

Overview of US Maternal Mortality Policy

Jennifer C. Villavicencio MD ¹

Katherine W. McHugh MD ²

Brownsyne Tucker Edmonds MD, MPH ³

¹Department of Obstetrics and Gynecology, University of Michigan, Ann Arbor, MI, USA

²Department of Obstetrics and Gynecology, Indiana University, Indianapolis, IN, USA

³Indiana University School of Medicine, Ann Arbor, MI, USA

Abstract

The United States maternal mortality rate has been rising for many years putting the US out of step with peer countries. There are many complex reasons for the rise in maternal deaths and recent data has demonstrated that there is a disproportionate risk for women of color. This article provides an overview of current policy and policy issues aimed at improving the maternal mortality rate in the United States.

Key words: maternity, mortality, pregnancy., policymaking, health policy

Introduction

The maternal mortality rate (MMR) in the United States is rising, as is the rate of severe maternal morbidity.¹ In fact, the United States has the highest MMR in the developed world, making it the most dangerous industrialized country in which pregnant women can live and deliver. Globally, maternal morbidity and mortality are considered important indicators of a nation's health quality. The Centers for Disease Control and Prevention estimate that ~700 US women per year die from pregnancy- or delivery-

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related complications, more than half of which are preventable.² The causes of the increased rate are complex, involving improved reporting as well as the increasing age and medical complexity of the US pregnant population.² There are also important racial, ethnic, and socioeconomic disparities represented in the data, which show a significantly higher rate of maternal morbidity and/or mortality in nonwhite pregnant patients.^{3, 4, 5}

The US MMR increased from 7.2 deaths per 100,000 live births in 1987 to between 16.9 and 23.8 deaths per 100,000 live births in 2016, depending on the source.^{6,7} Maternal mortality statistics are difficult to ascertain because of the differences in state reporting requirements, details included or not included on death certificates, and potential concerns regarding physician liability. These variations account for only some of the upward trend in maternal mortality.^{8,9} Studies have demonstrated that medical causes of maternal death have remained similar for >25 years.¹⁰ Despite differences in reporting and exact rate, it is undeniable that maternal mortality is increasing, making the US unique among other industrialized nations.

This review discusses the various clinical and legislative health policy issues and solutions affecting the effort to reduce MMR. This article is not meant to be a comprehensive review of all policies and issues related to maternal mortality; rather, the authors wish to give the reader an overview of issues and policies related to maternal mortality in the United States.

Race and Racism

Throughout this article, we discuss racial disparities in maternal health care. In some literature and clinical guidance, race is cited as a risk factor for many maternal conditions and outcomes, including death as a result of pregnancy. It is imperative to clarify that race is *not* a risk factor. Rather, racism is one of the main reasons that Native American women are twice as likely to die from pregnancy-related causes, with an MMR of 30.4 deaths per live births.⁶ The situation is even more dire in black women,

who are fourfold more likely to die in childbirth (MMR of 42 deaths per 100,000 live births).^{6,11} Structural racism at the federal, state, and institutional levels as well as provider bias—implicit and explicit, intended, and unintended—are key contributors to the US maternal health crisis.¹² Through the hard work of organizations like SisterSong, Black Mamas Matter Alliance, and the National Birth Equity Collaborative (among many others), the ugly truth of racism and white supremacy within the US health care system has been unearthed.¹³ And slowly, the medical and policy communities are starting to listen to the solutions proposed by those most affected. The National Birth Equity Collaborative offers “strategic racial equity training sessions”¹⁴ and implicit bias training for medical professionals and institutions. Diversity and equity initiatives to increase representation in the health care workforce as well as incorporation of antiracism and antioppression concepts into medical schools are all becoming more common. There has even been congressional legislation prioritizing grant funding to obstetrics and gynecology health professional training programs for implicit bias work.¹⁵

But these practices and policies are not universal, and they are not enough. Combating the deadly consequences that racism has on US mothers and their children requires swift and widespread action. Any effort to improve the MMR in the United States must be centered on the voices and lived experiences of those most affected, black women and other people of color, while ensuring that solutions are community based and informed by the principles of reproductive justice.¹⁶

