
Maternal Mortality in Kentucky

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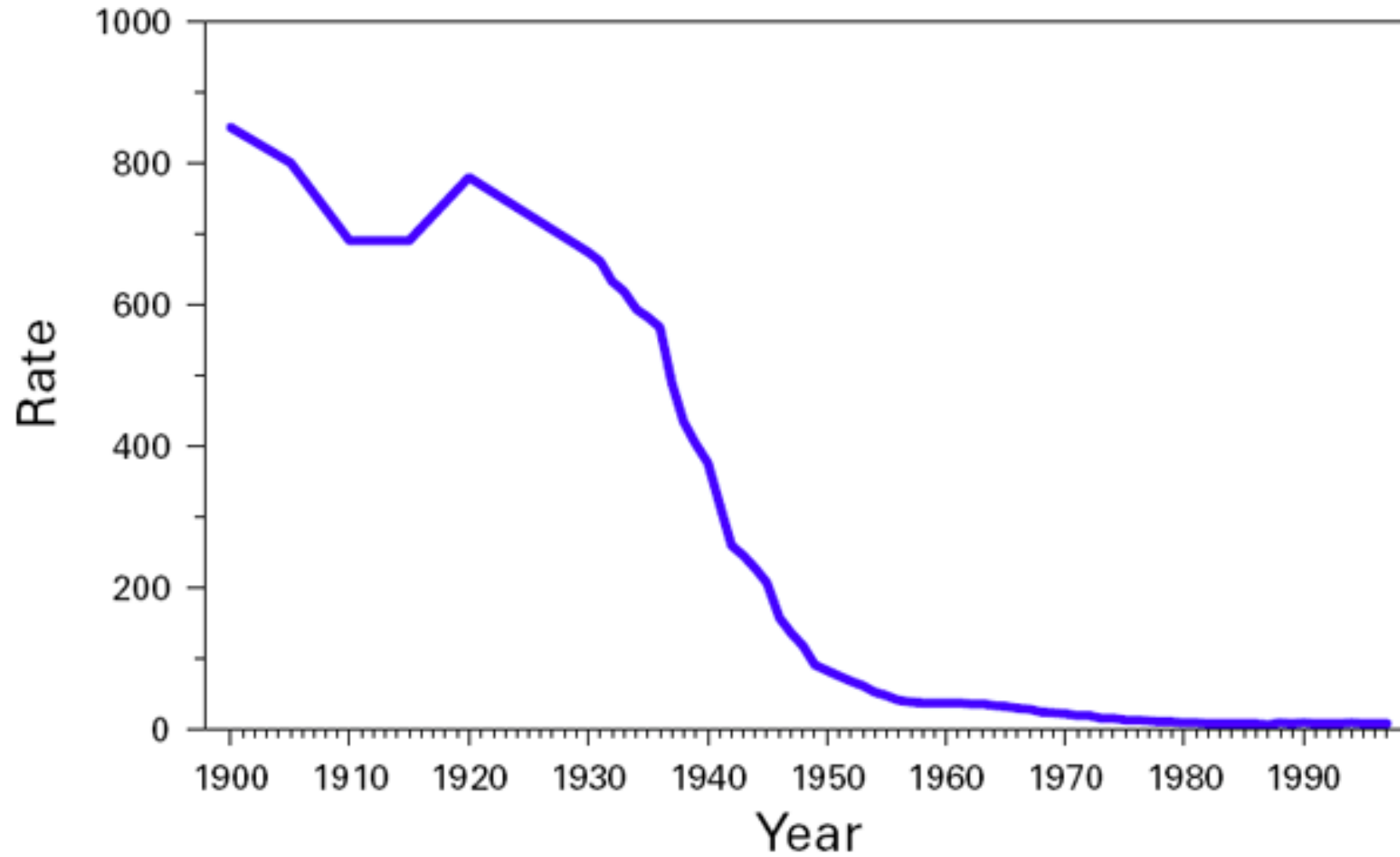


Maternal Mortality

- Prevention of maternal morbidity and mortality is the defining goal of modern obstetrical care
- Healthy babies and children require healthy moms

