Strengthening State Review of Maternal Deaths through Collaborative Learning - *The AMCHP Every Mother Initiative*

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Improving Maternal Health Through Planning and Intervention
**Presenter Disclosures**

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(1) The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose

*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)

17.8 deaths per 100,000 live births (2011)

52,000 experienced a severe morbidity in 2012
How can AMCHP Help?

• 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.

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

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

- Case Identification & Selection
- Data Collection & Abstraction
- Case Review & Synthesis
- Systems QI
- Recommend & Take Action

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
What do we know about maternal death and chronic disease?

**Causes of pregnancy-related death in the United States: 2011**

- Cardiovascular disease: 15.1%
- Non-cardiovascular disease: 14.1%
- Infection/sepsis: 14.0%
- Hemorrhage: 11.3%
- Cardiomyopathy: 10.1%
- Thrombotic pulmonary embolism: 9.8%
- Hypertensive disorder of pregnancy: 8.4%
- Amniotic fluid embolism: 5.6%
- Cerebrovascular accident: 5.4%
- Anesthesia complications: 0.3%

*Note: The cause of death is unknown for 5.9% of all pregnancy-related deaths.*

**CDC Pregnancy Mortality Surveillance System**
Chronic Disease and Maternal Health

Prevalence of Chronic Diseases Among Women of Reproductive Age

- Depression: 11.1%
- High blood pressure: 8.7%
- Serious psychological distress: 3.4%
- Diabetes: 3.3%

Prevalence of Chronic Disease Risk Behaviors and Risk Factors Among Women of Reproductive Age

- Insufficient physical activity: 49.2%
- Obesity: 32.5%
- Smoking: 18.3%
- High cholesterol: 7.6%

CDC Division of Chronic Disease Prevention and Health Promotion
Translation Project Examples
Technical Assistance Examples

- **November 2013**: Expanding MMR Committee Membership
- **March 2014**: Achieving Richer Case Data E-Learning Event
- **October 2014**: Assessing Contributing Factors and Discussing Preventability
- **May 2015**: Positioning Committee Findings for Action
31 NEW MATERNAL MORTALITY REVIEW COMMITTEE MEMBERS added to strengthen EXPERTISE & SUSTAINABILITY

ALCs Move Data to Action

8,400 heart health messages shared with women (NC)

122 Simulation participants trained to respond to complications (OH)

62 Nurses trained to safely move sick mothers to higher levels of care (DE)

11 Rural providers trained to manage pregnancy complications (CO)

= 552 HEALTH WORKERS TRAINED to deliver QUALITY care

337 Providers aware of Severe Blood Pressure in Pregnancy Guidelines (NY)

4,800 Flyers
100 Clinic Videos

shared on managing chronic conditions before pregnancy (GA)

20 Chronic disease specialists trained to make family planning referrals (GA)

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Lessons Learned and Next Steps

- **Ongoing question:** what is the role of maternal mortality reviews in chronic disease prevention and behavior change?
- Community perspectives are vital to the case review process
- Build upon existing relationships with CFR and FIMR
- Understanding of equity frameworks is still growing

- **Hop topics:**
  - Prescription drug abuse (opioid)
  - Geospatial analysis
  - Engaging women’s voices in systems transformation
Thank you!

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