Maternal Death Data Collection in the United States

There have been considerable issues in the reporting of maternal deaths in the United States for decades. A question regarding whether a female decedent was pregnant was added to the standard US death certificate in 2003. Unfortunately, this question was not uniformly added (in fact only half of the states did so prior to 2015). The United States has not published an official MMR since 2007¹⁷ because of these discrepancies. Since 2015, when all but 3 states had added the pregnancy question, renewed

efforts to establish a US MMR began. It became clear that the previously added question was not sufficient and did not provide a clear or accurate picture. For example, developing a consensus on a temporal definition of what constitutes a maternal or pregnancy-related death continues to be troublesome for researchers and policymakers. The World Health Organization defines a *maternal death* as one that occurs when a person is pregnant or within 42 days of the end of pregnancy (including miscarriage, termination, and delivery), regardless of the cause of death.¹⁸ The Centers for Disease Control and Prevention define a *maternal death* as one that occurs during pregnancy or up to 1 year after the pregnancy has ended.⁶ This variation in definition leaves a substantial gap in timing, which can lead to variances in reporting, calculations, and understanding of pregnancy-related deaths.

The failure of the US government to adequately collect data on pregnancy-related morbidity and mortality has affected evidence-based prevention efforts. As one author remarks, "Accurate measurement of maternal mortality is an essential first step in any prevention program: to identify at-risk populations, to target prevention efforts to the most vulnerable groups, and to measure the progress of prevention programs."¹⁷

Maternal Mortality Review Committees

Maternal mortality review committees (MMRCs) are multidisciplinary groups that gather at either the state, county, or local level to review pregnancy-related deaths. MMRCs utilize clinical and nonclinical information to understand, analyze, and, if needed, recommend preventive solutions.² MMRCs have demonstrated the utility of mandated and standardized reporting of pregnancy-related deaths as well as of studying causes, identifying population-based risk factors, and developing systems to address contributing factors.

In December 2018, the Preventing Maternal Deaths Act was signed into law. Prior to this law, there were no mandates for reporting pregnancy-related deaths or for having an established MMRC. This

legislation mandates reporting, provides significant financial support for state-based MMRCs, and ensures confidentiality of the case information, participants, and discussion.¹⁹ This federal policy is a direct result of physician and allied health provider advocacy from many organizations, including a multiyear campaign by the American College of Obstetricians and Gynecologists (ACOG).

Based on the early collated data from MMRCs, >60% of maternal deaths are preventable.²⁰ This percentage has since been confirmed by larger analysis of the MMRC data and use of the Pregnancy Mortality Surveillance System, a volunteer state-reported database from the Centers for Disease Control and Prevention.² The preventable causes of maternal mortality that have been identified thus far are cardiovascular disease (15.5%), infection (12.7%), hemorrhage (11.4%), preexisting illnesses (11.4%), and cardiomyopathy (11.0%).¹⁰

MMRCs and adequate, accurate data collection are crucial factors in reversing the rise in the US MMR. These data and the MMRC analyses, in conjunction with patient safety collaboratives, can inform the development of policy to address preventable causes of maternal deaths. MMRC members are tasked with crafting recommendations in cases of preventable maternal death to improve the care of future patients by supporting health care access and appropriate medical interventions. In addition, MMRCs must task themselves with understanding the contributions that implicit bias can have on the results of analysis; no committee or individual is immune to biases. Therefore, along with rigorous and standardized review, MMRC members must ensure that the committees are diverse, representative, and self-reflective.

Standardization of Health Care Delivery

Standardizing health care delivery has been recognized as an evidence-based tool of quality-improvement initiatives. This tool often comes in the form of bundles, protocols, or checklists to ensure appropriate patient care, which can subsequently improve outcomes.

Alliance for Innovation in Maternal Health

The Alliance for Innovation on Maternal Health (AIM) was developed by the Council on Patient Safety in Women's Health Care and boasts a partnership between 28 organizations, including ACOG, the American College of Nurse-Midwives, and the American Hospital Association. AIM is a “national data-driven maternal safety and quality improvement initiative” that “works through state teams and health systems to align national, state, and hospital level quality improvement efforts to improve overall maternal health outcomes.”²¹ AIM focuses on readiness and preparedness prior to the occurrence of a dangerous event, with the goal of eliminating preventable maternal deaths.

Once the components of preventable maternal mortality are identified, AIM develops evidence-based protocols called *bundles* that are adaptable in both rural and urban settings. The bundles are multidisciplinary and engage both state and hospital leaders in implementation. Current AIM bundles focus on issues such as hypertension in pregnancy, venous thromboembolism prevention, and obstetric hemorrhage, among others. Currently 20 states have implemented at least one bundle with funding from the Health Resources and Services Administration (HRSA). There is ongoing work to create bundles for the reduction of early cesarean deliveries and recognition of early maternal morbidity warning signs.²² Data collection is an essential component of the AIM program to ensure that the measures are having the desired impact.

