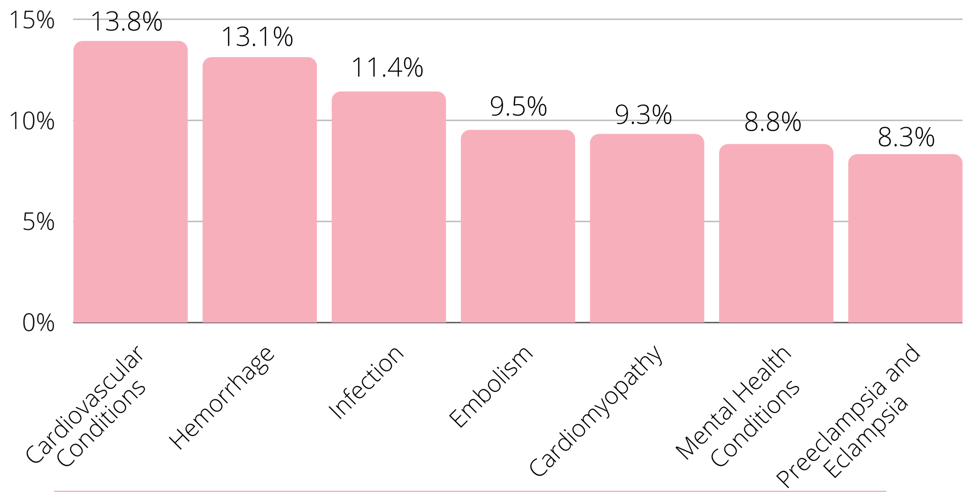
Maternal Mortality in the United States, 2008-2017*

The Maternal Mortality Review Committee (MMRC) data is unique because it contains information on preventability as determined by interdisciplinary case reviews. A total of 14 MMRCs voluntarily shared 2008-2017 data with CDC through the Maternal Mortality Review Information Application (MMRIA). Over a nine year period, 1,347 deaths to women during or within a year of pregnancy, a pregnancy-relatedness determination was made for 1,260 (93.5%) and among these, 454 (36.0%) were determined by the 14 MMRCs to be pregnancy-related.

Leading Causes of Pregnancy-Related Death



36.0% of All Cases Reviewed were Pregnancy-Related

Leading Causes of Death by Race/Ethnicity

White non-Hispanic	Black non-Hispanic
Mental health conditions related to suicide, overdose/poisoning, & unintentional injuries	Cardiomyopathy and cardiovascular conditions

65.8% of All Pregnancy-Related Deaths were Considered Preventable

Timing of Pregnancy-Related Death

39.4%	37.0%	23.6%
While Pregnant or Day of Delivery	Within 42 Days	42 Days to 1 Year

39.2% of All Pregnancy-Related Deaths were to Black non-Hispanic Women

Pregnancy-Related: The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

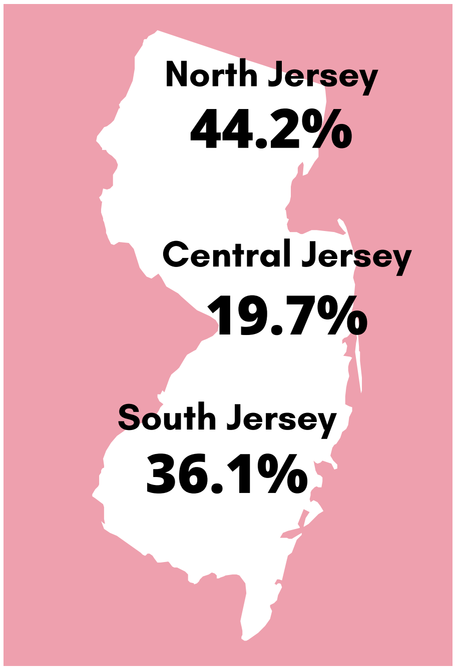
Preventability: The MMRC determines if the death was preventable during the review process. Deaths are classified as being able to be prevented (yes or no) and the likelihood of being able to be prevented (no chance, some chance, good chance).

