



The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America’s state legislatures, the people in them, and the policies, process and politics that shape them.

You can subscribe through iTunes, Google Play, Sticher or Spotify.

CDC and States Working to Reduce Maternal Mortality | Dec 7, 2020 | OAS Episode 114

Ed: Hello and welcome to “Our American States,” a podcast from the National Conference of State Legislatures. This podcast is all about legislatures: the people in them, the policies, process and politics that shape them. I’m your host, Ed Smith.

“The data show that the rate of death is not decreasing, and given that these deaths are largely preventable, the numbers are absolutely unacceptable.”

That was Dr. Wanda Barfield, Director of the Division of Reproductive Health at the Centers for Disease Control and Prevention. Dr. Barfield is one of the guests on the podcast, which is focused on maternal mortality.

An estimated 700 women will die from pregnancy-related complications in the U.S. this year, and most of those deaths are preventable. In addition, Black and indigenous women are two to three times more likely to die of pregnancy-related issues than White women.

Dr. Barfield discusses efforts by the CDC to reduce the number of deaths, including sharing strategies with state legislators if they try to craft solutions that work best in their states.

My second guest is Khanh Nguyen, a policy expert at NCSL who tracks legislation related to maternal mortality. She shares examples of specific legislation and approaches employed by states, including a focus on helping Black and indigenous women.

Let’s start with Dr. Barfield. Welcome to the podcast.

Dr. B: Thank you. Good morning.

Time Marker (TM): 01:43

Ed: Good morning. So, Doctor, thanks first for taking the time to be on the podcast. And I wonder if you could start by giving us an overall notion of how the U.S. is doing with maternal mortality and also how the U.S. stands compared with other countries.

Dr. B: Well, first of all, I just want to thank you for the opportunity to speak with you today about maternal mortality. This is a critical issue that our nation faces. And the ways that CDC is working to better understand and prevent these deaths is very important.

Sadly, about 700 women die during or within one year of the end of pregnancy each year in the United States as a result of pregnancy or delivery complications. Data from CDC's pregnancy mortality surveillance system shows that the pregnancy-related mortality ratio in the United States is estimated at 16.9 deaths per 100,000 in 2016, and this is the most recent data year available. The data show that the rate of death is not decreasing, and given that these deaths are largely preventable, the numbers are absolutely unacceptable.

Maternal mortality is often used as a measure of the nation's health. Factors that affect the health of the entire population can also affect mortality among pregnant and postpartum women.

TM: 03:16

Ed: Well, those are troubling statistics. Can you tell us more specifically about the types of complications that are causing these deaths?

Dr. B: Every pregnancy-related death is tragic and represents the loss of a special family member and friend. Data we collect using the pregnancy mortality surveillance system allow us to look at patterns in pregnancy-related deaths that happen each year in the United States, with nearly 31% happening during pregnancy, 36% happening during delivery or a week after, and 33% happening one week to one year after delivery.

Overall, heart disease and stroke cause more than one in three pregnancy-related deaths. However, the leading causes of death vary by timing of the pregnancy-related death. For example, obstetric emergencies like severe bleeding and amniotic fluid embolism, and this is when the amniotic fluid enters into a mother's bloodstream, causes most deaths at delivery.

Yet, in the week after delivery, severe bleeding, high blood pressure and infection are most common. And cardiomyopathy or a weakened heart muscle is the leading cause of deaths one week to one year after delivery.

In addition, we know that Black women are more likely to die in the late postpartum period, which is between 43 and 365 days after pregnancy, than White women. Data also show that the proportion of pregnancy-related deaths attributable to each cause varies by race/ethnicity.

TM: 05:18

Ed: My understanding is that certain groups of women are at higher risk of pregnancy-related deaths. Can you talk about that?

Dr. B: So, for example, cardiomyopathy hypotensive disorders of pregnancy contributed more to pregnancy-related deaths among Black women than White women, and hemorrhage and hypertensive disorders of pregnancy contributed more to pregnancy-related deaths among White women.

We know that considerable disparities exist with Black women and American Indian Alaskan Native women who are two to three times more likely to die from pregnancy-related complications than White women.

We know that pregnancy-related deaths increase with age, and data show that the racial/ethnic differences also increase with age. So, for example, among Black and AIAN women who are older than 30, the rate of dying from pregnancy-related complications was four to five times higher than it was for White women in comparable age groups.

When you dig deeper, looking at social determinants of health like education, the pregnancy-related mortality ratio for Black women with at least a college degree was five times as high as for women with a similar education. And even in places where pregnancy-related mortality ratios are low relative to other states, significant disparities persist.

As we improve the data, we will better be able to identify the drivers of these deaths, and most importantly address disparities. Developing a better understanding of the racial disparities in pregnancy-related deaths is critical to address this complex national problem.

TM: 07:26

Ed: Well, you've laid out the scope of the problem. Can you talk about what efforts the CDC is making at both the federal and state level to address these problems, especially as it relates to Black and indigenous women?

