

Written Statement for the U.S. Commission on Civil Rights

Briefing regarding “Maternal Health Disparities”

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Thank you Commissioners for the opportunity to provide this written statement regarding maternal health disparities. I am Dr. Melanie Rouse, the Maternal Mortality Programs Manager in Virginia Department of Health’s, Office of the Chief Medical Examiner, and I would like to commend you for holding this briefing. Thank you for the opportunity to speak on this important topic.

Virginia Maternal Mortality Review Team and Overall Data

Virginia’s Maternal Mortality Review Team was established in 2002 as a partnership between the Virginia Department of Health’s Offices of the Chief Medical Examiner and Family Health Services and is dedicated to the identification of all pregnancy-associated deaths in the Commonwealth and the development of recommendations for interventions in order to reduce preventable deaths. It is a multidisciplinary group with representatives from academic institutions, behavioral health agencies, and hospital associations, state chapters of professional associations, state medical societies, and violence prevention agencies. The disciplines represented include forensic pathology, maternal fetal medicine, nurse midwifery, obstetrics, pharmacy, nutrition, patient safety, psychiatry, public health, health services research, and social work. The Team collects data on and reviews the deaths of all Virginia residents who were pregnant within a year of their death regardless of the outcome of the pregnancy or the cause of death. These deaths are termed “pregnancy-associated deaths or “PADs”. The Team collects records from the hospital where the birth or pregnancy related issue, concern, or termination occurred, the birth attendant’s records, hospital records where the death occurred, the autopsy records and the Medical Examiner case investigation records. The Team also collects records from other health care providers and specialists, social service

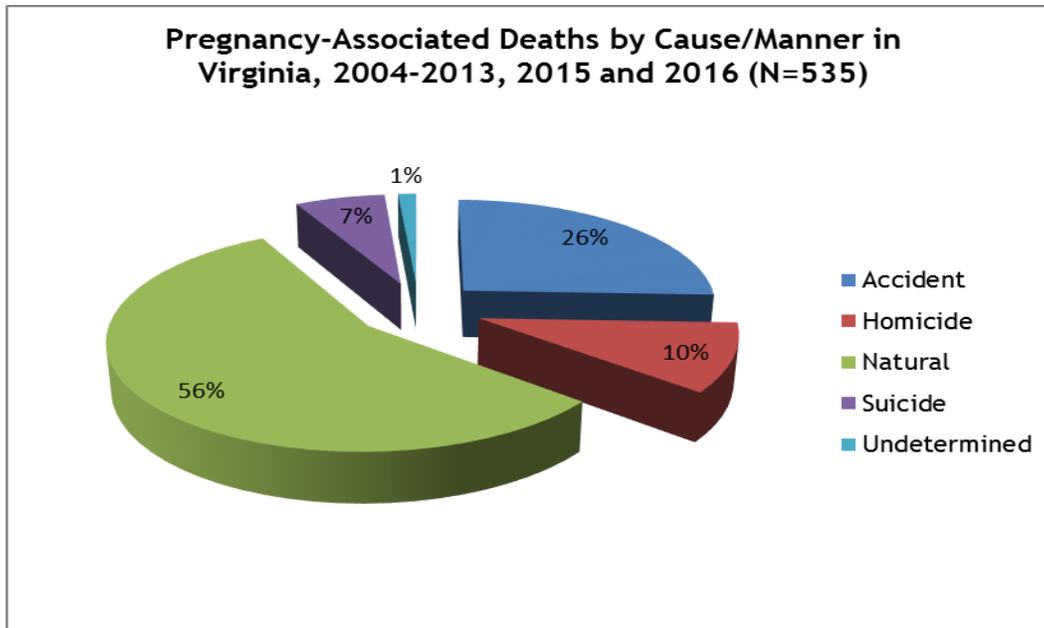
agencies, and mental health facilities to ensure that each review is comprehensive and thoroughly assesses the woman's life, health and healthcare utilization in the 5 years prior to her death. The Team reviews each case to determine the community-related, patient-related, healthcare facility-related and/or healthcare provider-related factors that contributed to the woman's death. The Team also assesses or recommends needed changes in the care received that may have led to better outcomes. The Team then uses consensus decision making to determine whether the death was preventable and/or related to the pregnancy.

Since 2004, 535 women have died of a PAD in Virginia. The number of deaths and rate of deaths varied from year to year with no clear pattern suggesting a clear increase or decrease (Figure 1). The overall maternal mortality rate¹ was 42.8 deaths per 100,000 live births during this period. Preliminary numbers for the years 2015 and 2016 suggest that maternal mortality rates in Virginia continue to follow a similar pattern with rates of 31.0 and 43.0, respectively².

Overall, approximately 56% of PADs in Virginia were due to natural causes (Figure 2). Accidental deaths represented the next largest manner of death among PADs in Virginia at 26%. Among the leading causes of death are cardiac disorders (14.4%), accidental overdoses (13.5%), motor vehicle accidents (10.5%), homicide (10.3%) and Suicide (6.5%). Nearly 52% of these deaths occurred 43 or more days following the end of the index pregnancy.

¹ Ratio provided is the Maternal Mortality Rate (MMR), which is calculated by dividing the number of deaths in a category by the number of live births and then multiplying that number by 100,000. The MMR is the standard measure for evaluating maternal morbidity and mortality.

