

Beyond The Preventing Maternal Deaths Act: Implementation And Further Policy Change



Maternal mortality is a death that occurs during pregnancy or within one year postpartum from “a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.” In the United States, maternal mortality is a clinical, public health, and social crisis. Between 1990 and 2013, maternal mortality nearly doubled in the US, while it declined elsewhere across the globe. The United States stands shamefully alone, and it is getting ever more deadly to give birth in the US. Statistics also show pernicious inequities in maternal and child health, with black women and infants being more likely than whites to die around the time of childbirth. Compared to families living in urban areas, rural women face greater risks in childbirth, and their infants are less likely to survive to celebrate their first birthday.

Despite these trends, the United States has only recently joined the rest of the developed world in establishing an infrastructure for systematically assessing maternal deaths. On December 21, 2018, the [Preventing Maternal Deaths Act](#) (HR 1318) was signed into law. This [legislation](#) sets up a federal infrastructure and allocates resources to collect and analyze data on every maternal death, in every state in the nation. The bill is intended to establish and support existing [maternal mortality review committees](#) (MMRCs) in states and tribal nations across the country through federal funding and reporting of standardized data.

The lives of women across this nation depend on the success of this legislation, including thoughtful implementation, consistent with the law's intent, as well as additional policy change to support the law in reaching its goals.

Maternal Mortality Review Committees: Variability Across States

While all [MMRCs](#) collect information to try to understand factors related to deaths during pregnancy, delivery, and the postpartum period, including health care and clinical factors, some also focus on [social determinants of health](#), such as housing, food access, violence, community safety, structural racism, and economic circumstances. Using the data gathered, MMRCs are optimized when they [provide recommendations and develop strategies](#) to prevent problems that arise during the prenatal and postpartum period.

Many state committees consist of public-private partnerships involving health providers, state department of health staff, and representatives from maternal and child health related organizations. In 2016, a collaboration among the [Association of Maternal & Child Health Programs](#), the [Centers for Disease Control and Prevention \(CDC\) Foundation](#), and the CDC's [Division of Reproductive Health](#) initiated [the Building US Capacity to Review and Prevent Maternal Deaths program](#), an effort aimed at assisting states in

launching and improving the capacity of MMRCs.

We reviewed available evidence to better understand the current status of maternal mortality reviews across the United States. Thirty-eight states have active MMRCs recognized by the CDC. Several more recently passed laws but have not yet begun reviewing cases. A total of 46 states and the District of Columbia now hold some level of maternal death review, a steady increase from the 22 committees that existed in 2010. Authorization is in place in 33 states and the District of Columbia that codifies these committees in statute.

We serve on the MMRCs in Minnesota, Indiana, Pennsylvania, and formerly Georgia and Tennessee, and we know that state MMRCs currently vary in how data are collected, which data are collected, how frequently these are reported, to whom, and who has access to maternal mortality data. This variability affects the nature of the evidence collected and the conclusions that can be drawn from the work of MMRCs. State laws and regulations also vary in describing the potential or required uses of information gleaned from these committees and any next steps or actions. For example, some states only mandate review and development of internal reports with no required action, while other states also mandate follow-up action via system-level changes. A few states experiencing small numbers of maternal deaths have either expanded their MMRCs to include severe maternal morbidity or have combined review of maternal deaths with other death reviews such as fetal and infant mortality reviews. This wide variability motivated the passage of federal legislation and is the starting point for implementation of the Preventing Maternal Deaths Act.

Implementation And Funding

While enormously important, the passage of the Preventing Maternal Deaths Act is just a first step, not a panacea. The implementation and financing of the act is just as important—perhaps even more important—than the language of the law itself.

