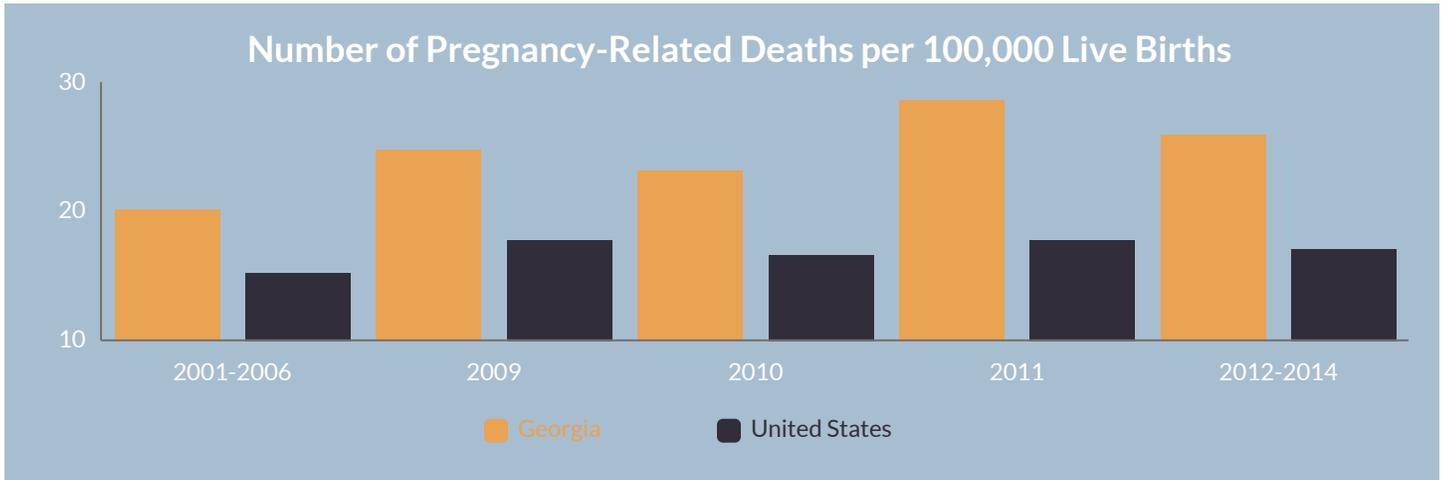


MATERNAL MORTALITY IN GEORGIA

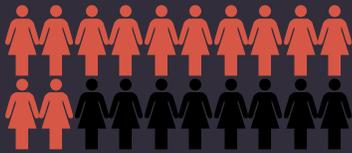


Increase in Georgia's maternal mortality rate from 2006-2011

42%

101 DEATHS

WERE PREGNANCY-RELATED IN 2012-2014



61% WERE PREVENTABLE

CARDIOMYOPATHY



Leading cause of death among white and black women



Pregnancy-related deaths that were Black, non-Hispanic women

THE FACTS

In 2010, Georgia was listed as the state with the highest maternal mortality rate in the country. Since then, Georgia's rate has only increased. Data from 2001-2006 shows that Georgia's pregnancy-related maternal mortality rate was 20.2 deaths per 100,000 live births. In 2009, Georgia had a pregnancy-related maternal mortality rate of 24.8 deaths per 100,000 live births. In 2010, the rate dropped to 23.2, but in 2011 the rate increased again to 28.7.

To better understand why women were dying during and after childbirth at such a high rate in Georgia, a partnership was created between the Georgia Department of Public Health (DPH), the Centers for Disease Control and Prevention (CDC), and the Georgia Obstetric and Gynecological (OBGyn) Society. The result was a three-year process of assessment, strategic planning, and collaboration, resulting in Senate Bill 273 (2014 Session), which established the Maternal Mortality Review Committee (MMRC). The MMRC is a multidisciplinary group comprised of over two-dozen professionals from across the state with expertise in obstetrics, gynecology, neonatology, cardiology, nursing, and public health.

