Maternal Mortality Review Program Fact Sheet

Connecticut Maternal Mortality Review Program • November 2019

Maternal Mortality

Approximately 700 women die each year nationally from pregnancy-related complications. The Centers for Disease Control and Prevention analyzed Pregnancy Mortality Surveillance System (PMSS) data for 2011-2015, and 13 Maternal Mortality Review Committees (MMRCs) from 2013-2017[1] and determined that approximately 60% of pregnancy-related deaths were determined to be preventable. A pregnancy-associated death is one from any cause during pregnancy or within one year of the end of pregnancy. A pregnancy-related death is one determined by the MMRC to have been directly related to the pregnancy.

Leading causes of maternal death are:

- Cardiovascular conditions (i.e. heart disease and stroke)
- Infection
- Hemorrhage

- **About 1/3 of deaths (31%) happened during pregnancy**
- **About 1/3 (36%) of deaths happened at delivery or in the one week after**
- **About 1/3 (33%) happened 1 week to 1 year postpartum**
- **Nationally, Black and American Indian/Alaska Native women were about 3 times as likely to die from a pregnancy-related cause as White women.**
- **P.A. 18-150, effective October 1, 2018, established a CT MMRC, at DPH, responsible for identifying maternal death cases in CT.**

What is happening in Connecticut?

The Connecticut Department of Public Health coordinates the CT Maternal Mortality Review Program (MMRP). In June, 2018, legislation passed, granting statutory authority to conduct a comprehensive, multidisciplinary review of maternal deaths for purposes of identifying factors associated with maternal death and making recommendations to reduce maternal deaths. The MMRC examines all deaths, identifies whether they are either a pregnancy-associated death, a pregnancy-related death or if there is not enough information to determine.

Connecticut Maternal Mortality Review Program

The Connecticut Department of Public Health coordinates a statewide program, to convene a multi-disciplinary MMRC to review all CT maternal deaths, determine preventability and produce recommendations for prevention opportunities throughout the state. The chairpersons of the MMRC are the Commissioner of Public Health, or the commissioner's designee, and a representative designated by the CT State Medical Society.

Connecticut Department of Public Health
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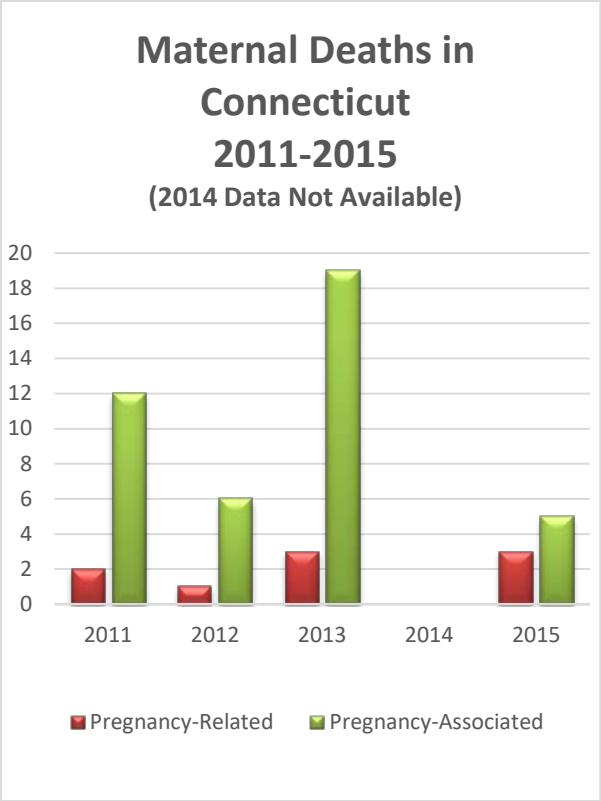
www.ct.gov/dph

Committee members include:

- Specialist in Obstetrics/Gynecology
- Licensed Clinical Social Worker
- Licensed Psychiatrist
- Consumer
- Nurse-midwife
- Chief Medical Examiner
- University of Connecticut Health Disparities Institute
- Community Health Worker
- Licensed psychologist



Pregnancy-Associated Deaths

A pregnancy-associated death is a broad category that includes the death of a woman while pregnant or within one year of the end of pregnancy, IRRESPECTIVE of cause. These may include accidents, and some homicides.

Pregnancy-Related Deaths

A pregnancy-related death is the death of a woman while pregnant or within 1 year of termination of pregnancy from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes. The CT Maternal Mortality Review Committee reviews all maternal deaths and separates them into one of these classifications.

Preventability

Pregnancy–related death can happen throughout pregnancy and after. Factors found to contribute include:

- Access to care
- Missed or delayed diagnoses
- Not recognizing warning signs

Implications

Strategies to address contributing factors to pregnancy-related deaths can be enacted at these levels:

- Community- support review of the causes behind every maternal death.
- Health facility- standardize coordination of care and response to emergencies.
- Patient + families- know and communicate about symptoms of complications.
- Provider- help patients manage chronic conditions, communicate about warning signs.
- System- improve delivery of quality prenatal and postpartum care, train non-obstetric providers

What Can I Do?

Having a healthy pregnancy is the best way to improve the chances of promoting a healthy birth. This can occur even before a woman chooses to become pregnant, with Preconception Care. The earlier a woman engages in preconception and prenatal care, the better at improving her chances for a healthy pregnancy.

Preconception Care. Focuses on care before and between pregnancies to plan and begin/continue healthy habits to increase the chances at having a healthy baby.

Develop a Plan. With your health care provider, discuss a plan to follow to become pregnant. This would include proper spacing of pregnancies, take folic acid, make sure all immunizations are up to date, address any chronic medical conditions, increase exercise to maintain a healthy weight, avoid smoking, alcohol and using drugs, get help for violence or dangerous environments, and get mentally healthy, by seeking a mental health professional, who can help with common stressors, such as anxiety, depression or other issues.

Prenatal Care. If you are pregnant, but are not under a doctor's care, it is critical that you speak with a medical professional to begin prenatal care. This will be a baseline to monitor you and your baby's health, growth and address any risks that may be present. Engaging with your Obstetrical provider in this crucial time of life is the best way to ensure you and your baby have the best chance at healthy outcomes.

Resources:

For more information on Prenatal and Preconception Care, visit the National Institutes of Health at https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care

For more information on Maternal Mortality, visit the Centers for Disease Control at https://www.cdc.gov/media/releases/2019/p0507-pregnancy-related-deaths.html

[1] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (May 17, 2019), Vol. 68. *Vital Signs:* Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017. Can be accessed at: https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm