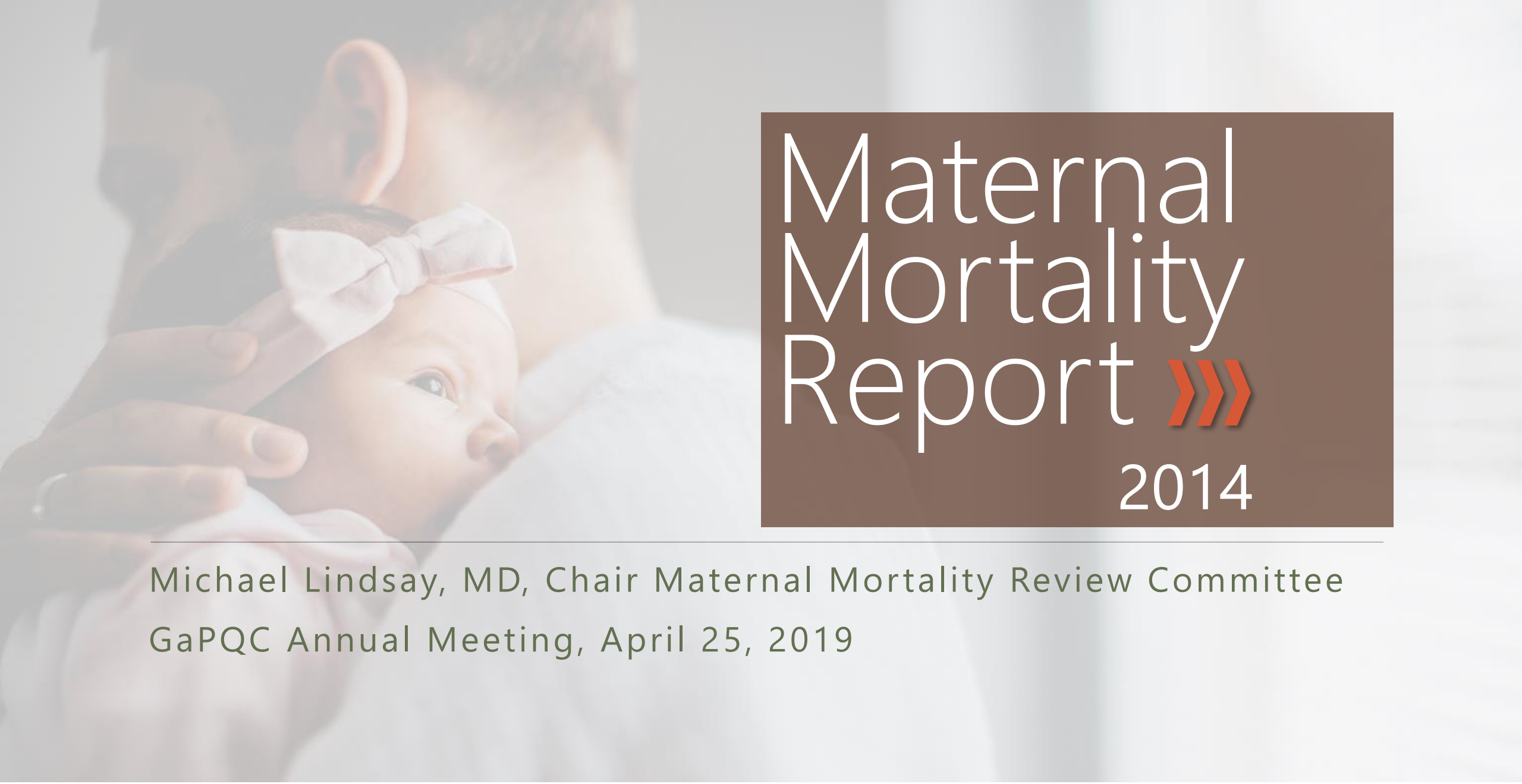


Maternal Mortality Report 2014

Michael Lindsay, MD, Chair Maternal Mortality Review Committee

GaPQC Annual Meeting, April 25, 2019

Maternal Mortality Review – Background

- In 2010 Amnesty International "Deadly Delivery: The Maternal Health Care Crisis in the USA" ranked Georgia 50th in maternal mortality
- Maternal Mortality Review Committee (MMRC) formed as a result of a three year process collaboration between:
  - Georgia Department of Public Health
  - Georgia Obstetric and Gynecological Society
  - Centers for Disease Control and Prevention
  - Georgia General Assembly and Governor Nathan Deal
- Legislation Georgia Law SB 273 recognized the GA MMRC, giving the abstractors the legal support to access and acquire information about the cases from relevant institutions.

Maternal Mortality Review

- Review of all deaths occurring to women while pregnant or within one year of the end of pregnancy regardless of pregnancy outcome.
- All maternal deaths are reviewed to determine whether they are pregnancy associated or pregnancy related.
- Pregnancy associated deaths are those occurring within the specified time frame but are not related to the current or recent pregnancy (car accident).
- Pregnancy related deaths are from any cause related to or aggravated by pregnancy or its management.

Maternal Mortality Review

- 2012: GA Maternal Mortality Review Committee (MMRC) was established
- 2014: SB 273 signed in to legislation providing legal access to case information and protection of review process
- GA MMRC is a multidisciplinary committee representing various specialties and systems that impact maternal and child health
- DPH contracts with GA Ob/Gyn Society to provide case abstraction and coordinate MMRC case review
- 2012 - 2014 case reviews have been completed and 2015 reviews are over 50% complete

Maternal Mortality Case Review

Six Key Questions

1. Was the death pregnancy-related?
2. What was the cause of death?
3. Was the death preventable?
4. What were the factors that contributed to this death?
5. What are the recommendations and actions that address these contributing factors?
6. What is the anticipated impact of these actions if implemented?

Pregnancy Related or Associated

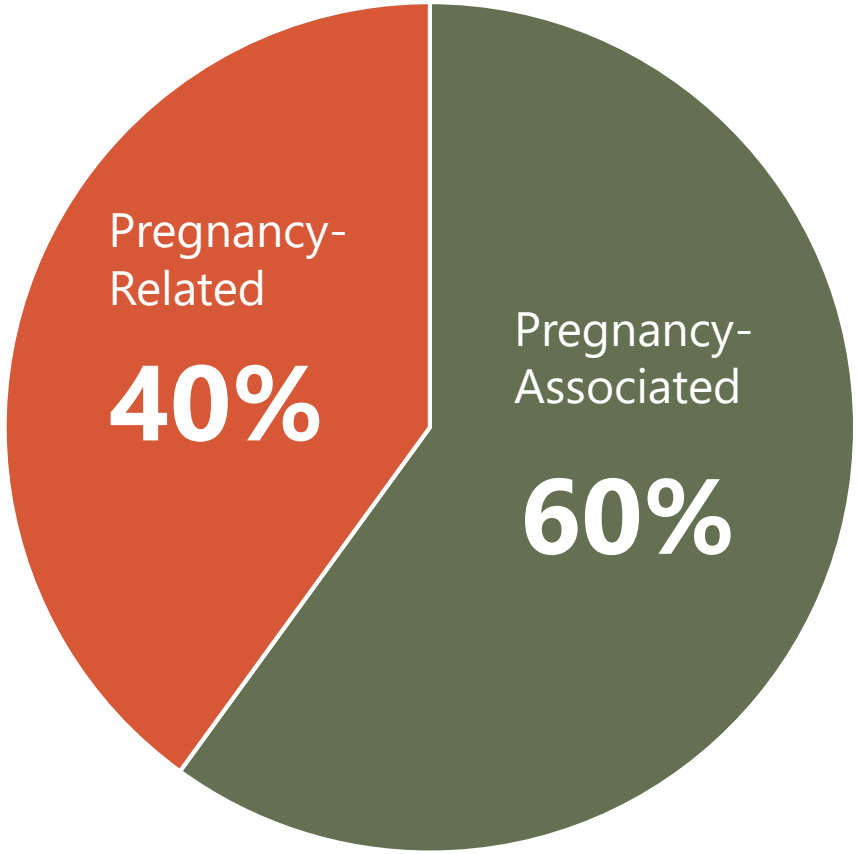
- **Pregnancy-related:** The death of a woman while pregnant or within one year of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by pregnancy or its management
- **Pregnancy-associated:** The death of a woman while pregnant or within one year of the end of pregnancy, due to a cause unrelated to pregnancy
- **Pregnancy-associated but unable to determine pregnancy-relatedness**.