CJFHC Central Jersey Family Health Consortium

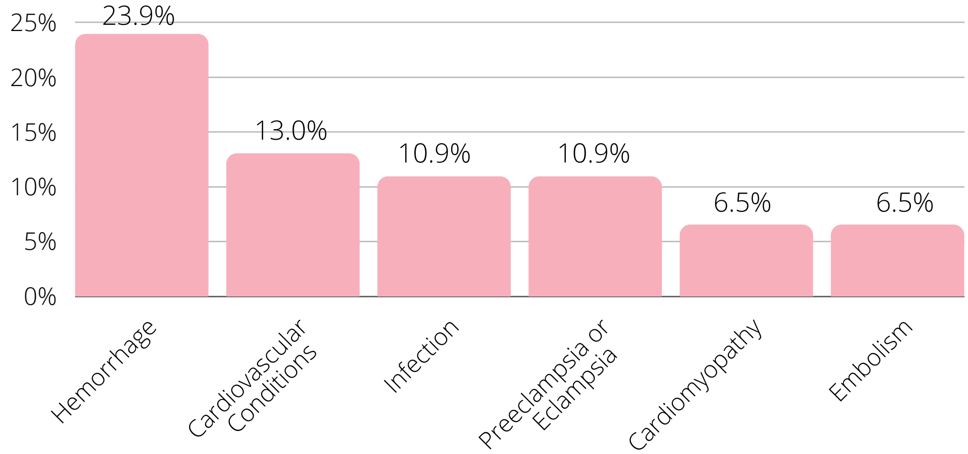
*Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. (2019). Retrieved from https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html

Maternal Mortality in New Jersey, 2014-2016*

The NJ MMRC reviewed a total of 151 cases from 2014 to 2016. Of these cases, 30.5% were determined to be pregnancy-related. Provisional data is presented below per New Jersey Department of Health.



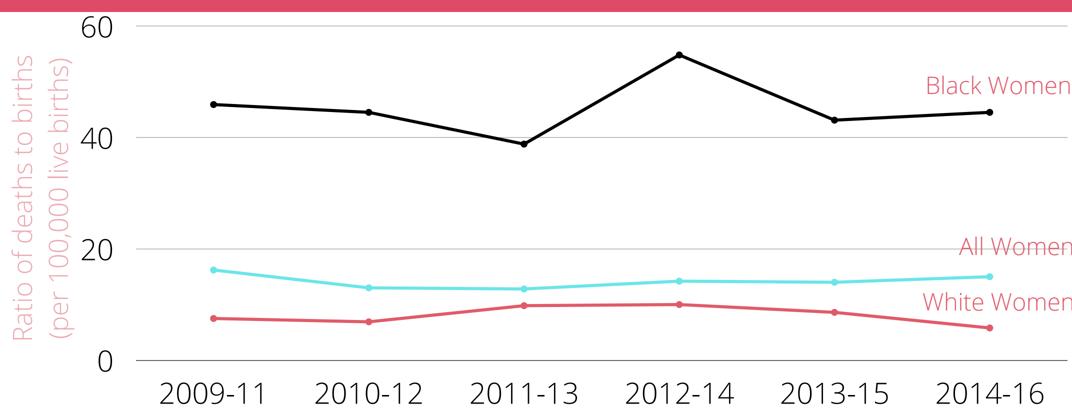
Leading Causes of Pregnancy-Related Death



Other causes of death include, amniotic fluid embolism (4.3%), mental health conditions (4.3%), metabolic/endocrine conditions (4.3%), cerebrovascular accidents (2.2%), malignancies (2.2%), seizure disorders (2.2%)

Racial Disparities

Black non-Hispanic women die from pregnancy-related causes at **7.6 times** the rate of White non-Hispanic women



Committee Recommendations

- **Clinical Practice/Professional Education**
  - Provider education on hemorrhage protocols
  - Educate and reinforce the use of AIM bundles throughout hospital systems
  - Reduction in time until postpartum follow-up
  - Referral to Central Intake, NJ's universal assessment and referral social service network for pregnant women
  - Interdisciplinary monitoring of women on medication-assisted treatment (MAT)
- **Consumer Education**
  - POST-BIRTH Warning Signs
- **Screening and Intervention**
  - Universal domestic violence screening
  - Intervention for mental health and substance use/abuse histories
  - Provision of Narcan at discharge for all patients with opioid use disorder
- **Reducing the Racial Gap**
  - Implicit bias and cultural sensitivity training for healthcare providers and all staff that interact with patients

*Maternal Mortality: New Jersey, 2014-2016. (2022). Retrieved from https://nj.gov/health/fhs/maternalchild/documents/NJ%20Maternal%20Mortality_2014-2016_12.14.21_Final.pdf