Dr. B: At the federal level, CDC is committed to preventing pregnancy-related deaths and ensuring the best possible birth outcomes by focusing on measuring maternal mortality and working with states to improve the quality of care pregnant and postpartum women receive.

Some of these activities that CDC is involved in include conducting national pregnancy-related mortality surveillance through the pregnancy mortality surveillance system or PMSS. And it includes death certificates for all women who die during pregnancy or within one year of pregnancy, and copies of the matching birth or fetal death certificates if applicable.

Each year, 52 reporting areas, which include 50 states, New York City and Washington, D.C., voluntarily send data. While national data are important for understanding national maternal mortality trends, they only tell part of the story. We need data that capture the factors contributing to a woman's death and we need to understand how to prevent future deaths.

So, to address the challenges and limitations of vital statistics data, CDC has emphasized the importance of detailed reviews of maternal deaths as a core state public health function. State and local maternal mortality review committees have the potential to get the most detailed, complete data on maternal mortality necessary for developing effective recommendations for prevention.

Maternal mortality review committees or MMRCs are a process by which a multidisciplinary committee at the state or city level identifies and reviews deaths that occurred during or within a year of pregnancy. Review committees have access to multiple sources of information, and they provide a deeper understanding of the circumstances surrounding a death.

In fiscal year 2019, CDC made 24 awards supporting 25 states for the enhancing reviews and surveillance to eliminate maternal mortality, or erase MM programs. This funding directly supports agencies and organizations that coordinate and manage maternal mortality review committees to identify, review and characterize maternal deaths, and identify prevention opportunities.

In addition to strengthening the data on maternal mortality, CDC also has several efforts to improve the quality of care women receive during pregnancy in the year postpartum. For example, CDC funds 13 state perinatal quality collaboratives or PQCs as well as the national network of perinatal quality collaboratives, and this supports nonfunded states.

PQC members identify healthcare processes that need to be improved and use the best available methods to make sure that there are changes that occur as quickly as possible throughout their state. And in many states, PQCs work with the review committees and then serve as an action arm that implements the prevention recommendations identified by the review committees.

CDC is also helping states to map risk-appropriate care through CDC's level of care assessment tool of LOCAT. And LOCAT can help develop coordinated, regional systems to help ensure that pregnant women and infants at high risk of complications receive the right care at the right time, and that that facility is best prepared to meet their needs. CDC provides this tool and related technical assistance to states at no charge.

We're also thrilled to announce that this fall CDC launched the "hear her" campaign, and you can find information about this at www.cdc.gov/hearher. And this is a campaign to increase the awareness of warning signs that could lead to pregnancy-related death or delivery complications and strengthen patient and provider communication.

TM: 12:24

Ed: We'll be sure to link to that resource from the podcast webpage. And I think you've given listeners a good notion of the efforts the CDC is making.

I wondered if you'd like to share any specific success stories from states.

Dr. B: So, states have made a tremendous amount of progress to drive efforts that address maternal mortality. For example, the Illinois MMRC put out their first report in 2018, and in 2019, there were 15 bills introduced into the state legislature, which were based on these recommendations.

In addition, in Illinois, there are linkages between the maternal mortality review committees and the Illinois perinatal quality collaborative. And as a result, the Illinois Department of Health

provided funding to ILPQC to improve outcomes for women with severe hypertension and opioid use disorder, two leading causes of maternal mortality in Illinois. The ILPQC has been a leader in the field in both of these areas.

And another example is in Mississippi. They have used data from their MMRC to inform and direct prevention efforts across the state. After analyzing their MMRC data, the state found that the leading causes of preventable death in Mississippi were chronic cardiovascular disease and mental health.

The findings from the data helped the state select and tailor initiatives to maximize impact and implement these efforts in the right places for families and communities who need them most.

These are strong examples of using data to inform action. As more states implement maternal mortality review and improve the standardization of the review process, the data will inform prevention efforts and address the drivers of maternal mortality.

TM: 14:28

Ed: Well, Dr. Barfield, before we wrap up, I'm wondering if you have a top message for state lawmakers who make up a lot of our audience?

Dr. B: Thank you. This work is not easy, but it is imperative, and with 66% of pregnancy-related deaths being identified as preventable, we have an incredible opportunity and a responsibility to save lives.

Preventing pregnancy-related deaths is a complex and multifaceted challenge, making collaboration essential to success. We must build strong partnerships across different sectors and disciplines to tackle this public health issue on multiple fronts.

We must work collectively to act based on robust data and ensure pregnant and postpartum women receive high quality care at the provider and facility level, and make big picture systems and community level changes that address the social determinants of health.

Preventing maternal mortality has rippling effects and broader societal implications for healthier, stronger families in communities across your state and the nation.

Thank you for the opportunity to discuss this important public health issue.

Ed: Well, Dr. Barfield, thank you again for your time and sharing your expertise with us. Please stay safe. I'll be right back with Khanh Nguyen.

MUSIC Gene VO:

The 2020 edition of Mason's Manual of Legislative Procedure is now available in both print and digital versions. Designed specifically for state legislatures, Mason's Manual is used by 79 of the 99 legislative chambers in the United States. Prepare for the next legislative session and order yours today at ncsl.org/masons manual.