² 2014 cases are not included due to significant errors in the electronic death certificate.



Several risk factors were identified among PADs in Virginia. The most prevalent risk factors identified included mental illness, chronic substance abuse, and chronic medical conditions. Over 25% of maternal decedents in Virginia had been diagnosed with depression and approximately 20% had been diagnosed with anxiety at some time in their life. Nearly 25% of maternal decedents were also found to have chronic substance abuse. Data from the Virginia Team reveals that many chronic conditions, including chronic substance abuse and chronic mental illness, are not adequately addressed prior to pregnancy, during the pregnancy, post-partum period and beyond. The data also reveals that there is a lack of coordination of care with many women not receiving the appropriate screenings, referrals and/or being left to navigate the complicated health care system on their own.

Racial Disparities in Maternal Mortality in Virginia

Throughout the years of maternal mortality review in Virginia, significant racial disparities have been identified in the rates, causes of deaths, manners of deaths and contributors to mortality. These disparities have been found to extend across all socioeconomic and educational backgrounds. The maternal mortality rate for Black women (78.8) is over two times as high as White women (34.9). While, the rate among other races was significantly lower than both African American and White women (22.1). There have also been significant differences found by race in regards to the manner of death. For the years 2004-2013, 2015 and

2016 (Table 1), Black women (66.4%) were found to be more likely to die a natural death than White women were (48.1%) and less likely to die an accidental death (15.2% vs. 34.0%, respectively).

Manner of Death	White	African American	Other
Natural	140(48.1%)	140(66.4%)	21(63.6%)
Accidental	99(34.0%)	32(15.2%)	6(18.2%)
Homicide	22(7.6%)	29(13.7%)	4(12.1%)
Suicide	28(9.6%)	5(2.4%)	2(6.1%)
Undetermined	2(0.7%)	5(2.4%)	0(0.0%)

There were also significant differences in the leading causes of death by race. The leading causes of death among White women were accidental causes, including accidental overdose (19.6%) and motor vehicle accidents (12.4%), followed by cardiac disorders (11.3%) suicide (9.6%) and cancer (9.6%). However, among Black and other race women, the top causes of death were natural causes followed by accidental causes. Among Black women, the leading causes of death included cardiac disorder (19.4%), homicide (13.7%), the exacerbation of a chronic disease (7.1%) and pulmonary embolism (7.1%). The leading causes of death among other race women included hemorrhage (21.2%), disorders of the central nervous system (12.1%) and homicide (12.1%).

Efforts to Improve Maternal Outcomes in Virginia

This past June, Governor Northam announced a goal of eliminating the racial disparity in Virginia’s maternal mortality rate by 2025. This means a more than 50% reduction in the maternal mortality rate for Black women in Virginia. We are currently developing a strategic

plan for improving maternal health based on the MMRT data and recommendations, recent literature and best practices.

We are focused on three key areas:

1.) Health Insurance Coverage:

- a. We expect Medicaid expansion to have a positive impact on maternal and infant health outcomes.
- b. Over 290,000 newly eligible adult Virginians have now been enrolled into Medicaid coverage, approximately sixty percent of which are women.
- c. Prior to January 1 of this year, pregnant women enrolled in Medicaid only received coverage during pregnancy and for 60 days postpartum. Now, with Medicaid expansion, women in the expansion population receive continuous coverage. This postpartum coverage is especially important considering the MMRT's data showing the majority of pregnancy-related deaths occurred more than 43 days post-delivery.
- d. The Medicaid program includes care coordination/navigation and transportation benefits. These are crucial to improving maternal health.

2.) Improving the quality of care received:

- a. VDH and the Virginia Hospital and Healthcare Association have worked closely to develop a plan for a collaborative partnership with ten Virginia hospitals and their ambulatory providers to implement evidence-based, culturally sensitive training, education, and best practices.
- b. Leadership at VDH and the Department of Health Professions are collaborating on strategies to increase cultural competency training, including implicit bias training, among our healthcare workforce.
- c. The Virginia Neonatal Perinatal Collaborative is working to facilitate the implementation of AIM (Alliance for Innovation on Maternal Health) bundles. They are specifically focusing on Maternal Hemorrhage patient safety bundles and maternal opioid use disorder patient safety bundle.

3.) Community-based programs and services:

- a. The Children’s Cabinet has endorsed a statewide framework for scaling home visiting programs in Virginia. We know that home visiting has been shown to improve both maternal and infant health outcomes.
- b. There is also a push to invest in community-based programs such as “Urban Baby Beginnings” in Richmond, Virginia. Organizations such as this one hire women from their community to provide doula support, home visiting, care navigation, breastfeeding and postpartum classes and childcare assistance.

Conclusion

Maternal mortality at the state and national level has been increasing over the last two decades. Maternal mortality review teams offer the opportunity to review these deaths, determine the factors that contributed to the deaths and to make recommendations for interventions and policies that can improve maternal health outcomes. The Team’s review of PADs in Virginia has demonstrated that there is a need for a system of affordable, coordinated, and standardized care in the U.S. as a cultural value, a medical standard of care, and a human right. Improving the health outcomes of pregnant and postpartum women involves changes at the community, provider, facility and system level.