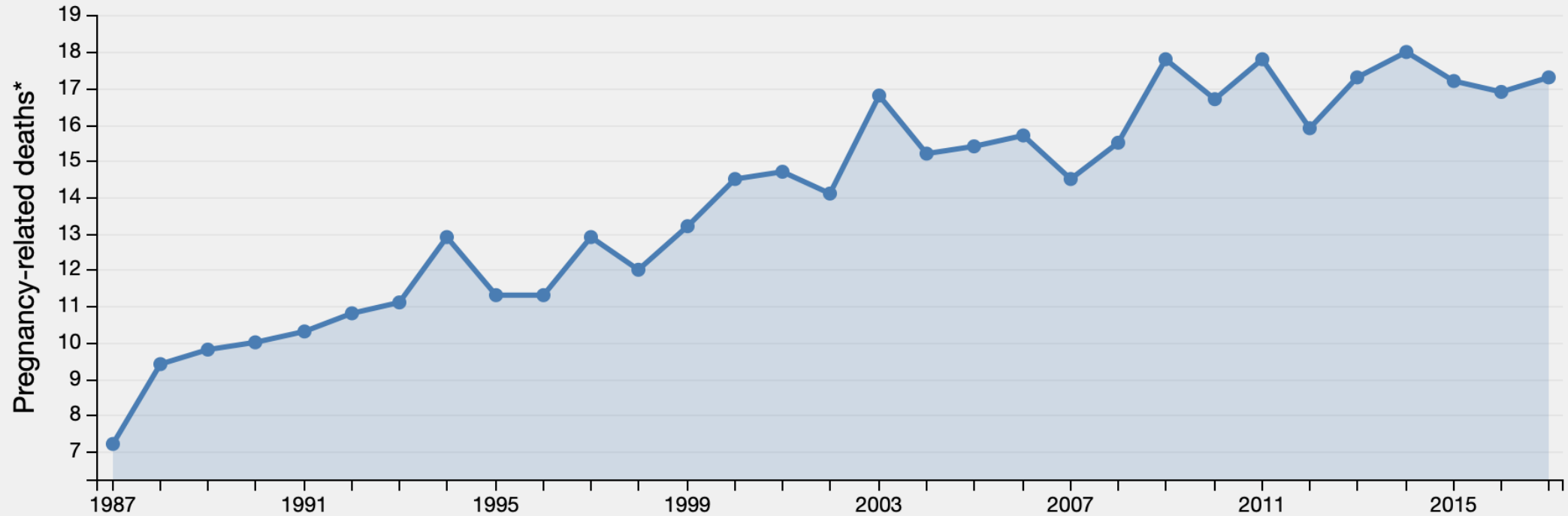


FIGURE 2. Maternal mortality rate,* by year — United States, 1900–1997



* Per 100,000 live births.

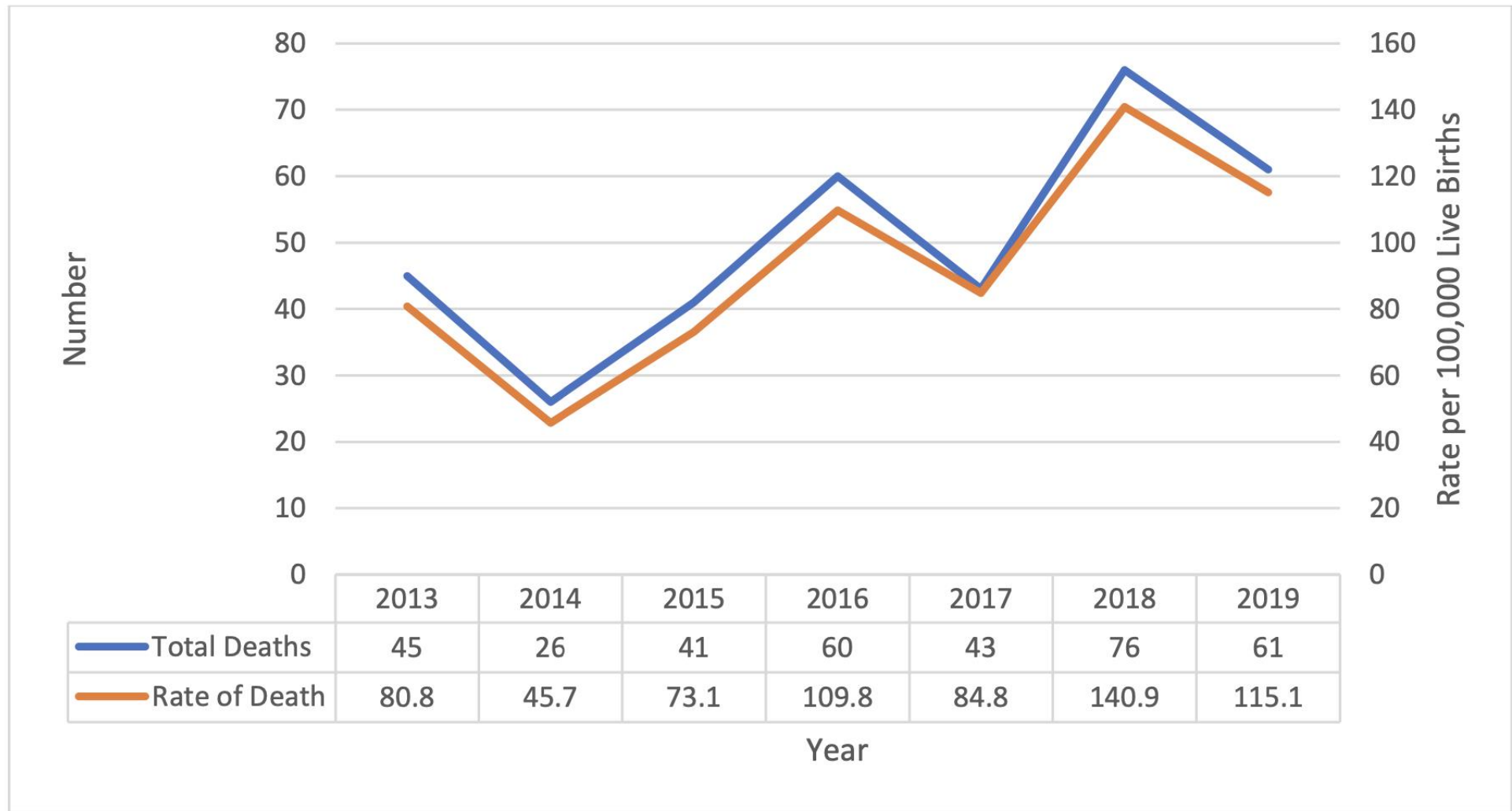
Trends in pregnancy-related mortality in the United States: 1987-2017