Levels of Maternity Care

Another method of standardizing processes includes implementing Levels of Maternity Care, which would be a uniform classification system of birth centers that denotes their defined ability to provide either basic care (Level 1), specialty care (Level 2), subspecialty care (Level 3), or their classification as a regional perinatal health care center (Level 4).²³ These kinds of designations are commonplace for other types of health care, such as trauma, neonatal intensive care, and transplant care. According to a

consensus statement developed collaboratively and endorsed by 12 medical professional organizations such as ACOG and the Society for Maternal Fetal Medicine, the goals of establishing this system are to standardize definitions and protocols, to clarify criteria requiring transfer to another center, and to implement risk-appropriate care systems that will reduce maternal mortality and eliminate existing disparities.²⁴ The statement discusses the regionalization of medical care using patient risk stratification to identify the safest place for patients to access care.

It is understood that, given that obstetric emergencies can be unpredictable, these levels of care would not mitigate unanticipated danger in patients without risk factors, but experts anticipate reductions in morbidity and mortality in the sickest patients.²³

Expansion of Health Care Access

Access to health care is a crucial aspect of maintaining and improving health.²⁵ Health care coverage and access to health care providers are vital pieces of the maternal mortality crisis. Generally, we know that the healthier a woman is at conception, the more likely she is to have a healthy pregnancy. We know that prenatal care is vital to ensuring a healthy pregnancy²⁶ and that those with high-risk pregnancies (often the result of chronic health conditions) are fivefold more likely to die as a result of their pregnancy if they do not receive prenatal care.²⁷ We also know that pregnancy-related risk does not end with delivery; in fact, 31% of pregnancy-related deaths happen in the postpartum period.³ It is for these reasons that ensuring access to high-quality health care for all reproductive-aged and pregnant women must be a part of the maternal mortality conversation.

US Health Care Coverage Review

It is necessary to understand the basics of the US health care system in order to analyze the policies affecting health care access and maternal mortality. In the United States, health care coverage is a patchwork of employer-sponsored insurance (49% of the US population), privately purchased/nongroup

insurance (7%), public tolerability net/entitlement insurance (34%), and military insurance (1%), which leaves ~9%, or 27 million people, without insurance.²⁸

Medicaid is a particularly important program when discussing maternal mortality and health care disparities, given that it is the safety net program that offers certain low-income families health coverage. Eligibility for Medicaid depends on income and other financial resources and is usually discussed in reference to the federal poverty level (FPL). Medicaid is co-regulated and co-financed by individual states and the federal government, which means that each state creates its own unique program, resulting in 50 different versions with some universal features that are required by the federal government. One of these federal requirements is coverage for all pregnant individuals who are at 133% FPL (pre-Affordable Care Act [ACA]).²⁹

The ACA, passed in 2010, is the most significant US health care reform in the past several decades. It expanded coverage and decreased the percentage of uninsured Americans from 17% to 10%. A decade later, changes in administration and congressional makeup have led to policies that have dampened, but not eliminated, the impact of the ACA.²⁸

Social Determinants of Health

Health care access, as a concept, is a complex interaction between patients, providers, finances, funders, and the social environment in which patients live. Policies addressing access must address all of these facets to truly have an impact on health care in the United States. Put simply, health care is about more than getting an appointment with a provider. Health care access is about how a patient gets to the appointment, whether she has the ability to take time off from work to do so, and whether she has child care or money to afford the copayment. It is about whether a patient trusts the medical system to truly care for her in the first place.

Social determinants of health contribute to whether a American is likely to be healthy; they are the conditions in which people are born, grow, live, work, and age and include socioeconomic status, neighborhood, education, access to housing and food, as well as employment.³⁰ These determinants are affected by several structural inequities, such as classism and racism, which cannot be ignored when discussing improvements in access to health care, decreases in health care disparities, and improvements in maternal mortality.

With these issues in mind, below are several recent policies, proposals, and issues that are related to maternal health.

Medicaid Expansion

One of the most significant and lasting effects that the ACA has had on health care coverage is the option for states to expand Medicaid eligibility to individuals living at 138% FPL. Medicaid expansion created a structure in which low-income, reproductive-aged women could have continuous coverage before and during pregnancy.²⁹ Thirty-six states and Washington, DC, have expanded Medicaid thus far, increasing the number of Medicaid enrollees by 16.1 million.³¹

Given that chronic health issues and maternal morbidity and mortality disproportionately affect low-income populations,^{32,33} Medicaid expansion is a policy intervention with the potential to directly influence these issues. A review released by Georgetown University³⁴ demonstrated that expanded access to Medicaid under the ACA was associated with several important indicators of perinatal health: better health coverage for reproductive-aged women (decrease of 7.4% in probability of uninsurance), improved adequacy of prenatal care, and perhaps most importantly, 1.6 fewer maternal deaths per 100,000 women.