Maternal Mortality Review 2012-2014

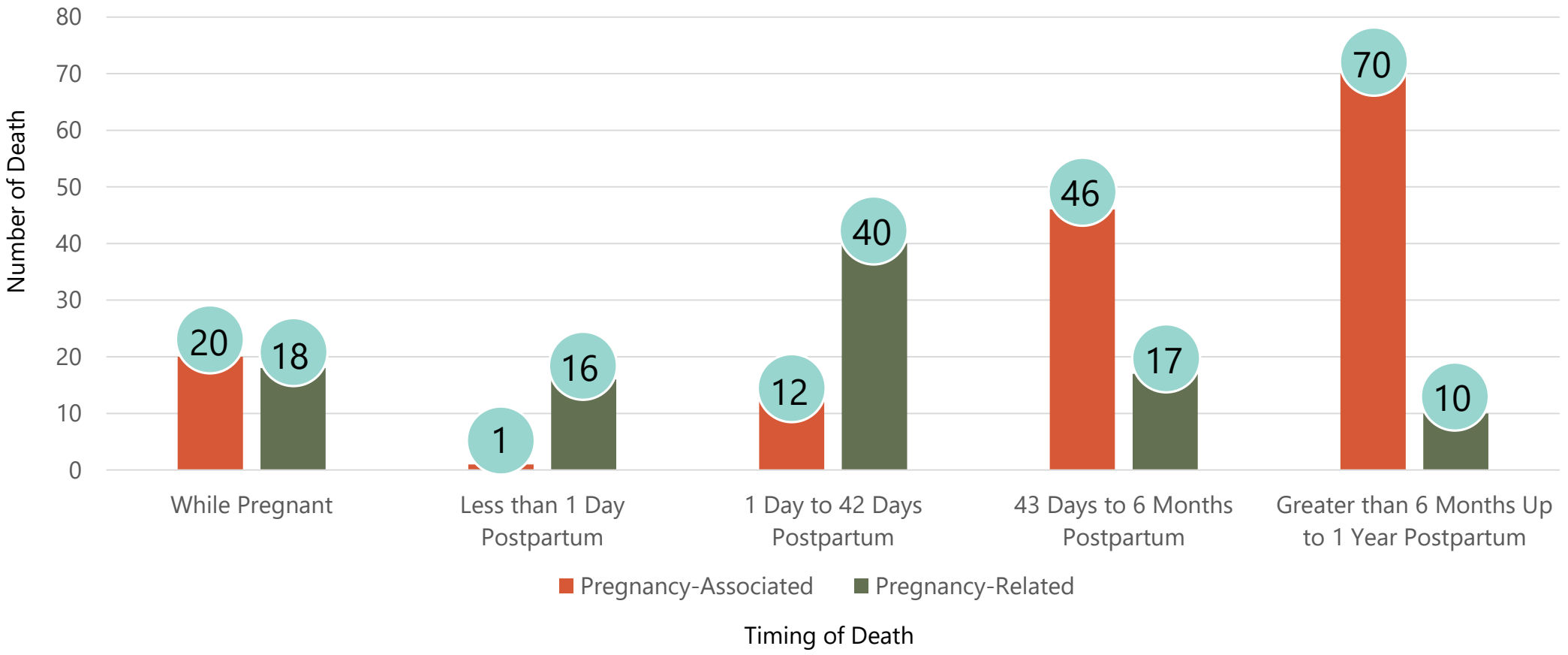
There were 64 maternal deaths for every 100,000 live births

» Of the 250 maternal deaths reviewed, 101 were determined to be pregnancy-related deaths » 60% of the pregnancy-related deaths were preventable » There were 26 pregnancy-related deaths for every 100,000 births.