*Per 100,000 live births

■ Pregnancy-related mortality ratio [Reset](#)

Figure 1: Total Number of Maternal* Deaths and Rate of Death; Kentucky, 2013-2019



Why focus on maternal mortality?

Tip of the iceberg

Each death = 70 cases of severe morbidity

Mothers who could have died, but didn't



Maternal Mortality Review Committee

Authorized by KY legislature in 2018 HB 167



Thank you for helping to improve
the health of women and babies in
Kentucky

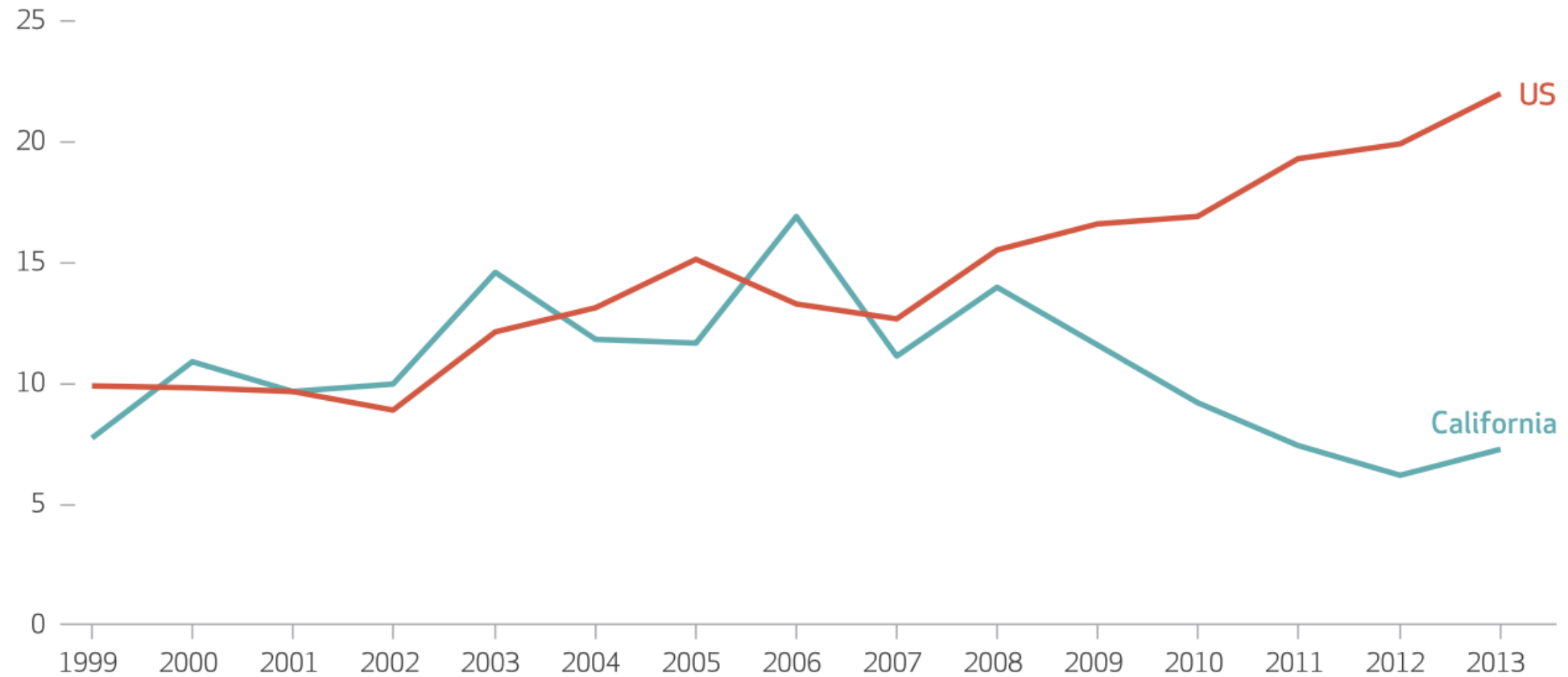


Why is formal review critical?

- We can't manage what we don't measure.
- Worsening mortality trend is reversible.



Maternal mortality rates per 100,000 live births in California and the United States, 1999–2013



SOURCES Authors' reproduction of data from the following sources in the public domain. For California: California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, March 2015; and the California Birth and Death Statistical Master Files. For the US: data for 1999–2007 from the National Center for Health Statistics (NCHS); and data for 2008–13 from CDC WONDER, Centers for Disease Control and Prevention. **NOTE** Maternal mortality is defined in the text.

KY Maternal Mortality Review Committee Findings

Preliminary review of 2017-2019

- At least 8.4% of deaths due to suicide.
 - On a subsequent review of Medicaid patients, #1 reason for readmission within 90 days of delivery was suicidal ideation.
- Of 128 deaths ruled “accidental,” substance use disorder was:
 - A contributing factor in 53%
 - A possible contributing factor in an additional 14%

KY Maternal Mortality Review Committee Findings

Most recent year for complete review is 2018

- **91%** of deaths related to or associated with pregnancy were **potentially preventable**.
- Mental health condition of substance use disorder was a factor in **53%** of deaths

Next Steps

- Department for Public Health
 - Oversees the MMRC
 - Numerous interventions outlined on the CHFS website and in the Maternal Mortality Review Report
 - Oct 2019- Kentucky Perinatal Quality Collaborative (KyPQC)
 - www.KYPQC.org

Next Steps

