Talking Points & Testimony: Maternal Mortality Review Committees (MMRC)

Use these talking points to advocate for a House of Delegates Resolution in your State Medical Society or a bill in the Legislature and to gain support from stakeholders and others.

For a refresher on MMRCs, refer to the MMRC Facilitation Guide at http://reviewtoaction.org. This online resource hub, launched in 2016, is a partnership of the Association of Maternal and Child Health Programs (AMCHP) and the CDC Foundation and CDC Division of Reproductive Health.

Start early to identify partners and build your legislative coalition. You’ll need to do this several months before the start of the legislative session. Your local AAP, ACNM and March of Dimes chapters are likely allies. In some states, especially small and rural states, you’ll likely need the support of your State Medical Society. Consider introducing and passing a resolution supporting MMRCs at the next House of Delegates meeting.

Buy-in from your state health department officials is critical. Your new MMRC will likely be housed in the health department and staffed by health department professionals. In most states, health departments may not take a public position on legislation, but will be instrumental in galvanizing support internally and making maternal mortality surveillance and prevention a priority within the department.

Talking Points

Option 1: Bill in the Legislature
I am here to speak in support of [Bill xxx]. This legislation would establish a committee in the [NAME of your State Agency, eg Department of Health] to systematically review pregnancy-related deaths in our state. The goal is to improve processes, systems and knowledge that are lacking and then remedy gaps to avoid another maternal death or near-miss. This legislation also recommends that the committee follow national best-practices guidelines by the Centers for Disease Control and Prevention.

Option 2: House of Delegates Resolution
I am here today to speak in support of [Resolution xxx] which calls on [NAME of YOUR State Medical Society] to support legislation establishing a committee in [NAME of your State Agency, eg Department of Health] to systematically review pregnancy-related deaths in [STATE NAME] – within a culture of promoting safety, not assigning blame. The goal is to improve processes, systems and knowledge that are lacking and then remedy gaps to avoid another maternal death or near-miss. This Resolution also specifies that [State Medical Society] members should be on the committee and recommends using the Centers for Disease Control and Prevention’s best-practices guidelines.
Talking Points

Maternal mortality: alarming trends

Maternal mortality is an important indicator for quality – in the health of our communities, our patient populations, and our health systems.

It might surprise you to know that there has been no significant improvement in maternal mortality in the US for more than 25 years. In fact, maternal deaths jumped more than 25 percent from 2000 to 2014 (18.8% in 2000 to 23.8% in 2014). California is the exception which showed a declining trend; and Texas had an alarming spike in maternal deaths in 2011-12.

The international trend among other industrialized countries is in the opposite direction. The US lags way behind other industrialized countries in maternal mortality.

It also might surprise you to know that about half of all maternal deaths in the US are believed to be preventable.

Maternal near-deaths are also on the rise – for example from preeclampsia and high blood pressure. Increasingly, more pregnant women in the US have chronic health conditions and are overweight or obese. These conditions put pregnant women, especially those 40 years of age and older, at higher risk of adverse outcomes. For every maternal death, there are an estimated 50 pregnant women who have near-death complications.

And there are significant and widening disparities in maternal mortality among black, Hispanic and white women. This highlights the need to better understand how social determinants of health and barriers to risk-appropriate care can be addressed to promote optimal outcomes for all women.

The CDC and ACOG support MMRCs

The Centers for Disease Control and Prevention and the American Congress of Obstetricians and Gynecologists have long prioritized the reduction of the maternal deaths in the U.S. CDC and ACOG started calling for the establishment of state review teams a decade ago. CDC and ACOG recommend that all states have an active, confidential Maternal Mortality Review Committee that uses standardized, uniform data collection and reporting tools including the recommended 5 questions on the death certificate.

About 30 states have an active Maternal Mortality Review Committee in place or on the drawing board. We know that reviewing maternal deaths in a systematic manner for the purpose of taking action can reduce the risk of women dying from complications of pregnancy.

It’s time for [STATE NAME] to act. No process exists in our state for the confidential identification, investigation and dissemination of findings and recommendations on maternal deaths. Passing this [bill / resolution] would be an important step in preventing poor health outcomes for countless mothers.
In the past decade, there have been major advances in the approach to obstetric emergencies. There are national initiatives underway that seek to mobilize clinical and public health resources to improve safety in maternity care. ACOG has joined with multiple professional organizations to create maternal safety bundles for implementation in all birthing facilities. Standardized protocols for conditions such as obstetric hemorrhage have been shown to reduce the rates of hysterectomy and blood use. A state Maternal Mortality Review Committee helps to support these important initiatives.

**What is the function of a Maternal Mortality Review Committee?**

MMRCs give us specific, data-driven recommendations to prevent future maternal deaths.

These committees identify, study and review cases of maternal deaths. They examine the medical and non-medical circumstances of deaths that occur during pregnancy up to one year post-delivery.

Maternal deaths are defined as the death of a woman during or within 1 year of pregnancy that was caused by a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Leading causes include cardiovascular disease, cardiomyopathy, thromboembolism, obstetric hemorrhage, preeclampsia, sepsis, hypertension and obesity.

Committees review medical records and other relevant data including birth and death certificates and autopsy, hospital ER, medical transport, social services and mental health records and reports.

Committees also develop recommendations for the prevention of maternal deaths and disseminate findings and recommendations to policy makers, health care practitioners, health care facilities and the public.

Committees conduct their confidential reviews of medical records and interviews within a culture of promoting safety. The focus is on identifying opportunities for improvement of systems – not on assigning blame.

Maternal Mortality Review Committees help us identify gaps in services and systems to prevent future deaths and near-misses. Committees help identify what is contributing to the problem and then raise awareness and educate health professionals and others on appropriate remedial actions. Committees also identify strengths in the systems of care that should be supported or expanded.

**Concluding comments**

**For House of Delegates Resolution:**

As [STATE NAME] physicians, we should lead the way. Passing this [Resolution xxx] would signal our commitment to excellence in maternal health care. It would put our state on the path to alignment with best-practices in obstetric care being implemented across the country. And it would help galvanize the public and the support of our state legislators to join with us in confronting and preventing maternal mortality and morbidity.