Preventing Maternal Mortality and Morbidity in the US

The Need for Public and Private Collaboration

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What We Know
The Good News

Deaths per 100,000 live births

Years

Deaths per 100,000 live births


Years
The Bad News - Recent Trend

Deaths per 100,000 live births

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Direct (54%)
- Directly related to the birth process
- Most are within 14 days from birth

Indirect (46%)
- Not directly related to the birth process
- Often underlying medical condition
- Can be remote from the day of birth

May require different approaches for prevention.
The Bad News – Persistent Disparities

Maternal Mortality Rate by Race/Ethnicity 2005-2007

Maternal Mortality by Location

Maternal Deaths per 100,000 Live Births

- New England: 6.2
- West North Central: 9.4
- East North Central: 11.8
- Mountain: 11.2
- Pacific: 12.1
- Mid Atlantic: 19
- South Atlantic: 16
- West South Central: 14.7
- East South Central: 11.9
Tip of the Iceberg

Maternal Mortality

Maternal Morbidity
Contributing Factors

- Demographics of childbearing are changing
- Women are entering pregnancy with more chronic conditions

Increasing Obesity Among U.S Women (20-39 yrs.)

Source:
*Ages 20-35 through NHANES 1988-94
What We Don’t Know

- If quality of care delivered differs by race.
- If race is a proxy for socioeconomic status, and other factors unrelated to the system of care.
- The rest of the story. We only know part of how to reduce maternal morbidity and mortality, and racial disparities that may contribute to these outcomes.

Valuable Data Relies on Federal and State Governments Working Together

→ HR 4216, The Maternal Health Accountability Act
What Are Women’s Health Providers Doing in the Meantime?
National Partnership for Maternal Safety

PROVIDER ORGANIZATIONS

- ACOG
- Society for Maternal and Fetal Medicine
- Association of Women’s Health, Obstetric, and Neonatal Nurses
- National Association of Nurse Practitioners in Women’s Health
- American College of Nurse-Midwives
- American Association of Nurse Anesthetists
- Society of Obstetric Anesthesia and Perinatology
- American Academy of Family Physicians
- American Hospital Association
- Voluntary Hospital Association
- American Association of Blood Banks
- American Association of Birth Centers

PUBLIC HEALTH AND SAFETY ORGANIZATIONS

- Association of Maternal and Child Health Programs
- The Joint Commission
- Centers for Medicare and Medicaid Innovation

PATIENT SAFETY AND ADVOCACY ORGANIZATIONS

- CRICO (Risk Management)
- Preeclampsia Foundation
- Pulse of New York
Activities

- Training and Coordination with American Hospital Association-Hospital Engagement Network (HEN) and The Health Research & Educational Trust (HRET)
  - Contract with Centers for Medicare and Medicaid Services to support the Partnership for Patients Campaign
  - Reduce inpatient harm by 40 percent and readmissions by 20 percent
  - Includes obstetric adverse events as 1 of 10 focus areas
  - 1,600 participating hospitals in 34 states

“What every birthing facility in the US should have…”
Maternity “Safety Bundles”

- **A structured way of improving care and patient outcomes.**
  - A small, straightforward set of evidence-based practices that, when performed collectively and reliably, improve patient outcomes

- **Implement Bundles/Standards**
  - Risk Assessment
  - Prevention
  - Readiness
  - Recognition
  - Response
  - Root-Cause Analysis/Unit-Learning After Event

- **Bundles Developed to Date**
  - Obstetric Hemorrhage
  - Venous thromboembolism (VTE)
  - Hypertension in Pregnancy (Pre-Eclampsia)
Other Partnership for Maternal Safety Initiatives

- **Coordination with Joint Commission**
  - Made Maternal Mortality A Sentinel Event in 2010
  - Working to Make Maternal Morbidity a Sentinel Event

- **Coordination with Individual Partnership Member Projects** (funded by Merck)
  - ACOG District II (NY): State-wide adoption of standards re: handling obstetric emergency events
  - California Maternal Quality Care Collaborative: State-wide implementation of QI toolkits for obstetric hemorrhage and pre-eclampsia
  - Assn. of Women’s Health, Obstetric and Neonatal Nurses (GA, NJ, DC): Postpartum Hemorrhage Project
  - Association of Maternal and Child Health Programs (CO, DE, GA, NY, NC, OH): Strengthening maternal mortality review boards to translate lessons learned into policies and practices that improve maternal health outcomes.
- Reach Providers via Professional Literature and Web

Organizations United to Provide Safe Health Care for Every Woman

www.SafeHealthcareForEveryWoman.org

- Develop and Promote Facility Review Process
For More Information

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