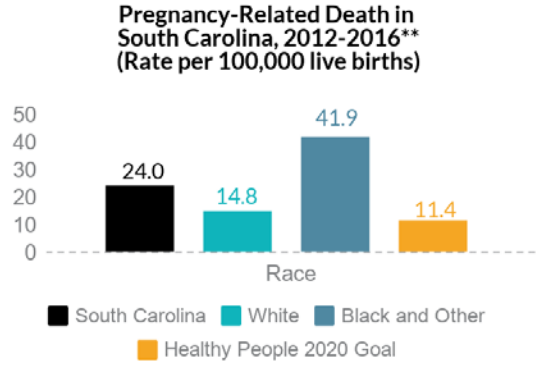
South Carolina Maternal Mortality and Morbidity Review Committee

Legislative Brief 2017

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.*



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

During 2012-2016, the maternal death rate in South Carolina was higher than the Healthy People 2020 goal of 11.4 maternal deaths per 100,000 live births.

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.

2016-2017 MMMR Committee Accomplishments

Established the Committee

Members include stakeholders from multiple disciplines.

Best Practices

Trained members on the mission, goals, best practices, and data structure.

Began Data Review

Identified cases through voluntary hospital reporting. Collected and reviewed data on 8 deaths.

*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.

**Vital Statistics. (2017, October). South Carolina Vital and Morbidity Statistics 2016. Retrieved from http://www.dhec.sc.gov/Health/docs/BiostatisticsPubs/VMS2016.pdf.

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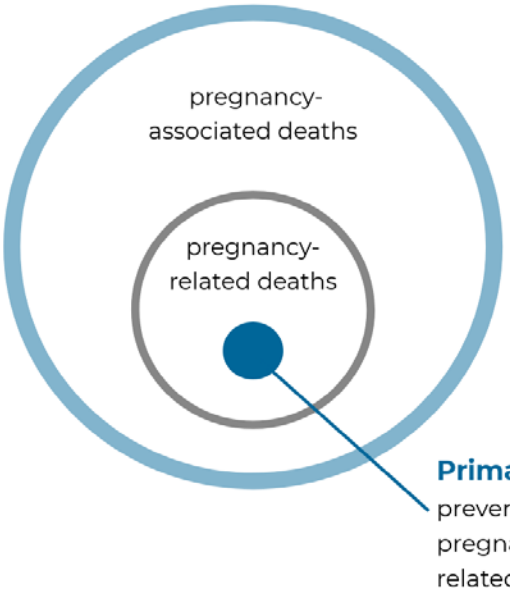
Scope of Case Review



Primary Focus
preventable pregnancy-related deaths

MMMR Committee Findings

During 2016-2017, **7 of the 8 total maternal deaths reviewed** in S.C. were determined to be **pregnancy-related.**

87.5%

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

Once access to vital records is gained, a complete, more robust analysis will be possible. Review of all pregnancy-related deaths will provide the committee with the ability to see trends in contributing factors and make recommendations for prevention.

MMMR Committee Recommendations

Since 2016, the committee, has identified actions that 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.

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.

South Carolina's Contribution to National Efforts

In partnership with the Centers for Disease Control and Prevention (CDC), South Carolina recently contributed its aggregate data to national surveillance efforts in the 2018 "Report from Nine Maternal Mortality Review Committees"*. This effort allows the committee to better understand trends in maternal deaths, contributing factors, and recommendations for prevention in our state.

South Carolina's partnership with the CDC has led the state to the deployment of the Maternal Mortality Review Information Application (MMRIA), a comprehensive database that can be used for surveillance, monitoring, and research of maternal mortality. MMRIA will support the work of the committee and improve case investigation efforts.

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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