Pregnancy-Related Deaths 2012-2014

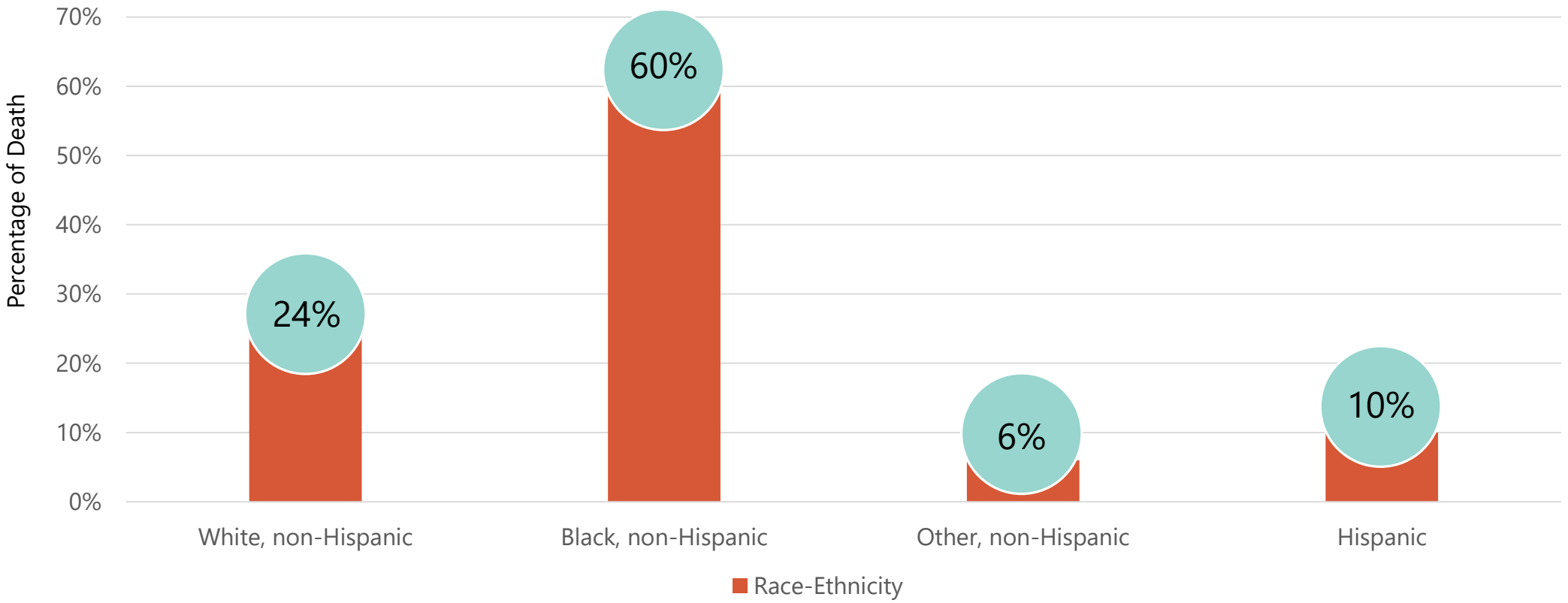


Timing of Death in Relation to Pregnancy 2012-14



Timing of Pregnancy-Related Deaths 2012-2014

