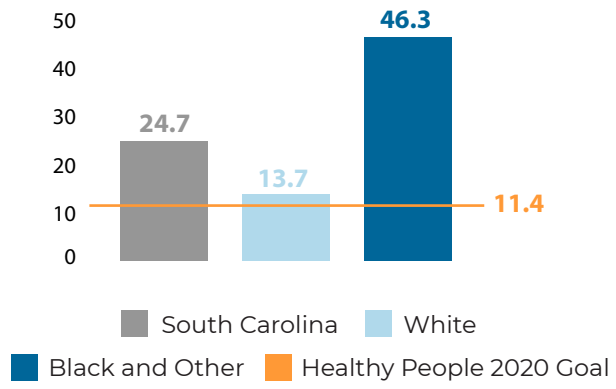
South Carolina Maternal Mortality and Morbidity Review Committee

Legislative Brief 2018

The South Carolina Maternal Mortality and Morbidity Review (MMMR) Committee, established by state law in 2016, investigates the death of mothers associated with pregnancy to determine which ones can be prevented. A pregnancy-related death occurs when a woman dies while pregnant or within 1 year after the pregnancy. The cause must be related to or made worse by her pregnancy or its management. This does not include accidental or incidental causes.[1]

South Carolina Pregnancy-Related Death by Race, 2013-2017[2]

Rate per 100,000 live births



Across the United States, approximately 700 women die each year from the result of pregnancy or delivery complications. Some groups of women in South Carolina experience this tragic event at a much higher rate than in other groups.[2]

During 2013-2017, the rate of pregnancy-related death in South Carolina (24.7 deaths per 100,000 live births or 71 total deaths) was higher than the Healthy People 2020 goal of 11.4 deaths per 100,000 live births.

Compared to the previous five-year period, the rate of pregnancy-related death increased among minority populations and in South Carolina overall.

Goals of the South Carolina MMMR Committee

1. Determine the annual number of pregnancy-associated deaths that are pregnancy-related.
2. Identify trends and risk factors among preventable pregnancy-related deaths in South Carolina.
3. Develop actionable strategies for prevention and intervention.

2018 MMMR Committee Accomplishments

The Maternal Mortality Review Information Application (MMRIA), a standardized database for case abstraction, was deployed. This database strengthens our state's ability to perform surveillance, monitoring, and research of maternal mortality.

South Carolina contributed aggregate state data to national surveillance efforts for the 2018 "Report from Nine Maternal Mortality Review Committees[3]" and has also contributed to the upcoming 2019 report.

[1]Berg, C., Danel, I., Atrash H., Zane, S. Bartlett, L. (Eds.). Strategies to reduce pregnancy-related deaths: From identification and review to action. Atlanta: Centers for Disease Control and Prevention; 2001.
[2]Vital Statistics (2018, November). South Carolina Vital and Morbidity Statistics 2017. Retrieved from https://scdhec.gov/sites/default/files/media/document/Vital-Morbidity-Statistics_2017.pdf

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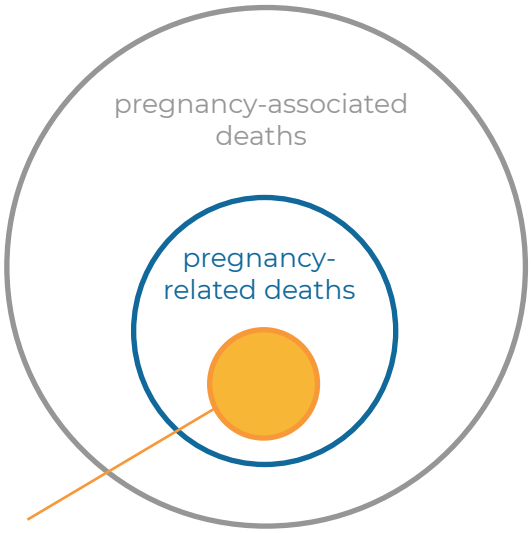
Scope of Case Review



Primary Focus
preventable pregnancy-related deaths

MMMR Committee Findings

During the 2016-2018 review period, 13 of the 15 maternal deaths reviewed in South Carolina were determined to be pregnancy-related. One death was determined to be pregnancy-associated but not related to pregnancy, and the other could not be determined. Among the 13 pregnancy-related deaths, 54% were determined to be preventable.

54%

As reported nationally[3], the findings from South Carolina's MMMR Committee show that the common causes of maternal death include cardiovascular and coronary conditions, hemorrhage, infection, and embolism.

MMMR Committee Recommendations

These identified actions could improve South Carolina's ability to understand causes of pregnancy-related death.

Remove Barriers to Accessing Data

Allow linkage to vital records to improve case identification. This information would provide the true burden of maternal death in S.C. and would enable a more representative number of cases to be reviewed for improved recommendations for prevention.

Identify Funding

Identify funding that would provide resources for the review of all pregnancy-related deaths.

Improve Reporting of Maternal Deaths

Establish routine hospital and birthing center reporting, which would allow more cases to be reviewed.

Recent Federal Legislation

The recent passing of the Preventing Maternal Deaths Act of 2018 underscores maternal mortality as a national priority and lends support for statewide activities. It was enacted to support states' reviews of pregnancy-related and pregnancy-associated deaths (maternal deaths), establish and sustain a maternal mortality review committee to review relevant information, ensure that state departments of health develop a plan for ongoing health care provider education in order to improve the quality of maternal care, disseminate findings and implement recommendations, disseminate a case abstraction form for uniformed information collection, and provide resources for more comprehensive state reporting.

[3]Centers for Disease Control and Prevention. (February 2018). Report From Nine Maternal Mortality Review Committees. Retrieved from http://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs_1.pdf.

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