Key implementation decisions require attention to the heterogeneity of current MMRCs and could guide greater consistency and utility of the data that are collected. Based on our experiences in numerous different states, these could include

1. How deaths are identified and flagged as pregnancy-associated or pregnancy-related;
2. Whether and how to define and capture data on near misses;
3. The extent to which both clinical and nonclinical data about the death are available and accessible (including information on broader social determinants of mortality and morbidity);
4. How systematically data are collected, how flexible data collection and management can be, and how data can be harmonized across committees to determine whether trends are localized or generalized; and
5. How best to report information for population subgroups at greatest risk but for whom small numbers may pose a challenge (including racial and ethnic groups, sexual minority groups, and rural populations).

Funding opportunities to support implementation of the act must align with the intent of the legislation. For example, the Centers for Disease Control and Prevention forecasted a potential state-based grant opportunity on December 12, 2018. However, this grant provides funding only to states with existing MMRCs that have been meeting for at least 12 months and are currently reviewing deaths. This may disqualify some of the 11 states that passed laws establishing MMRCs in 2018 from participating in the federal funding, technical assistance, and data standardization offered in this funding opportunity.

Representation

Moving forward, it is essential that MMRCs—and the grant programs and federal and state infrastructure that undergird them—include people who

have been most affected. First and foremost, this includes women who have given birth. [Women who have experienced maternal morbidity](#) and family members of [those lost to maternal death](#) play a crucial role in reviewing and assessing evidence about maternal death. [Additionally, committee representation ought to include those who are disproportionately affected by maternal morbidity and mortality.](#) The extent to which these voices are currently present in MMRCs is not known but deserves a razor-sharp focus as the current legislation is implemented.

Next Steps For Legislative Action

To address the broad clinical and policy challenges that render US mothers at [growing risk of maternal mortality, and to specifically address the structural inequities that put black, indigenous, and rural families at disproportionate risk,](#) further legislation is needed. For example, in August 2018, [Sen. Kamala Harris](#) (D-CA) introduced The [Maternal Care Access and Reducing Emergencies \(CARE\) Act](#), which focuses squarely on dismantling [structural racism](#) by creating training programs to address [implicit bias](#) among clinicians and encouraging integrated health care services that [honor the strength of culture](#) and support pregnant women with evidence-based care.

Another [key area ripe for policy change to support maternal health is Medicaid policy.](#) [Medicaid](#) finances half of births nationally, and [more than half](#) of pregnant women with public health insurance coverage at the time of childbirth experience a gap or change in their health insurance coverage in the year after giving birth. Disruptions in health insurance (including postpartum) can have [adverse health consequences](#), and [Medicaid expansions have reduced mortality.](#) In September 2018, [Sen. Cory Booker](#) (D-NJ) proposed [legislation](#) that would extend pregnancy-related Medicaid coverage for one year following childbirth, among other research-informed changes to the Medicaid program. For example, the legislation also recommends Medicaid reimbursement for [doula services](#) to improve health and equity by supporting women during and after pregnancy outside of the

biomedical, hospital-based model.

A final example comes from US rural areas, where more than half of all rural counties have no hospital that offers maternity care. [Access to care](#) is complicated by distance in rural communities, and health is affected by high rates of poverty, chronic disease, and unemployment as well as workforce shortages. In October 2018, [Sen. Heidi Heitkamp](#) (D-ND), who was not re-elected, introduced the [Rural Maternal and Obstetric Modernization of Services \(MOMS\) Act](#), which includes provisions to improve maternal health data sharing in rural communities, to create regional networks and to increase workforce capacity by training more rural clinicians. [Sen. Tina Smith](#) (D-MN), a member of the Senate Health Committee and leader of the Senate Rural Health Caucus, has indicated an interest in carrying this work forward.

Discussions around these bills and other legislation addressing social determinants of maternal outcomes and health equity ought to be re-invigorated as the US establishes an infrastructure to combat maternal mortality across the nation. Above all, addressing maternal mortality requires confrontation of social determinants and health inequities necessitating that our work center and elevate the voices and experiences of populations at disproportion risk.