Pregnancy-Related Deaths by Race

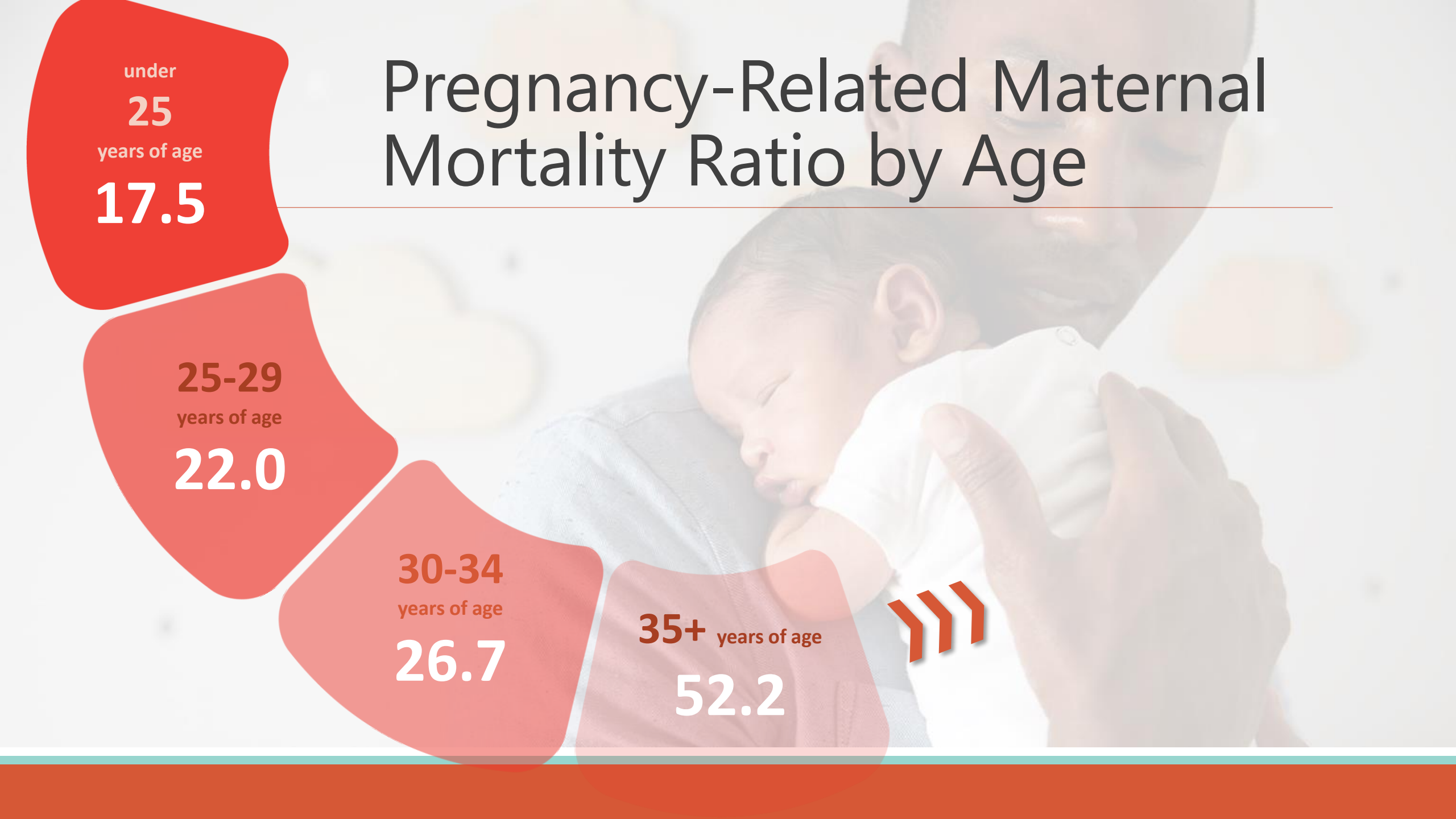


Pregnancy-Related Deaths by Race

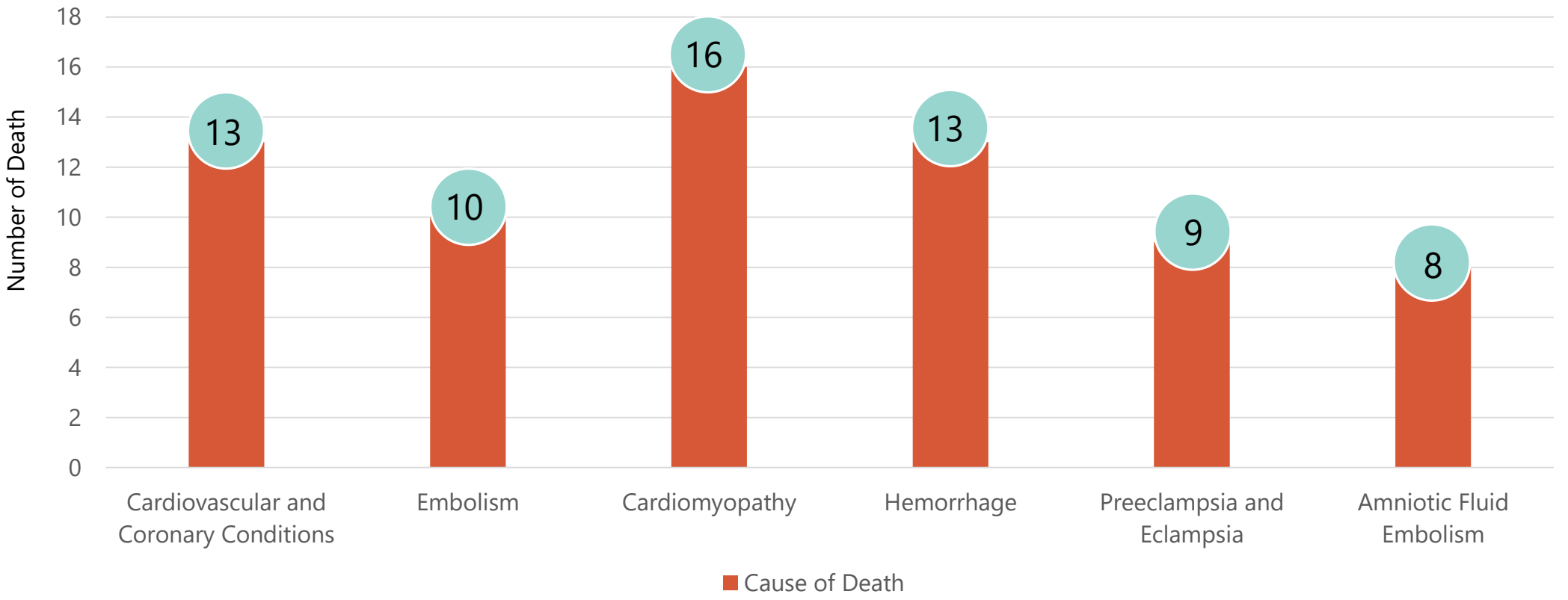
- White, Non-Hispanic: 14.3 deaths