Ed: Khanh, welcome to the podcast.

Khanh: Hi. Happy to be here. Thanks for inviting me.

TM: 16:44

Ed: Khanh, I know one of your roles at NCSL is to track state maternal mortality legislation. Can you tell us what types of bills you've seen over the last couple of years?

Khanh: Sure, thank you. We've seen quite a bit of activity on this topic over the last couple of years. Since the beginning of 2018, there have been at least 139 bills enacted in 41 states related to maternal mortality and morbidity. These range from resolutions recognizing the issue or commissioning studies of causes and solutions to bills with targeted interventions.

The trends we're seeing include policies addressing perinatal quality collaboratives, maternal mortality review committees, and Medicaid coverage. The policies related to Medicaid coverage include allowing reimbursement for doula services or extending postpartum coverage, which currently ends 60 days after delivery unless states get approval from the Centers for Medicare and Medicaid Services to extend it.

TM: 17:53

Ed: Well, let me drill down a little bit on that. Can you give me some specific examples of state legislation that follow those trends?

Khanh: Sure. The first trend I mentioned relates to perinatal quality collaboratives. These are teams or networks of teams working to improve the quality of healthcare for mothers and infants. These teams identify healthcare processes that need to be improved and they use quality improvement principles to make swift changes to address gaps in care.

Arkansas, for example, established a maternal and perinatal outcomes quality review committee in 2019, and Delaware created a perinatal quality collaborative just this summer.

States have also created or updated provisions related to their maternal mortality review committees. For example, Kansas established their committee in 2018 and Nevada established theirs in 2019.

Another example is an Oklahoma bill passed in 2019 that requires its maternal mortality review committee to also look at quality of care, lack of transportation and lack of financial resources.

And lastly, Vermont passed a bill this year revising certain details of their review panel related to membership, access to information and consideration of health disparities and social determinants of health.

TM: 19:22

Ed: Tell us more about how these maternal review committees can reduce maternal mortality.

Khanh: So, at least 40 states have some form of these multidisciplinary committees that examine each maternal death in their state. The committees identify maternal deaths, investigate the underlying causes of each death, and provide specific recommendations to prevent future deaths.

This review process can help interpret trends, identify high risk groups, and develop effective interventions that can lead to fewer maternal deaths.

TM: 19:58

Ed: Now, Dr. Barfield, earlier in the podcast, shared some sobering information about racial disparities in maternal mortality. Are states passing bills to address these gaps specifically?

Khanh: Yes, they are, Ed. I mentioned earlier that some states are looking at Medicaid coverage policies to reduce maternal mortality. Because Medicaid covers a large share of births among communities of color, addressing Medicaid health plans has been a key policy option for states to address racial disparities.

For example, New Jersey and Indiana passed bills last year to allow Medicaid coverage for doula care. Doulas are trained professionals who provide physical, emotional and informational support to mothers before, during and after childbirth.

Pilot programs in some other studies show that support from doulas is linked to better health outcomes such as lower C-section rates, lower chance of low-birth-weight babies and higher chance of initiating breastfeeding. These bills aim to provide the option of doula services to meet the need for increased birthing support for underserved women, particularly Black women.

Also, in 2019, Georgia established the House Study Committee on Maternal Mortality, requiring certain representation from African American female legislators. The committee provided recommendations to reduce maternal mortality and address disparities and released its report at the beginning of 2020.

This report included extending postpartum Medicaid coverage, and this summer, the Georgia legislature unanimously passed a bill extending coverage to six months postpartum.

Illinois also allowed extending the state's pregnancy-related Medicaid coverage through 12 months postpartum, citing the state's significant racial disparities in maternal mortality.

And for a couple of final examples, we've also seen legislative action to reduce disparities through addressing quality of care. Louisiana created the Healthy Moms Healthy Babies Advisory Council to address racial and ethnic disparities in maternal health outcomes through a community engaged approach.

And lastly, Illinois recently expanded the scope of its perinatal quality collaborative to include an initiative to reduce racial and ethnic disparities and address implicit bias in healthcare.

TM: 22:35

Ed: Well, is there anything else you'd like to share with the audience before we wrap up?

Khanh: Yes. Just that we've seen an increasing number of bills enacted and other state efforts to address maternal mortality over the last few years. So, if this trend continues, there is a lot of hope for reversing the rising rates of maternal mortality and related racial disparities.

States are prioritizing the health of their mothers and babies and, in many cases, working across party lines to achieve results.

Ed: Khanh, thanks for discussing this important issue and sharing what states are doing. Stay safe.

MUSIC

Ed: And that concludes this edition of our podcast. We encourage you to review and rate our episodes on iTunes, Google Play or Spotify. You may also go to Google Play, iTunes or Spotify to have these episodes downloaded directly to your mobile device when a new episode is ready. For the National Conference of State Legislatures, this is Ed Smith. Thanks for listening and being part of "Our American States."