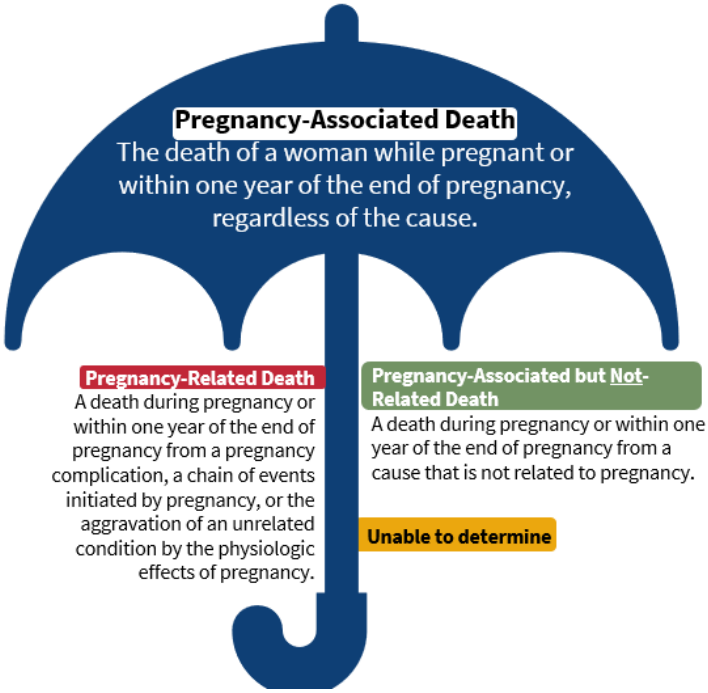
Pregnancy-Associated Mortality Review Overview

The Pregnancy-Associated Mortality Review, also known as PAMR, Committee is Ohio's maternal mortality review committee (MMRC). MMRCs are the only way we can understand why women are dying from pregnancy-related causes during pregnancy, childbirth, and in the postpartum period; see how these deaths could have been prevented and make recommendations to prevent future deaths. Nationally MMRCs:

- Use a comprehensive process to identify, review, and analyze deaths during pregnancy, childbirth, and the year postpartum; disseminate findings; and act on results; and
- Are a group of experts and stakeholders in maternal health that convene regularly to review deaths and identify key learnings and opportunities to prevent future deaths.

Definitions:



These definitions help the PAMR committee answer the question,

"If the woman had not been pregnant, would she have still died?"

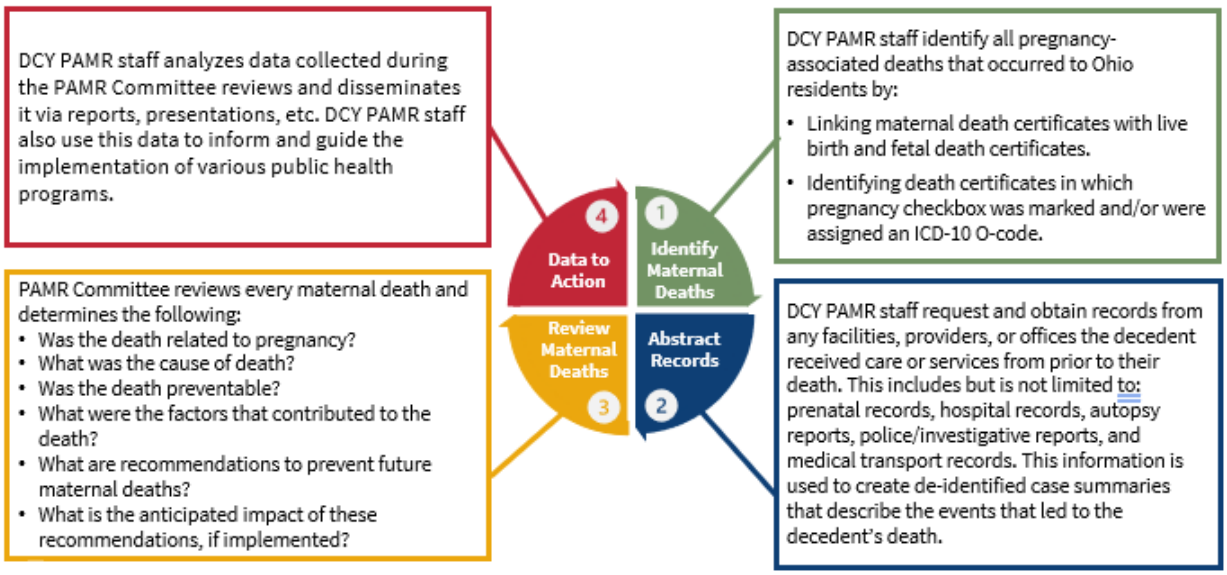
If the answer is no, then that death is considered pregnancy-related.