  PER 100,000 LIVE BIRTHS

- Black, Non-Hispanic: 47.0 deaths
  PER 100,000 LIVE BIRTHS

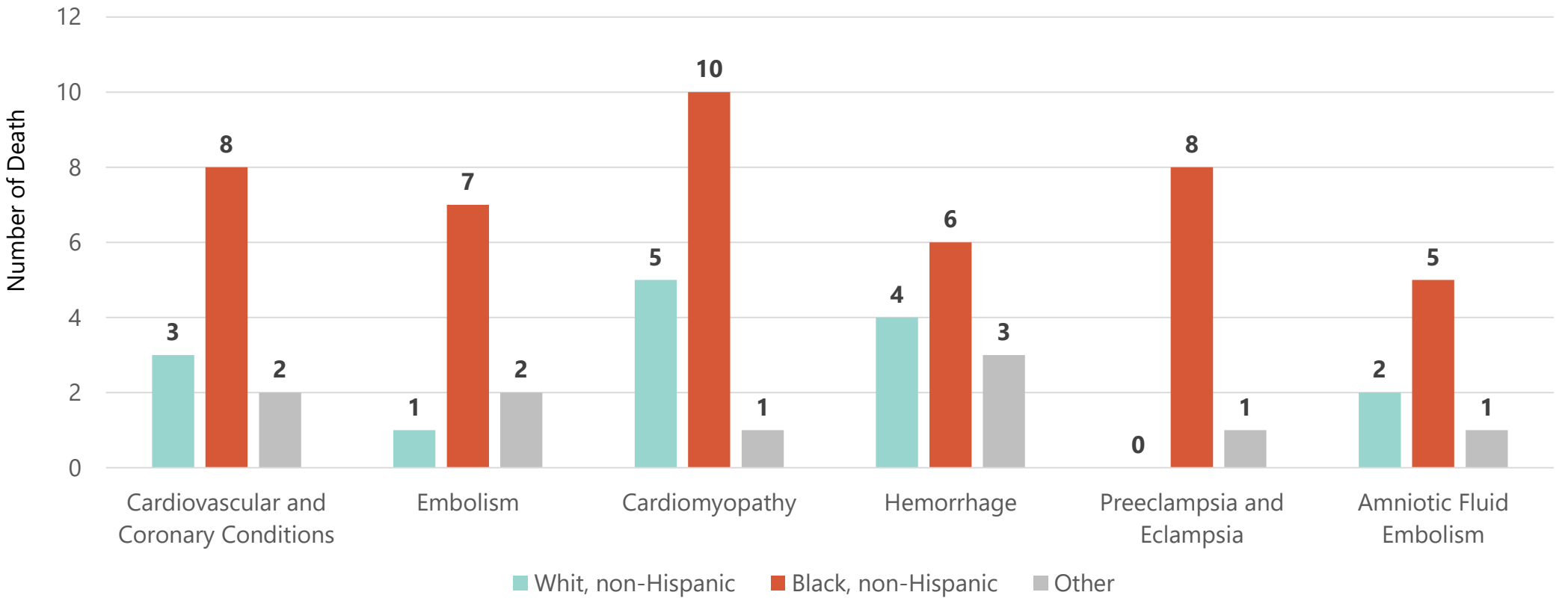
Pregnancy-Related Maternal Mortality Ratio by Age