The MMRC is collecting data and has now reviewed all of the pregnancy-related and pregnancy-associated deaths from 2012-2014. During this time period, the MMRC identified 101 pregnancy-related deaths, equaling a rate of 26 pregnancy-related deaths for every 100,000 live births. It is estimated that 60 percent of these pregnancy-related deaths were preventable. The leading cause of pregnancy-related death was cardiomyopathy, followed by hemorrhage and other cardiovascular and coronary conditions. Of the pregnancy-related deaths, 18 percent occurred while pregnant and 55 percent occurred within the first 42 days postpartum. Additionally, data shows that black, non-Hispanic women were 3.3 times more likely to die from pregnancy-related complications than white, non-Hispanic women.

REDUCING THE RATE

Starting in 2017, the General Assembly began funding initiatives to address the maternal mortality crisis. In the FY 2018 budget, \$100,000 was appropriated to evaluate and recommend a program to reduce maternal mortality using outcomes-based research. This assessment led to the FY 2019 appropriation of \$2 million, which provided two-year quality improvement grants to 20 rural birthing hospitals to implement maternal hemorrhage and hypertension patient safety bundles, collect data for the perinatal surveillance system, and plan for sustainable perinatal quality improvement efforts. Additionally, the FY 2019 budget included \$500,000 to implement Medicaid reimbursement for evidence-based group prenatal care programs, also known as centering, to help provide more prenatal care in rural and underserved areas.

In the FY 2020 budget, \$1.05 million was provided to screen, refer, and treat maternal depression and related behavioral disorders in rural and underserved areas. The MMRC determined that six percent of pregnancy-related deaths were due to mental health conditions and there is inadequate screening of pregnant and postpartum women for depression and other mental health issues, a lack of access to mental health services, and a lack of awareness among patients and providers of the benefits and safety of antidepressant therapy during pregnancy and the postpartum period. The FY 2020 funds provide a telepsychiatry program through select county health departments in partnership with Emory University and Healthy Mothers, Healthy Babies to provide needed access to mental health treatment for pregnant and postpartum women who are uninsured or underinsured.

Additional items funded in the FY 2020 budget include \$200,000 for additional nurse abstractors for the MMRC and \$500,000 for a Center of Excellence on Maternal Mortality at Morehouse School of Medicine to research, train providers and para-professionals on best practices, and provide community engagement through on-site education.

ADDITIONAL RESOURCES

[Georgia MMRC Reports:](https://dph.georgia.gov/maternal-mortality)

<https://dph.georgia.gov/maternal-mortality>

[CDC Pregnancy Mortality Surveillance System:](https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm)

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>

[USA TODAY Maternal Mortality Investigation:](https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/)

<https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/>



During the fall of 2020, the House Study Committee on Maternal Mortality met and heard testimony from experts all across the state on how the legislature could address the issue in Georgia. The top recommendation from the committee was to extend the Medicaid coverage for postpartum women beyond the current 60-day limit. In the FY 2021 budget, \$19.7 million is provided to extend the Medicaid coverage period to six months postpartum. Additionally, the FY 2021 budget includes \$125,000 to cover lactation care and services in the Medicaid program.

Currently there are 75 counties in Georgia that have no practicing OB/GYN, resulting in a void of prenatal care in almost half of Georgia's counties. Since FY 2017, the state has added additional funds each year for OB/GYN residency slots and now funds \$1.6 million annually for 104 slots spread between Emory University, Medical College of Georgia, Memorial Health University Medical Center, Morehouse School of Medicine, and Navicent Health Care Macon.

Lastly, HB 909 (2018 Session) allows DPH to develop and designate levels of maternal and neonatal care through onsite inspections of Georgia's birthing hospitals. A Georgia hospital survey showed that 45 percent of hospitals were operating at a level of care lower than the level they self-designated as, and research indicates that mothers and babies have better outcomes when they are in a facility that is able to support their level of risk. Hospitals began applying for these designations in July 2019, and through the designation process, facilities will learn which patients they are capable of caring for and which patients should be transferred to a higher level of care.