LOUISIANA DEPARTMENT OF HEALTH

PARTNERS FOR FAMILY HEALTH LOUISIANA

Bureau of Family Health

2017-2019 PAMR Report September 14, 2022

OVERVIEW

The rate of maternal mortality in the United States is unacceptable. Evidence-based, data drive action is needed to improve outcomes. It is for this reason, the Louisiana Pregnancy Associated Mortality Review (PAMR) Committee reviews all maternal deaths, regardless of cause, to understand the drivers of maternal mortality, complications of pregnancy, and understand disparities. We use these data to determine and identify interventions at patient, provider, facility, system, and community levels.

The Bureau of Family Health (BFH) within the Office of Public Health in the Louisiana Department of Health "works to promote optimal health for all Louisiana women, children, teens, and families". The Louisiana PAMR, an initiative of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality, contributes to the body of research that identifies the areas of prevention needed to achieve optimal health. Our Committee, through a comprehensive review process, has key recommendations to prevent maternal mortality in Louisiana.

UNDERSTANDING THIS REPORT

This report is a review of all maternal deaths of Louisiana residents occurring between 2017 through 2019. This includes deaths of individuals who were pregnant, had a miscarriage or ectopic pregnancy, or had delivered a baby within one year of the time of their death. (*this is referred to as pregnancy-associated deaths in the report*)

- By reviewing all of these deaths, we are joining the nation in an effort to look at all deaths, and not just those specifically related to the pregnancy.
- To understand this report, it is important to understand how pregnancy deaths are defined. These definitions can be found on page 4 of the report.
- We work to understand the drivers of maternal mortality, complications of pregnancy and understand disparities. This information is used to form recommendations by "who" can implement changes:
    - Healthcare professionals
    - Healthcare systems
    - Social and local community organizations
    - Policy makers
    - Payers and insurance carriers

- Government public health agencies
- Public health researchers

KEY FINDINGS

A. Finding: The leading causes of pregnancy-associated deaths were accidental overdose, homicides, and motor vehicle crashes.

a. By expanding our review to include all pregnant people, or those who had recently delivered a baby at the time of their death, we find the drivers of maternal mortality go beyond clinical causes and also point to social factors.

B. Finding: Racial disparities exist among all deaths of women who are pregnant, or who had recently delivered a baby at the time of their death (*pregnancy-associated deaths*). However, these disparities are more prominent in those deaths specifically related to the pregnancy (pregnancy-related deaths).

a. For all pregnancy-associated deaths, Black mothers were more than twice as likely to die as white mothers in Louisiana.
b. For pregnancy-related deaths, Black mothers are 2.5 times as likely to die as white mothers.
c. Among pregnancy-associated, but not related deaths, Black mothers were twice as likely to die as white mothers.

C. The majority of these deaths are preventable. The review committee deemed 77% of *pregnancy-related* deaths, 83% of *pregnancy-associated, but not related* deaths, and 88% of *pregnancy-associated, but unable to determine relatedness* deaths to be potentially preventable.

A comprehensive review of all deaths has a parallel need for comprehensive prevention. Prevention efforts will need to cover a lot of ground. While communities, facilities, healthcare professionals and policy makers working at each of these levels can use these recommendations to help inform and guide their efforts to improve maternal health outcomes, eliminating maternal deaths takes all of us. Everyone has a role to play in eliminating maternal mortality.

PRIORITY AREAS FOR PREVENTION

Eight overarching needs or themes emerged consistently throughout the review:

1. Improved care coordination before during, and after pregnancy, include support for continued healthcare during the fourth trimester
2. Ensure pregnant individuals receive the appropriate level of care

3. Expand the obstetric healthcare workforce
4. Address racial and cultural bias
5. Improve and expand identification of and treatment for substance use and mental health during pregnancy
6. Address social determinants of health
7. Increase access to data and medical records
8. Contribute to the public health evidence base

DATA TO ACTION

How is the Louisiana Department Health using this data?

The Louisiana Department of Health through the Bureau of Family Health (BFH) uses the recommendations generated from the PAMR report to form initiatives to improve maternal outcomes in Louisiana.

- **Monitoring Maternal Outcomes**
    - Through the **Louisiana Pregnancy Associated Mortality Review**, launched in 2018, under the CDC's Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program, we continue to identify drivers of maternal mortality.
    - **Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS)** is an ongoing, population-based surveillance system designed to describe maternal behaviors and experiences that occur before, during, and immediately following pregnancy.
    - **The Injury and Violence Prevention Program** works to prevent injuries and violence, which are the leading causes of death for residents ages 1–44 years
- **Supporting Clinical and Systems Change**
    - **Louisiana Maternal, Infant and Early Childhood Home Visiting (LA MIECHV)** provides family support and coaching through two evidence-based home visiting models: Nurse-Family Partnership (NFP) and Parents as Teachers (PAT).
    - **The Louisiana Perinatal Quality Collaborative (LaPQC)** is a network of perinatal care providers, public health professionals, and advocates who provide support to hospitals for continuous quality improvement work to improve outcomes for birthing persons, families and newborns in Louisiana.
    - **Louisiana Mental Health Perinatal Partnership (LAMHPP)** is a provider-to-provider consultation system for licensed healthcare clinicians serving pregnant and postpartum women and their families.
    - **Reproductive Health Program (RHP)** is the state's sole grantee of the Title X Family Planning Services Grant (Title X). Title X is the only federal program

dedicated to providing access to high-quality contraceptive services, supplies and information to anyone who needs or wants them.

- **Policies that Enable or Support a Strong System of Care**
  - **Addressing the Hospital Licensing Standards for Maternal Levels of Care …**under the leadership of BFH, a multidisciplinary workgroup has made recommendations to the Office of the Secretary to update the Louisiana licensing standards for Levels of Maternal Care to ensure they reflect the national recommendations and standards.
  - **Implementing Act 182**… under the guidance of BFH, the Louisiana Doula Registry Board has been established for the purpose of reviewing and approving doula registration to allow for health insurance reimbursement of doula services.
  - **Implementing Act 320**… within the Louisiana Department of Health, a Domestic Abuse Fatality Review Committee is being established. This will include a panel of experts who will review cases of domestic abuse fatalities and recommend improvements for systems serving victims of domestic abuse, develop components for prevention and education programs, and trainings to improve the identification and investigation of domestic violence fatalities in Louisiana.