That study also concluded that the 14 states that have yet to adopt Medicaid expansion are “missing an opportunity to address stark racial disparities in maternal health.” This missed opportunity is, in part,

due to the fact that states in the South, where most of the nonexpansion states are located, are home to a larger black population that, then, is disproportionately likely to be and remain uninsured.³⁵ Combined with the fact that nearly half of all births occurring in these states are covered by Medicaid,³⁶ some policy experts and advocates are focusing efforts to encourage state lawmakers in nonexpansion states to expand Medicaid as a method of reducing maternal mortality.

Insurance Churn

Unfortunately, Medicaid expansion did not entirely solve the issue of lack of health care coverage.

Insurance churn, or moving between insured and uninsured states or between different plans, is associated with disruptions in care and worsened health outcomes.³⁷ In a study of 3000 US patients in 3 states, 1 in 4 patients had a change in coverage in the previous year.^{37,38} This statistic demonstrates that even though the overall number of insured US patients has increased since the ACA, their ability to maintain that insurance coverage or use it to positively affect their health may not have. This issue is especially true for those individuals in nonexpansion states. There are various policy proposals aimed at either reducing insurance churn or the negative effects of churn, including continuous eligibility, increasing Medicaid eligibility to 200% FPL, or a single-payer insurance system, at either the state or national level. We discuss below one proposal that specifically addresses this issue in low-income postpartum women: Medicaid extension.

Medicaid Extension

An adjacent strategy to Medicaid expansion and one that specifically addresses insurance churn in the postpartum period is *Medicaid extension*. At any time, a pregnant woman who does not qualify for Medicaid in her state (regardless of expansion status) is eligible to receive federally mandated pregnancy-related Medicaid for the duration of pregnancy until 60 days postpartum. This 60-day postpartum period has emerged as a concerning policy, given that a significant proportion of pregnancy-

related deaths occur in the postpartum period (up to 1 year).⁶ The termination of health care coverage 2 months after delivery leaves millions unable to access care for the rest of that high-risk year. Nearly 50% of women in Medicaid nonexpansion states and ~30% of those in Medicaid expansion states experience an interruption in their insurance (churn) from the prepregnancy period to the postpartum period.³⁹ Complicating matters more, nearly 20 states have applied to the Centers for Medicare and Medicaid Services for an allowance to impose work requirements on those receiving Medicaid⁴⁰—which means that some women eligible for Medicaid outside of pregnancy may be required to return to work shortly after delivery in order to maintain coverage. This work requirement has the potential to affect a patient's ability to continue the postpartum and longer-term care needed to reduce her risk for pregnancy-related mortality.^{41,42}

Many expansion states have chosen to alter their pregnancy coverage post-ACA, but currently only 4 states (California, Illinois, Missouri, and South Carolina) are seeking to extend various elements of Medicaid to 1 year postpartum. California passed legislation in 2019 that utilizes state funding (unmatched federally) for the extension of the full breadth of Medicaid coverage in women diagnosed with a pregnancy-related health condition.⁴³ The other 3 states are likely to pursue Section 1115 waivers from the Centers for Medicare and Medicaid Services, which would allow the states to alter the federal Medicaid program and fund the extension by demonstrating improved outcomes. It is worth noting that the Helping MOMS Act of 2019 was introduced into the House Committee on Energy and Commerce in November 2019. This bipartisan legislation would allow states to bypass the waiver process to extend postpartum Medicaid coverage to 1 year.

Chronic Disease and Substance Use Disorder

Chronic disease is a known contributor to maternal mortality, with obesity, diabetes, hypertension, and self-reported poor health status being cited as significantly associated with maternal death⁴⁴ and more

likely to cause life-threatening complications today than in the past decade.⁴⁵ As discussed earlier, expanding access to health care and prepregnancy chronic disease management has been identified as an intervention to decrease maternal mortality.

Unfortunately, certain known contributors to maternal morbidity, including substance use disorders (SUDs), are less well studied.^{46,47} This issue is exacerbated by the general struggle that the US health care system has had in managing the crises of mental health issues and opioid addiction. The ACA and Medicaid expansion have allowed certain states to address some of these issues, but more work must be done.

