women into groups where, in addition to medical care, they receive emotional peer support; education about nutrition, labor and delivery; breastfeeding and self-care advice; depression screening and group interaction. The program lowered the risk of preterm birth by 33 to 47 percent. Medical practices in at least 46 states have adopted the Centering Pregnancy model.

Data Delivers

Dr. Morgan McDonald is the assistant commissioner and director of the Division of Family Health and Wellness at the Tennessee Department of Health. She has overseen the implementation of 2016 legislation that created the committee there.

"Data is the first benefit with a maternal mortality review committee," she says. "Until it's in place, you just have vital records and it relies on the coding and timing of death, which may not give you the information you need."

The review process verifies whether a death was related to pregnancy and identifies factors that may have prevented that death. The legislation for Tennessee's review committee took effect in 2017.

"I can't overestimate the impact of the maternal mortality review legislation in Tennessee," McDonald says. "It has galvanized the prevention and I have no doubt it will direct our efforts to reduce our maternal mortality rate. It is a big win for women's health and for everybody, that is not controversial."

Tennessee Senator Sara Kyle (D) says she hopes the legislation will help prevent "senseless" maternal deaths. "Studies

show us that America's maternal mortality rate is higher than in any other developed country, and Tennessee's is above th national average. I think we have to ask ourselves the tough question: Why are these pregnant women dying at a higher rate than in any other developed country?"

To date, only California has successfully reduced its maternal mortality rate. The state's Department of Public Health calculates that between 2006 and 2013, the rate fell by 55 percent, from 16.9 to 7.3 deaths per 100,000 live births. Currently, the rate is 4.5, the lowest by far of any state.

California used data collection and information from its review committee to focus on improving labor and delivery in hospitals. In short, the state linked birth and death records, hospital data files and coroner reports; reviewed each pregnar cy-related death; and translated findings into quality-improvement initiatives that could be used statewide. To support the state's hospitals, the California Maternal Quality Care Collaborative, a public-private partnership, created informational toolkits with C-section and early-delivery rates and other statistics to identify where improvements could be made. These toolkits were the model that the Alliance for Innovation on Maternal Health used to create its maternal safety bundles—the how-to guides now being used in birthing facilities in 18 states.

Hope on the Horizon

State legislatures will continue to explore opportunities to improve their maternal care systems, so that families don't have to face the pain of losing a mother and wife the way Kira Johnson's family did.

"I do not have the words to describe the loss my family has suffered," Kira's husband, Charles, told the U.S. Energy and Commerce Subcommittee last fall. "My boys no longer have their mother. Kira was the most amazing role model and mother any boy could ever wish to have."

In a sign that the maternal mortality crisis is getting needed attention, President Trump signed the bipartisan Preventing Maternal Deaths Act of 2017 on Dec. 22 last year. The new law authorizes programs to promote safe motherhood and to support states in establishing or improving maternal mortality review committees, so officials can better understand how to keep moms alive and healthy.

It could be a meaningful step toward changing America's regretful status as the most dangerous place in the developed world for a woman to have a baby.

Tahra Johnson directs NCSL's maternal and child health program.

A Troubling Trend

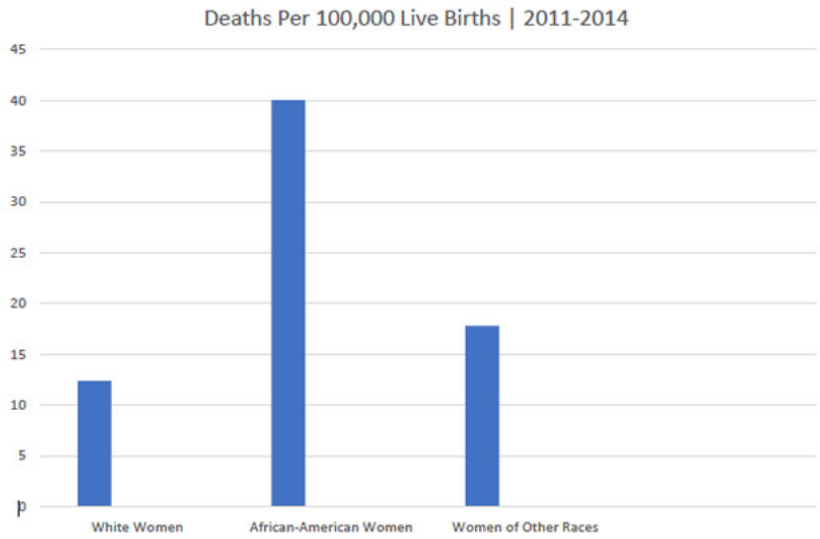
There is significant racial disparity in health outcomes in the United States. Not only are African-American women 22 percent more likely to die from heart disease and 71 percent more likely to perish from cervical cancer than white women, they also are 243 percent more likely to die from pregnancy- or childbirth-related causes, regardless of their socioeconomic or educational levels.

Research shows that chronic stress, often higher in African-American women, takes a physical toll during pregnancy and childbirth. "As women get older, birth outcomes get worse. ... If that happens in the 40s for white women, it actually starts to happen for African-American women in their 30s," says Dr. Michael Lu, a professor at George Washington University and former associate director of the Maternal and Child Health Bureau of the Health Resources and Services Administration.

The United States is one of just 13 countries where the rate of maternal mortality—the death of a woman related to pregnancy or childbirth up to a year after the end of pregnancy—is now worse than it was 25 years ago, The New York Times reports. There are an estimated 700 to 900 maternal deaths in the United States annually. And every year the Centers for Disease Control and Prevention records more than 50,000 potentially preventable near-deaths—a number that increased some 200 percent from 1993 to 2014, the last year for

which figures are available.

Black women are three to four times as likely to die from pregnancy-related causes as their white counterparts, according to the CDC.



Source: Centers for Disease Control and Prevention

What causes the black-white divide? The reasons have been debated by researchers and doctors for more than two decades, according to the Times report. But, as the newspaper explained it, there has been growing acceptance of what, for many, is a shocking idea: "For black women in America, an inescapable atmosphere of societal and systemic racism can create a kind of toxic physiological stress, resulting in conditions—including hypertension and pre-eclampsia—that lead directly to higher rates of infant and maternal death. And that societal racism is further expressed in a pervasive, longstanding racial bias in health care—including the dismissal of legitimate concerns and symptoms—that can help explain poor birth outcomes even in the case of black women with the most advantages."

As Dr. Sanithia L. Williams, an African-American OB-GYN in the Bay Area and a fellow with the nonprofit organization Physicians for Reproductive Health, told the newspaper, "Actual institutional and structural racism has a big bearing on our patients' lives, and it's our responsibility to talk about that more than just saying that it's a problem. That has been the missing piece, I think, for a long time in medicine."

For more on the treatment of people of color, particularly black people, in the U.S. health care system, see the 2002 report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," published by a division of the National Academy of Sciences.

Additional Resources

NCSL Resources

- Subscribe to State Legislatures magazine
- State Legislatures homepage

Denver

7700 East First Place
Denver, CO 80230
Tel: 303-364-7700 | Fax: 303-364-7800

Washington

444 North Capitol Street, N.W., Suite 515
Washington, D.C. 20001