# Maryland
# Maternal Mortality Review Program

The Maryland MMR Program is in the Department of Health and Mental Hygiene (DHMH), Maternal and Child Health Bureau. It is funded through the Title V MCH block grant.

DHMH contracts with MedChi, The Maryland State Medical Society, to administer the program. MedChi assists in obtaining medical records, abstracting cases, and hosting the Maternal Mortality Review Committee, a committee of clinical experts from across the State.

The MMR Program was established in statute in 2000 (Health-General Article, §13-1201 through §13-1207, Annotated Code of Maryland) to identify maternal death cases; review medical records and relevant data; determine preventability of death; develop recommendations for the prevention of maternal deaths; and disseminate findings and recommendations. An annual report is sent to the Governor and the General Assembly.

***Our vision is the elimination of preventable maternal deaths in Maryland.***


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Current MMR Committee Chair:
Clark Johnson, MD, MPH
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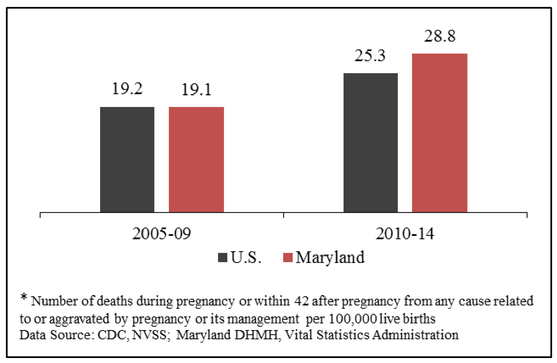
The MMR Committee meets monthly from September to June to review cases. All pregnancy-associated deaths are reviewed. These cases are identified by cause of death, pregnancy checkbox questions on the death certificate, linking death certificates for women aged 10-50 years with birth certificates and fetal death certificates, and manual review of cases reported to the centralized Medical Examiner. An average of 40 pregnancy-associated deaths are reviewed each year. All cases are reviewed for pregnancy-relatedness and potential preventability.

Maryland's maternal mortality rate (MMR) has generally been higher than the national average. Between the two 5-year periods shown below, the U.S. MMR increased by 32 percent and the Maryland rate increased by 51 percent.

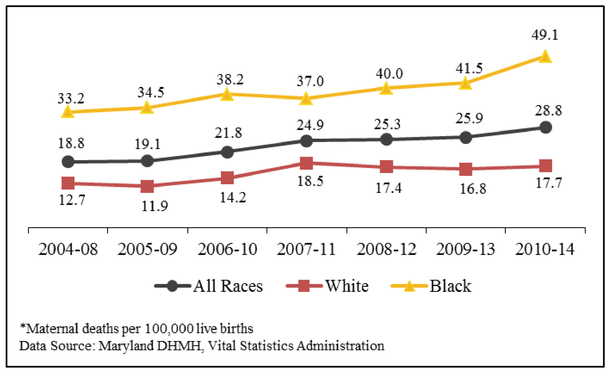
**Maternal Mortality Rates*, U.S. and Maryland**
**2005-09 and 2010-14**




* Number of deaths during pregnancy or within 42 after pregnancy from any cause related to or aggravated by pregnancy or its management per 100,000 live births
Data Source: CDC, NVSS; Maryland DHMH, Vital Statistics Administration

Maryland also has a large and persistent racial disparity in maternal deaths., as shown below.

**Five Year Rolling Average Maternal Mortality Rate***
**by race, Maryland, 2004-2014**




*Maternal deaths per 100,000 live births
Data Source: Maryland DHMH, Vital Statistics Administration

Among 2014 deaths in Maryland, the leading cause of pregnancy-associated death was substance use disorder-unintentional overdose. The leading cause of pregnancy-related death was hemorrhage.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Successes:

2012 in response to an MMR report of deaths from homicide, DHMH convened an IPV Task Force, developed a 3-question screening tool for IPV assessment , conducted trainings to educate obstetric providers, and developed an IPV website.

2013 in response to MMR obstetric hemorrhage recommendations, the Maryland Perinatal System Standards for all delivery hospitals were updated to include a requirement for a written protocol to respond to massive obstetric hemorrhage and a plan to maximize accuracy in determining blood loss.

2014 in response to an MMR review of overdose deaths, DHMH sent a letter and resource information to all obstetric providers encouraging them to screen for substance use disorders, refer to treatment, and register with and use the Maryland Prescription Drug Monitoring Program.

2015 DHMH contracted with an MMR Committee member, board certified in both obstetrics and addiction medicine, to provide training for substance use treatment providers on best practices for treating pregnant women with substance use disorder.

2016 the MMR Committee held a Summit: *"Maryland Maternal Mortality Review Five-Year Perspective 2009-2013"*

Challenges:

Difficulty identifying prenatal care provider and obtaining prenatal care records.

Lack of access to substance use disorder and mental health treatment records.