- Interventions must be
 - Directed by analysis of data
 - Evidence-based (i.e., clinical studies demonstrating effectiveness)
- Avoid
 - “Ideas that sound good”
 - Additional statutory mandates and regulations
 - Unless truly impactful
- Improve the system of care, not the rules

Alliance for Innovation on Maternal Health (AIM)

- National Program to Reduce Maternal Morbidity and Mortality
- Led by ACOG + 22 Partners
- National Program
 - Implemented at the state level
 - KY is now an AIM state
- www.saferbirth.org





Alliance for Innovation on Maternal Health (AIM)

- Creates evidence-based “Patient Safety Bundles”
 - Hemorrhage
 - Hypertension
 - C-Section Reduction
 - Cardiac Care
 - Sepsis
 - **Postpartum Discharge Transition**
 - **Perinatal Mental Health**
 - **Substance Use Disorder**

<https://saferbirth.org/patient-safety-bundles/>



RECOGNIZE POSTPARTUM WARNING SIGNS

Ask: "Are you pregnant, or have you been pregnant in the past 12 months?"

Watch for these warning signs:



Persistent headache
Changes in vision
Dizziness or fainting



Fever
Thoughts about hurting self or baby
Overwhelming fatigue



Significant swelling of hands or face



High blood pressure
Chest pain or rapid heart rate
Difficulty breathing



Swelling, redness, or pain in legs



Persistent, severe abdominal pain
Severe nausea and vomiting



These warning signs may indicate serious complications, which can occur up to 12 months after pregnancy. If a client experiences any of these warning signs, connect them with emergency care right away.





What can the legislature do to help?

- State participation in AIM is voluntary.
- Institutional participation in the KY PQC is voluntary (although presently 71% of birthing hospitals have identified a PQC champion).
- Participation in efforts to improve quality and safety should be mandated by the legislature.
- The Cabinet for Health and Family Services should have a legislative mandate and authority to reduce maternal morbidity and mortality.



Thank you for your efforts to improve
healthcare quality and safety for women
and infants in Kentucky