PAMR consists of two primary sets of partners:

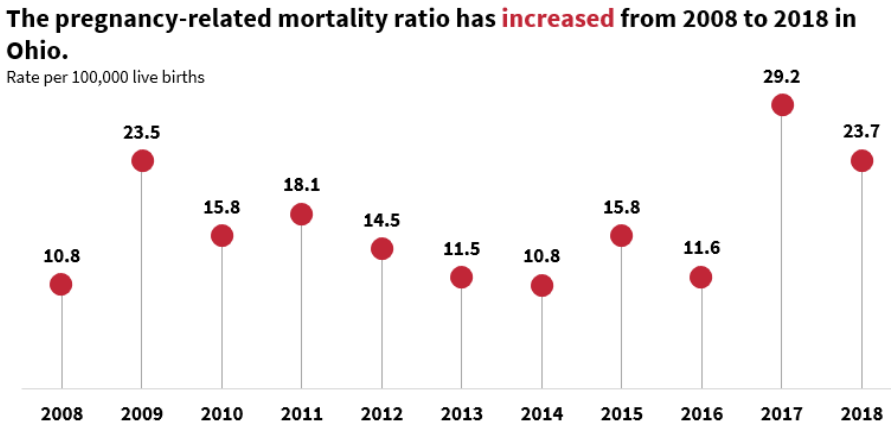
1. PAMR Staff who are responsible for the identification, abstraction, and data entry of maternal death cases, and
2. The multidisciplinary PAMR committee is made up of members from a diverse group of disciplines and backgrounds, including both clinical and non-clinical settings.

Together, PAMR Staff and the PAMR Committee work to identify and review all pregnancy-associated deaths in Ohio and promote systems change to reduce preventable maternal deaths by implementing the below action cycle.

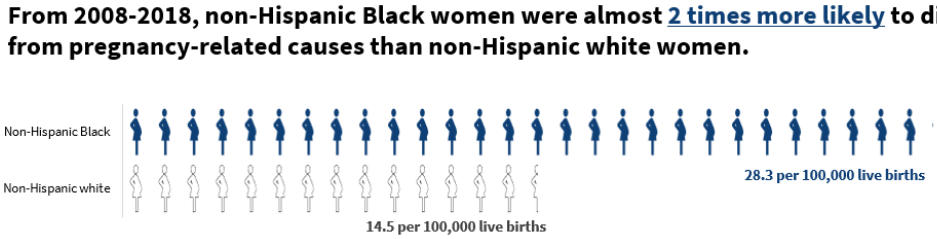
PAMR Process



Maternal deaths are increasing in Ohio. The pregnancy-related mortality ratio has increased from 2008 to 2018 in Ohio, from 10.8 to 23.7 deaths per 100,000 live births respectively.



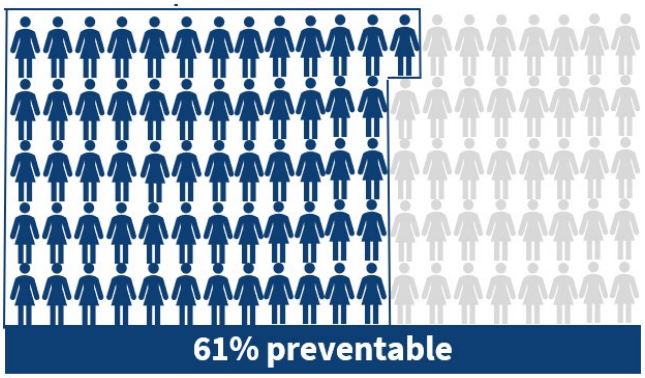
Mental health conditions was the leading cause of pregnancy-related deaths in Ohio from 2008-2018, and this included those due to substance use disorder/overdose, depression, anxiety disorder, and other psychiatric conditions. Followed by other leading causes of death such as Cardiovascular conditions, infection, hemorrhage, and hypertensive disorders of pregnancy.



