Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
Enrolled

House Bill 1518 (Delegate Wilkins, *et al.*)
Health and Government Operations Finance

Public Health - Maternal Mortality Review Program - Report and Stakeholder Meetings

This bill requires the Maternal Mortality Review Program to include specified information in its annual report. The Secretary of Health must convene a meeting of specified stakeholders at least twice a year to review the annual report, as specified. **The bill takes effect July 1, 2018.**

Fiscal Summary

State Effect: The bill's requirements can be handled with existing budgeted resources. Revenues are not affected.

Local Effect: Local health departments can participate in the annual stakeholder meetings with existing resources. Local revenues are not affected.

Small Business Effect: None.

Analysis

Bill Summary: At least twice a year, the Secretary of Health must convene a meeting of specified stakeholders, including the Maryland Office of Minority Health and Health Disparities, the Maryland Patient Safety Center, and local health departments. One meeting must be held within 90 days after submission of the annual report to (1) review report findings and recommendations; (2) examine issues resulting in disparities in maternal deaths; (3) review the status of implementation of previous recommendations; and (4) identify new recommendations with a focus on initiatives to address issues resulting in disparities in maternal deaths. Another meeting must be held within six months after

the first meeting to review the status of implementation of previous recommendations and consider any new information that may be relevant to identify additional recommendations.

The Maternal Mortality Review Program's annual report must include a summary of any stakeholder meetings held during the immediately preceding 12-month period including (1) stakeholder responses to existing recommendations and (2) stakeholder recommendations that address factors contributing to maternal mortality.

Current Law/Background: Chapter 74 of 2000 established Maryland's Maternal Mortality Review Program. The purpose of the program is to: (1) identify maternal death cases; (2) review medical records and other relevant data; (3) determine preventability of death; (4) develop recommendations for the prevention of maternal deaths; and (5) disseminate findings and recommendations to policymakers, health care providers, health care facilities, and the public. Maternal mortality reviews are conducted by a committee of clinical experts from across the State, the Maternal Mortality Review Committee. The program must submit an annual report on findings, recommendations, and program actions to the Governor and the General Assembly.

According to the program's 2016 annual report, Maryland continues to have a slightly higher maternal mortality rate than the U.S. average. This in part reflects efforts in the State to accurately identify maternal deaths. Enhanced surveillance methods include questions on the death certificate about pregnancy within the year prior to death, linkage of women's death certificates with birth and fetal death certificates from the previous year, review of medical examiner records, and detailed case review by the committee.

The 2016 annual report uses a number of definitions from the World Health Organization and the U.S. Centers for Disease Control and Prevention to analyze and describe data related to maternal mortality:

- "maternal death" is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes";
- "pregnancy-associated death" is "the death of a woman while pregnant or within one year or 365 days of pregnancy conclusion, irrespective of the duration and site of the pregnancy, regardless of the cause of death"; and
- "pregnancy-related death" is "the death of a woman while pregnant or within one year of conclusion of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes."

The program reported that in 2014, 33 pregnancy-associated deaths were identified. Of these cases, 16 (48%) were determined to be pregnancy-related, meaning the cause of death was related to or aggravated by the pregnancy or its management. The leading cause of pregnancy-associated death was substance use and unintentional overdose. Hemorrhage was the leading cause of pregnancy-related death. A majority of these deaths (70% of pregnancy-associated deaths and 81% of pregnancy-related deaths) were considered preventable or potentially preventable.

The report found that of the 33 pregnancy-associated deaths during 2014, 12 (36%) occurred among non-Hispanic White women, 18 (55%) among non-Hispanic Black women, and 3 (9%) among Hispanic women. The pregnancy-associated mortality rate for non-Hispanic Black women was 2.1 times higher than the rate for non-Hispanic White women. All of the unintentional overdose deaths were among non-Hispanic White women.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Maryland Department of Health; Maryland Association of County Health Officers; Department of Legislative Services

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