Melbourne, FL, June 6, 2012 ~ With global news about maternal mortality like this out of the United Kingdom
and
this from the World Health Organization
, and with the US still ranking 50th in the world in maternal mortality, it's clear that even in developed nations, we still have work to do. In the UK, 20 out of 22 maternal deaths from 2006-2008 resulted from substandard care; usually failure to deliver antihypertensive medications to treat excessive systolic blood pressure, but also other basic failings such as poor diagnosis and failure to act on obvious serious disease.

The American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention (CDC) hosted a day long session of the CDC/ACOG maternal mortality interest group during the College's 2012 Annual Clinical Meeting. The goal of the meeting was to share information about maternal mortality review (MMR) efforts and how some states are transforming reviews into action. Several states shared their experiences and the 18 presentations are now available .

Dr. Maurice Druzin reported from the California Maternal Quality Care Collaborative (CMQCC) that findings from the CA-PAMR (California Pregnancy-Associated Review) are being used to develop a Preeclampsia Toolkit. This collection of checklists and brief guidelines will outline best practices in recognizing and treating preeclampsia, the second leading cause of maternal death in California. the Toolkit will address issues throughout pregnancy and in outpatient clinis and emergency departments as well as Labor & Deliver units. The goal is to improve both maternal and perinatal outcomes among California's 530,000 annual births, which comprise 1/8 of the nation's total births. The Toolkit will be publicly available in late 2012. The Preeclampsia Foundation is playing an active role in this effort, representing patient interests and information

needs.

Elliott Main, MD, CMQCC's Medical Director and chair of the CDC/ACOG maternal mortality study group, said,"The CMQCC Preeclampsia Toolkit represents an ongoing commitment by the California Department of Public Health, Maternal Child and Adolescent Health Division to address preventable causes of maternal mortality and improve health outcomes for all California mothers and their newborns. CMQCC has the ability to leverage the volunteer efforts of an incredible team of expert clinicians from obstetrics, maternal fetal medicine, emergency medicine and anesthesia to address all facets of the preeclampsia issue in developing this Toolkit."

Other states such as New York, Illinois, Alaska and North Carolina also reported on their efforts to develop quality improvement programs based on MMR findings and health disparities.

While a bit oversimplified, the process of MMR boils down to this:

- Each state must have a standardized pregnancy "checkbox" on its death certificates. (The National Center for Health Statistics has announced it will not publish US Maternal Mortality Rates until all states adopt a pregnancy check box and use a standard US death certificate, which is estimated to be developed in 2013 at the earliest.)
- Identify maternal deaths.
- Systematically review de-identified cases and analyze for recurring points of failure.
- Aggregate the findings from across the state without identifying any hospital or physician.
- Disseminate the findings.
- Transform findings into improved care guidelines.
- Implement quality improvement practices and tools.
- Measure improvement.

So what's the problem? For starters, states with Maternal Mortality Review programs sometimes delay reporting their findings, whether due to scarce resources, or because they fear a public relations issue. States that don't have an MMR program either don't have the resources - data collection and analysis is time consuming and expensive - or don't have enough maternal deaths to produce statistically significant data.

Two potential solutions to the latter problem are 1) aggregating state data across the nation and 2) including the harder to collect but extremely meaningful data that would come from "near misses" - cases that include severe maternal or perinatal complications.

Does your state have a pregnancy checkbox on its death certificate? Does it have an MMR program? Would you be interested in advocating for one? Let us know .