It is important to note that when we disaggregate this data by race and ethnicity the leading causes differ between groups. Non-Hispanic White women's leading cause of death are mental health

conditions while the leading causes of death for non-Hispanic Black women include medical conditions such as embolism, hypertensive disorders of pregnancy, infections, and cardiovascular conditions. There is an unacceptable disparity in pregnancy-related deaths for non-Hispanic Black women in Ohio and nationally. From 2008-2018, non-Hispanic Black women were almost 2 times more likely to die from pregnancy-related causes than non-Hispanic white women.

Most pregnancy-related deaths in Ohio from 2008 to 2018 occurred during the postpartum period. The majority of deaths, 67%, occurred in the post-partum period which includes up to a year after the end of pregnancy.



Over the decade of 2008-2018, 61% of pregnancy-related deaths in that time were deemed preventable. This is where there is significant opportunity to impact the maternal mortality crisis and must do better.

PAMR data helps us to better understand our opportunities to prevent maternal deaths in Ohio by developing interventions and strategies that address these leading causes, turning data into action.

PAMR Recommendation	Strategy
Convene a Maternal Health Task Force, comprised of stakeholders representing individuals and organizations from across the state to identify Ohio-specific gaps and assist in the development of an Ohio-focused strategic plan informed by PAMR data.	Ohio Council to Advance Maternal Health (OH-CAMH). • Built trust in collaboration with 187 individuals from 77 organizations. • Drafted Ohio's Maternal Health Strategic Plan with 11 key strategies. • Created 11 implementation teams working on activities to address each strategy.
Increase multidisciplinary communication and collaboration between clinical care providers, community-based organizations, and public health service organizations.	Compassionate, Accountable, Respectful, Equitable CARE Quality Improvement Project. • CARE seeks to improve equitable maternity care for pregnant women and their partners. • In its current pilot phase, the CARE Project is working with institutions and care teams in a Learning Community with 13 maternity sites.

	• Teams in the Learning Community are working to improve their readiness to address equitable maternity care through assessment, prioritization, and testing changes.
Encourage the adoption of the corresponding patient safety bundles through the Patient Safety Council on Women's Healthcare, the Alliance for Innovation on Maternal Health (AIM), Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the California Maternal Quality Care Collaborative.	<u>Implement the AIM patient safety bundles throughout delivery hospitals in Ohio to reduce preventable maternal deaths.</u> • Severe Hypertension in Pregnancy: 84/91 birthing hospitals participated across Waves 1, 2, and 3. • Obstetric Hemorrhage: 24 hospitals completed Wave 1 this fall. 27 hospitals recruited for Wave 2. • Substance Use Disorder bundle to begin in July.
Educate providers and patients on recognition, treatment, and prevention of obstetric complications.	<u>Implementation of the Urgent Maternal Warning Signs education in public health settings.</u> • Educating providers, pregnant women, and communities on the urgent material warning signs to increase knowledge of and improve health outcomes among women at risk for an adverse prenatal or postpartum event.
Educate providers and patients on recognition, treatment, and prevention of obstetric complications.	<u>Obstetric Emergency Simulation Trainings for Emergency Medicine Providers.</u> • Provide educational opportunities to emergency medicine physicians, physician assistants, nurse practitioners, nurses, and first responders to increase their knowledge and preparedness for obstetric emergencies.
Work to recognize disparities at both the personal and systems level.	<u>Disparities in Maternal Health Community Grant.</u> • Fund solutions identified by communities and address unmet needs through a disparities-focused, equity-driven lens through the Disparities in Maternal Health Community Grant Program.