Data to Action: Maternal Mortality Reviews
Addressing Injury Prevention

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Epi in Action: Innovative uses of NVDRS, Syndromic Surveillance and Maternal Mortality Review Data
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Who is AMCHP?

- **Mission:** AMCHP supports state maternal and child health programs and provides national leadership on issues affecting women and children.

- **Members:** Leaders and staff from state and territory health agencies who manage and implement programs that preserve, protect, and improve the health of women, children, and families in their state.

- **Context:** Title V MCH Services Block Grant (and beyond...)

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*Note: Number of pregnancy-related deaths per 100,000 live births per year.

CDC Pregnancy Mortality Surveillance System
The “M” in MCH

10 deaths per 100,000 live births (1990)

16.7 deaths per 100,000 live births (2010)

52,000 experienced a severe morbidity in 2012
What about injury-related deaths?

**Cause of Death Among Colorado Maternal Deaths, Pregnant Up to One Year Post Delivery, 2004-2012, N=211**

- Accidental drug overdose (37)
- Motor vehicle crash (36)
- Suicide (26)
- Cardiovascular conditions (22)
- Homicide (15)
- Pulmonary Embolism (12)
- Infection (10)
- Pulmonary (10)
- Neurologic (9)
- Cancer (9)
- Hemorrhage (7)
- Amniotic Fluid Embolism (7)
- Other non-cardiovascular conditions* (7)
- Other** (4)

Cardiovascular conditions include:
- Cardiomyopathy (12)
- Other Cardiac Conditions (10)

*Other non-cardiovascular conditions include renal, hematologic and gastrointestinal conditions.
**Data suppressed due to low numbers.

Source: Colorado Death Certificate Data, May 2014
How can AMCHP Help?

• There is significant national momentum around this topic; AMCHP is well-positioned to play a key role in convening and leading multi-disciplinary partnerships.

• Block Grant Transformation:
  - NOMs: Maternal death rate per 100,000 live births; Severe maternal morbidity per 10,000 delivery hospitalizations
  - NPMs: Percent of women with a past year preventive visit; Percent of cesarean deliveries among low risk first births

• Roughly half of all U.S. states have a maternal mortality review — a key step in understanding why maternal deaths occur and preventing future loss.

Strategic Focus: Strengthen capacity of states to improve maternal health outcomes, starting with maternal mortality reviews.
The MMR ‘Action Cycle’

AMCHP’s Every Mother Initiative

- **Strategic Focus**: Strengthen state maternal mortality surveillance systems and enhance the ability of states to translate data into policy and programs that improve maternal health outcomes.

- **Key Components**:

  - Two 15-month Action Learning Collaboratives with 6 states per cohort
  - Action planning and state sub-awards
  - Peer-to-Peer activities (calls, site visits) & Virtual Learning Events
  - Beta-testing of the CDC Maternal Mortality Review Data System
  - Partners as Technical Experts/Advisors
AMCHP’s Every Mother Initiative

Cohort 1

Cohort 2

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Translation Project Examples

• **COLORADO (C1):** Conducted qualitative research with women who experienced severe depression, substance abuse, or IPV and were able to obtain support (what worked)

• **ILLINOIS (C2):** Establish an injury review within the Illinois MMR, including assessing current processes and identifying committee members

• **LOUISIANA (C2):** Identify and develop a protocol for the implementation of a lethality assessment screening tool in a community experiencing high IPV rates (Touro Hospital) to link at risk women with immediate resources and care
Technical Assistance Examples

• March 2014: Achieving Richer Case Data E-Learning Event
  o Content covered included qualitative data (CityMatCH), NVDRS (CDC) and PDMP (CDC)

• April 2015: Injury Review Membership and Participation E-Learning Event
  o Three states (CO, MD, MI) share their experiences with injury review and incentivizing and retaining committee members

• Ongoing connection to mentors and expertise within and across cohorts

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Results – Colorado

*Through the Every Mother Initiative, the state...*

- Reached 17 women at high risk for injury-related death and 11 health professionals via semi-structured interviews and focus groups – contracted with a clinical psychologist
- Partnered with the Pregnancy-Related Depression SAC
- Conducted a literature review
- Added 5 new committee members with injury expertise

*More broadly, the ALC assisted in...*

- Defining a clear role for public health in the review and creating a sustainable programmatic infrastructure
- Increasing representativeness of committee and engaging volunteer committee members with a clear intention
Lessons Learned and Next Steps

• Improve understanding and use of NVDRS for mortality reviews and in particular, case abstraction and achieving richer case data
• Expand access to injury expertise and engage them in the state review process
• Build upon existing relationships with Child Fatality Review and FIMR with respect to engaging injury expertise
• Document translation successes and best practices
• **Hop topics:**
  o Prescription drug abuse (opioid)
  o Engaging women’s voices in systems transformation
Coming Mother’s Day 2015: Health for Every Mother – A Maternal Health Resource and Planning Guide for States

**Infrastructure Elements**

1. Strengthen Maternal Health Surveillance Systems
2. Partner mobilization

**Action Elements**

3. Enable health living
4. Improve access to care
5. Provide high quality preventive serves
6. Ensure readiness and response to obstetric emergencies

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Example: Domain 1

- **Three recommendations:** Build capacity to learn from each maternal death; use administrative data and surveys to monitor outcomes and performance; and integrate data from surveys and other qualitative sources.
  
  - Ideas to consider for “Find all pregnancy-associated deaths”: evaluate quality of the pregnancy checkbox, prospective agreement with state medical examiners and coroners for notification of deaths of women of reproductive age.

- **Resource Boxes:** NVDRS, CDC Directory of State ME and Coroners Organizations, HCUP State Inpatient Database, Listening to Mothers Survey

- **Examples from the Field:** Georgia MMR Legislation, Illinois Maternal Death Identification, Tracking Preconception Health in North Carolina, Hawaii PRAMS, Oklahoma Focus Groups

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Thank you!

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