ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS
KANSAS SECTION

Maternal Mortality Legislation – HB 2573
Position: Proponent

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Senate Public Health and Welfare 118-N

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Maternal mortality: alarming trends

Maternal mortality is an important indicator for quality – in the health of our communities, patient populations, and health systems.

Our national organization reports that there has surprisingly been **no** significant improvement in maternal mortality in the US **for more than 25 years**. Nationally, maternal deaths **jumped more than 25 percent from 2000 to 2014** (18.8% in 2000 to 23.8% in 2014).

The international trend among other industrialized countries is in the opposite direction. The US lags behind other industrialized countries in maternal mortality.

It is estimated that about half of all maternal deaths in the US could be prevented.

Maternal near-deaths are also on the rise – for example from preeclampsia and high blood pressure. Increasingly, more pregnant women in the US have chronic health conditions and are overweight or obese. These conditions put pregnant women, especially those 40 years of age and older, at higher risk of adverse outcomes. For every maternal death, there are an estimated 50 pregnant women who have near-death complications.

And there are significant and widening disparities in maternal mortality among black, Hispanic and white women. This highlights the need to better understand how social determinants of health and barriers to risk-appropriate care can be addressed to promote optimal outcomes for all women.

The CDC and ACOG support Maternal Mortality Review Committees (MMRCs)

The Centers for Disease Control and Prevention and the American Congress of Obstetricians and Gynecologists have long prioritized the reduction of the maternal deaths in the U.S. CDC and ACOG started calling for the establishment of state review teams a decade ago. CDC and ACOG recommend that all states have an active, confidential Maternal Mortality Review Committee that uses standardized, uniform data collection and reporting tools.

About 30 states have an active Maternal Mortality Review Committee in place or on the drawing board – we would like to finish that work here in Kansas. We know that reviewing maternal deaths in a systematic manner for the purpose of taking action can reduce the risk of women dying from

complications of pregnancy. We are pleased that your committee is talking the steps to consider this legislation.

In the past decade, there have been major advances in the approach to obstetric emergencies. There are national initiatives underway that seek to mobilize clinical and public health resources to improve safety in maternity care. ACOG has joined with multiple professional organizations to create maternal safety bundles for implementation in all birthing facilities. Standardized protocols for conditions such as obstetric hemorrhage have been shown to reduce the rates of hysterectomy and blood use. A state Maternal Mortality Review Committee helps to support these important initiatives.

What is the function of an MMRC?

MMRCs give us specific, data-driven recommendations to prevent future maternal deaths.

These committees identify, study and review cases of maternal deaths. They examine the medical and non-medical circumstances of deaths that occur during pregnancy up to one year post-delivery.

Maternal deaths are defined as the death of a woman during or within 1 year of pregnancy that was caused by a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Leading causes include cardiovascular disease, cardiomyopathy, thromboembolism, obstetric hemorrhage, preeclampsia, sepsis, hypertension and obesity.

Committees review de-identified medical records and other relevant data including birth and death certificates and autopsy, hospital ER, medical transport, social services and mental health records and reports.

Committees also develop recommendations for the prevention of maternal deaths and disseminate findings and recommendations to policy makers, health care practitioners, health care facilities and the public.

Committees conduct their confidential reviews of medical records and interviews within a culture of promoting safety. The focus is on identifying opportunities for improvement of systems – not on assigning blame.

Maternal Mortality Review Committees help us identify gaps in services and systems to prevent future deaths and near-misses. Committees help identify what is contributing to the problem and then raise awareness and educate health professionals and others on appropriate remedial actions. Committees also identify strengths in the systems of care that should be supported or expanded.

HB 2573 – Important Protections for the Kansas MMRC

The legislation you are considering today will open the door for an MMRC to begin working in Kansas.

The provisions in HB2573 provides the Secretary of Kansas Health and Environment the authority to collect data and assemble a committee to review cases of maternal mortality. The legislation also provides important legal protections for committee members.

One reason that Kansas lacks a maternal mortality review committee is that legal action could be taken against those serving on the review committee to compel their input into lawsuits related to any case they might (or might not) have reviewed. I commend to your attention the written testimony of Dr. Melissa Hague, the chair of the KS Section of ACOG in which she offers several pertinent points as to why these types of protections are necessary for the successful implementation of maternal mortality review here. The testimony from the Kansas Medical Society in support of HB 2573 also provides more background on the protections afforded in HB 2573. The legislation you are considering has been drafted with the same protections that exist in other states for MMRC.

Thank you to the Committee for hearing the merits of HB2573 and the MMR process. We hope you will see fit to pass this measure on to the House for its consideration.