Mirroring the increases in the general population, opioid-related maternal deaths are on the rise.⁴⁸

Although data are limited, drug overdose has been increasingly linked to maternal mortality, with one study finding that overdose (predominantly opioid) was the second-leading cause of death after cardiovascular disease.^{7,48} As with the general US opioid epidemic, the health care system plays a large role in the nearly fivefold increase in opioid overdoses that US women have experienced since 1999.⁴⁹

Where patients receive their health care and what insurance they have affect whether they will be exposed to opioids at all. In one study, providers in states in the South were more likely to prescribe opioids than were those in the Northeast.⁵⁰ In another study, 20% of pregnant Medicaid-enrolled women were prescribed opioids during pregnancy.⁵¹ To make matters worse, in pregnant women with SUDs, getting or continuing treatment while pregnant can be a significant challenge, with postpartum continuation even more challenging. According to the Substance Abuse and Mental Health Services Administration, only 23% of inpatient treatment programs offer pregnant and postpartum women's services,⁵² and many of them offer only withdrawal or detoxication support, which is not in accordance with ACOG guidance.⁵³

Clinical strategies for improving the care of pregnant women with SUDs include increasing screening for the disorder at prenatal, postpartum, and well-baby visits; increasing the availability of medication-assisted treatment in pregnant women; and encouraging a team-based approach to pregnancy care in which the pregnant patient is centered.^{53,54}

There have also been several legislative policies introduced to combat the opioid epidemic. As of 2018, 33 states had enacted legislation regulating the prescription of opioids. These policies are aimed at reducing the amount of opioids available for diversion and improving prescribing practices.⁵⁵

Policymakers in many states have also worked to ensure that SUDs are included in plans for Medicaid expansion and postpartum expansion (for example, Missouri is considering Medicaid extension to 1 year postpartum *only* in those postpartum patients with a diagnosis of SUD). Efforts to decriminalize SUD in pregnancy where it is currently criminalized, as well as combat legislation that imposes criminal consequences on pregnant women with SUDs, have also been seen as important parts of ensuring that patients feel comfortable disclosing substance use to their providers.⁵⁶

Rural Access

Expanding health care access is important everywhere, but particularly in rural areas where health care disparities are often magnified by provider scarcity and geographic distance to high-acuity care centers.

According to a study by Kozimannil et al,⁵⁷ rural patients have a 9% greater risk for severe maternal morbidity and mortality than do those living in cities. Kozimannil et al argue that increased access to quality maternity care in rural areas is crucial to reducing maternal mortality. Suggested policies for improving rural maternal health care disparities include improving the childbirth-reimbursement rates so that hospitals are not choosing whether to keep maternity services open with their bottom line.⁵⁸ This effort is particularly salient given the increasing rate at which rural maternity wards are closing.⁵⁹ In December 2018, Congress passed the Improving Access to Maternity Care Act, which aims to identify

and publish data on geographic areas impacted by shortage of maternal health care providers. This bill is championed by ACOG and midwifery organizations for the focus on ameliorating rural maternal health care disparities.⁶⁰

Contraception and Abortion Access

Optimizing health and planning pregnancy are 2 ways to increase the likelihood of a healthy pregnancy and postpartum period as well as to decrease maternal deaths.⁶¹ Increasing access to contraception can aid individuals in their ability to plan whether and when to become pregnant and under what circumstances, therefore creating time and space for health optimization if desired.

Access to contraception is affected by many factors. Providers willing to prescribe contraceptive pharmaceuticals and devices may not be geographically available, a fact worsened by the rural health care disparity discussed earlier. Additionally, increasing numbers of Catholic Health Care Services that abide by the Ethical and Religious Directives have the potential to affect access to contraceptives as well as physician training in family planning.⁶² Then, even if a patient is able to obtain a prescription for contraceptives or emergency contraception, she may not be able to fill it at her local pharmacy due to conscientious objection by the pharmacist.^{63,64}

As with most access issues, low-income individuals are the most affected. Title X is a federal grant program that prioritizes providing low-income individuals family planning services, including contraception, breast and cervical cancer screenings, sexually transmitted infection testing and treatment, as well as pregnancy testing and counseling.⁶⁵ In the past year, the Trump administration has implemented administrative changes to the program, also known as “the gag rule.” The changes restrict Title X grants from organizations that refer pregnant patients desiring abortion to appropriate clinics and no longer require nondirective contraceptive counseling.⁶⁵ This rule change eliminates Planned Parenthood Federation of America (PPFA) as a grantee (PPFA officially withdrew from the program in

