10 Actions Hospitals Can Take to End Maternal Mortality in the U.S.

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The U.S. has a problem with maternal mortality, and it is not getting better. The trend has been even more alarming in recent years. According to CDC data, in 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births, which was up from 23.8 in 2020 and 20.1 in 2019. Even more troubling, the maternal mortality rate in 2021 for non-Hispanic Black women was 69.9 deaths per 100,000 live births, which is 2.6 times the rate for non-Hispanic white women. More recent 2022 data indicate a decline in the rate, but due to a sharp increase during the COVID-19 pandemic, this decline shows the rate going back to its prepandemic rate.[1]

Moreover, factors like income levels are not protective for Black women when it comes to maternal and infant health outcomes. According to the National Bureau for Economic Research, outcomes for Black families at the top income levels are markedly worse than outcomes for white families at the lowest income levels, and educational attainment follows the same pattern.[2] All of this is especially tragic considering that more than 80% of maternal deaths are preventable, according to CDC data.

The publication of ProPublica's "Lost Mothers" series in 2017, along with online and media focus on additional maternal deaths, galvanized policymakers and the public to a heightened response to this long-standing issue. Solutions have been posited to reach the goal of no maternal deaths in the U.S. Some solutions are evidence-based, and others are rooted in history, which predates childbirth moving from homes into hospitals in the early 20th century.

Evidence is still being gathered on other promising approaches. Many of the solutions focus on addressing the leading causes of pregnancy-related death, which, according to CDC data, by race/ethnicity are cardiac and coronary conditions (for non-Hispanic Black women), mental health conditions (for Hispanic and non-Hispanic white women) and hemorrhage (for non-Hispanic Asian women).

Regardless of which solutions finally turn the curve on the data, where mothers access care matters when it comes to closing the gap in rates by race. Catholic hospitals care for more than one out of seven patients in the United States and deliver approximately 500,000 babies annually.[3] Thus, they have a crucial role to play in eliminating maternal deaths. This includes work to reduce disparities for Black women, who, in many states, are more likely than white women to receive care at a Catholic hospital.[4]

IMPROVING MATERNAL HEALTH

To address solutions for eliminating maternal deaths, the following list describes 10 ways that Catholic hospitals can act on this issue. Funding

for research and implementation is more plentiful now, as the surgeon general in 2020 and the White House in 2022 have named reducing maternal mortality a top health care priority.

1 Partnering with Doulas and Other Community-Based Workforces

Doulas are trained professionals who provide emotional, physical and informational support to families whom they accompany in pregnancy, childbirth and the early postpartum period. Acting in this supportive, nonclinical role, the evidence demonstrating that doulas improve maternal health outcomes is unequivocal.[5]

Currently, much attention is put toward training more doulas and overcoming the barrier of the cost of doula care for families by reimbursing their services through state Medicaid plans. The National Health Law Program tracks states' progress on these policies. Amid the rollout, hospitals can begin partnering with doulas and other local workforces like community health workers or home visitors (as part of a program to ensure every family bringing home a child gets at least one home visit from a nurse or other professional)[6] to integrate them into the care team. Groups like the Supportive Birth Collaborative at Harvard's Beth Israel Deaconess Medical Center model how clinical staff, patients and doulas can collaborate toward better outcomes.

2 Quality Improvement and Alliance for Innovation on Maternal Health Bundles

The Alliance for Innovation on Maternal Health released a series of patient safety bundles, a collection of evidence-based best practices, for safer births that focus on key drivers of maternal mortality. While quality improvement requires staff time, having a clinical champion, a state perinatal quality collaborative and how-to resources from the Institute for Healthcare Improvement can assist teams in implementing these lifesaving protocols and improving upon their efforts over time.

3 Technology

Several Black advocates and entrepreneurs have partnered with technology, including Kimberly Seals Allers, founder of the Irth app, which crowdsources health care reviews from patients of color. Navigate Maternity, led by a team of Black women, increases access to wearable devices, like blood pressure cuffs, which focus on reducing heart failure and blood pressure disorders, two of the primary causes of maternal death for Black women.[7]

4 Diversifying the Health Care Workforce

Concordance between a provider's and a patient's race can improve the care experience, specifically when it comes to obstetric care.[8] However, the proportion of Black obstetrics and gynecology residents is declining.[9] This is not helped by more than 90% of midwives identifying as white and the overall scarcity of midwives in the U.S. when compared to other countries.[10] Unlike a doula, a midwife is a certified professional or advanced practice nurse who is able to practice some diagnostic and medical services within their scope of work.

Several organizations and federal funding are committed to growing and diversifying the midwifery workforce.[11] However, this work must coincide with efforts for reimbursement parity for midwifery care, as nearly 25% of midwives stop practicing due to inadequate compensation.[12]

5 Anti-Racism Training

Much attention has been paid to the individual biases that providers bring into the care experience, prompting interest in implicit bias training, which helps in becoming aware of one's biases to then override them. However, the evidence of its effect on behavior change is not compelling.[13]

Instead, training that focuses on anti-racism — which rejects harmful systemic and structural policies, practices and behaviors while creating new ones that undo harm — is worth more consideration. The Institute for Perinatal Quality Improvement's "SPEAK UP Against Racism" program — which provides strategies to help individuals and groups dismantle racism, provide quality equitable care and reduce perinatal health disparities — is an excellent starting point for anti-racist training in maternity care. Tracking obstetric racism, using scales like the Patient-Reported Experience Measure of Obstetric Racism (PREM-OB) Scale, developed by Dr. Karen Scott, is one tool to see if progress is being made in this area among clinical teams.[14]

6 Bridging the Postpartum to Primary Care Chasm
Many states have chosen to expand coverage for postpartum care up to one year.[15] While this may help improve access to care, the barriers a newly postpartum woman faces in accessing care are plentiful. For example, despite patients diagnosed with gestational diabetes having a tenfold risk of developing type 2 diabetes,[16] studies find glucose testing within 12 weeks postpartum hovers at 36%.[17] Access is only one part of the issue, as follow-up and coordination of care in the postpartum period are severely lacking.

7 Provider Accountability
Part of the solution also includes addressing accountability along the care continuum.[18] A joint initiative by the National Committee for Quality Assurance and the Reproductive Health Impact, called the "Birth Equity Accountability Through Measurement" project, will "create, test and implement a quality measurement approach that makes being pregnant and giving birth safer — especially for people from historically marginalized communities."[19] This initiative, which already entered its second of three phases earlier this year, is one to watch closely.

8 Patient Education
Many mistakenly think that the cause of maternal mortality lies in a lack of education. However, we know from countless stories of maternal death that patients' self-advocacy was met with dismissal or fatal delays in care. As health care systems work on internal changes, like quality improvement and training for providers, initiatives like "POST-BIRTH Warning Signs" and "Hear Her" can help patients to trust their intuition further when they feel something is wrong.[20] This is especially important because 52% of maternal deaths occur in the postpartum period.[21]

9 Building Networks of Appropriate Levels of Care
Thirty-six percent of counties in the U.S. lack a hospital that provides obstetric care or an obstetric provider, termed a maternity care desert.[22] Establishing accredited freestanding birth centers (a health care facility for childbirth where care is provided in the midwifery and wellness model) and appropriate transfer relationships with local hospitals can help address this need.

However, even in areas that are not defined as deserts, a childbearing patient may not deliver at a hospital that is best suited to address their level of risk or complications resulting from birth. Developing levels of maternal care,[23] like those for newborns, set up levels of care designations so that women can be taken to the appropriate care setting when their health is at risk.

A hospital can start by maximizing the resources that already exist, and that begins with believing women when they come to seek care. Without this core value, we will continue to repeat the themes heard in so many stories of maternal death.

10 Funding and Ensuring Representation on Maternal Mortality Review Committees
Maternal Mortality Review Committees formally exist in 49 states, though there are differences in their requirements to review deaths.[24] Maternal mortality reporting, however, has recently added three more contributing factors to the review of death: discrimination, interpersonal racism and structural racism.[25]

While the addition of these data is crucial, these committees also need to expand the diversity of its members by better including those from communities where maternal deaths are highest. Such an expansion will allow states to focus on specific areas of risk, like substance use-related deaths, which are exponentially on the rise.[26] Programs like Moms Do Care (substance use) and Postpartum Support International (perinatal mood disorders) are just some examples of organizations that focus on specific risks.

STOP, LISTEN AND RESPOND

The gamut of these solutions is wide, and it can be overwhelming to know where to begin. A hospital can start by maximizing the resources that already

exist, and that begins with believing women when they come to seek care. Without this core value, we will continue to repeat the themes heard in so many stories of maternal death.

The effects of not listening and not acting swiftly, particularly when combined with racism and discrimination in care, are known to have deadly outcomes. At the same time, Catholic hospitals are uniquely positioned to make the most progress toward the goal of no maternal deaths. Following the example of Jesus, who was confronted with the woman suffering from bleeding in Luke's Gospel, the call to us is to stop, listen and heal.

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NOTES

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