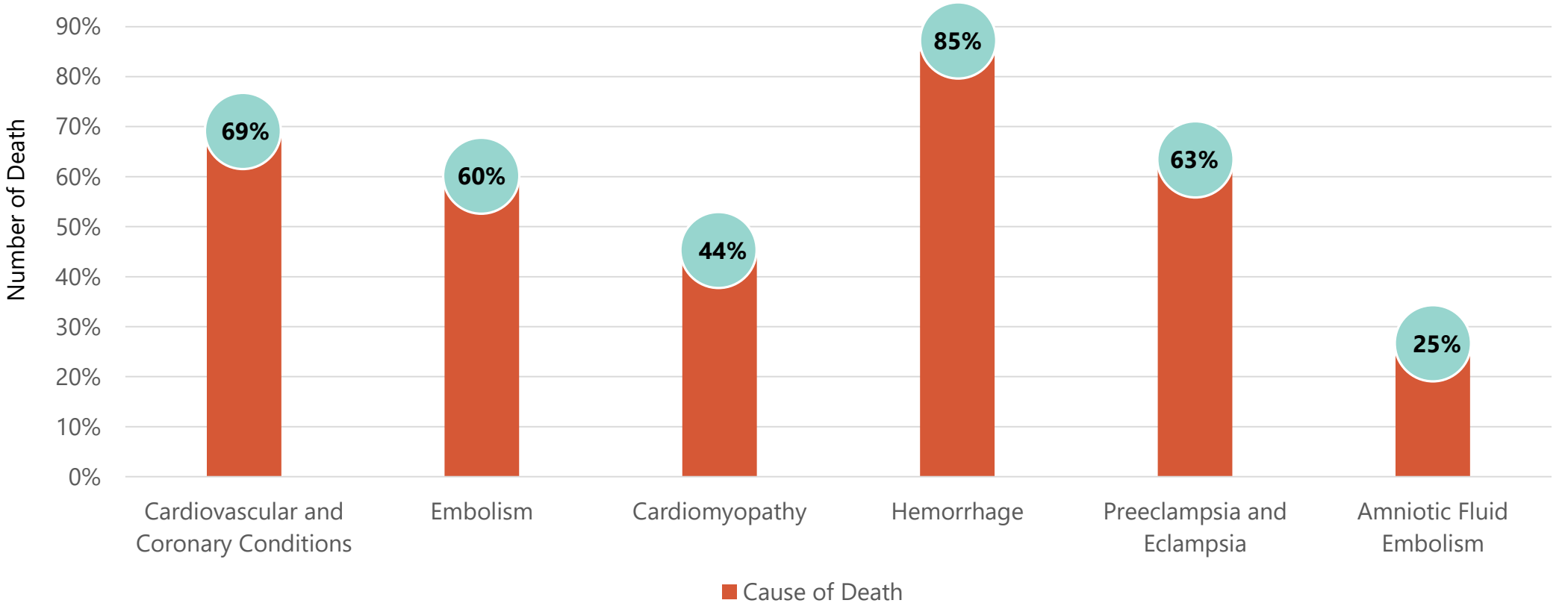
Pregnancy-Related Cause of Death 2012-2014



Pregnancy-Related Cause of Death by Race



Pregnancy-Related Deaths: Preventability



Moving Forward

- Increase the number of case abstractors to bring case review current
- Publish at least Maternal Mortality Review Report annually
- Expand the sharing of MMRC findings to providers, communities, agencies and patient advocacy groups
- Increase the number of MMRC recommendations that have action plans in place for prevention

Questions