August 2019), which leaves the 41% of all Title X recipients who were cared for at PPFA clinics without a contraceptive provider.⁶⁶ Federally qualified health centers, health departments, and other clinics that choose to comply with the rule change and remain grantees would have to increase their contraceptive caseloads by 70%, a massive, likely impossible, challenge for an already stretched safety net system.⁶⁶

There are also recent policies that have positively affected access to contraceptives. The ACA mandates no-cost sharing (no copayment or co-insurance) for preventive services, including contraception, thereby making birth control “free” if insured. Currently, 41 states have implemented policies to ensure that immediate postpartum long-acting reversible contraceptives are reimbursed,⁶⁷ which improves patients' ability to access the devices. Additionally, efforts to increase access to oral contraceptives and emergency contraception are taking hold. There are increasing numbers of on-line retailers utilizing telemedicine for screening and mailing contraceptives directly to the patient⁶⁸ as well as a movement within the research and reproductive health communities to make oral contraceptives either pharmacist prescribed (13 states) or over the counter.⁶⁹ Policies that require coverage of a year's supply of oral contraceptives have also been implemented in 18 states.

Under the best of circumstances, contraceptive failure is possible. Combine that with the above-mentioned barriers and we find that nearly half of all US pregnancies are unintended.⁷⁰ For those individuals with an unplanned pregnancy who choose to continue, unfettered access to high-quality health care is crucial to maternal health. And for those individuals who choose not to continue their pregnancies, compassionate and safe access to abortion care is equally crucial to maternal health. Abortion is increasingly regulated by state governments, with little evidence to support any benefit. In fact, data show that states with the most abortion restrictions have the worst maternal health outcomes.⁷¹ Using global data, reform of abortion laws to increase access and decrease barriers may have an association with a reduction in maternal mortality.

Access to contraception and abortion is key in preventing maternal mortality, as they increase the likelihood that a person can plan whether and when to become pregnant, and they ensure that if a person decides to end a pregnancy, she can do so safely and without interference.

Intimate Partner and Structural Violence

Research reports that 3%–9% of pregnant women and 7% of postpartum women⁷² may experience *intimate partner violence (IPV)*,^{73,74} defined as abusive behavior directed toward an individual and that includes sexual violence, stalking, physical violence, psychological aggression, and control of reproductive and sexual health.⁷⁴ Factors that may increase the risk for IPV include pregnancy, younger age, less education, and nonwhite race.^{75,76} IPV has been associated with adverse maternal and infant outcomes.⁷³ The US Preventive Services Task Force recommends screening for IPV in pregnancy,⁷⁵ and there is literature demonstrating positive outcomes of screening in the postpartum period at pediatric appointments.⁷⁷ It is crucial that policymakers keep maternal health in the forefront of their minds when addressing IPV, given the increased risk that pregnant women face. Additional research focusing on specific maternal outcomes such as mortality in relation to IPV will support evidence-based policy interventions in the future. Likewise, structural violence also has the potential to adversely affect the health and well-being of pregnant women. Little is known about the implications of mass incarceration, immigrant detainment, and other forms of state-imposed violence on pregnancy outcomes and reproductive health, raising the need for research on the implications of interpersonal and structural violence and trauma on the mental, emotional, and physical safety of pregnant women.

Conclusions

Maternal mortality is a multifaceted and complex problem within the US health care system. Although maternal mortality affects people across demographics, and medical causes of pregnancy-related death have remained largely stable, there are significantly worse outcomes in people of color, specifically black

women. Solutions for improving the US MMR are just as complex. Understanding the problem requires ongoing standardization and improvement in data collection, which will inform the depth and breadth of the problem as well as potential interventions. Using that data to make changes in care delivery systems, paired with attention to the impact that social determinants of health have on maternal health outcomes, can help to close the demographic, racial, and geographic gaps in maternal mortality. Harnessing national efforts to standardize health care delivery, including protocol-based care, mandatory case reporting and review, and guidelines on transferring to a risk-appropriate health care setting in high-risk patients also have the potential to directly affect the rising MMR. Expanding and improving access to health care through state and federal policy changes will improve the health and well-being of pregnant women in the United States. Ultimately, any intervention must be multifaceted, multidisciplinary, evidence based, and aimed at reducing disparities. If we can respond to this crisis with a coordinated and robust response, we may finally decrease the US MMR.

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