American Academy of Nursing

President's Message

Global maternal mortality rate declines—Except in America

The broad topics I will address this issue fall under Reproductive Rights and our value of social justice. The Academy stated mission and vision on policy and advocacy work is based on using the best available scientific evidence. This allows us to lend objectivity to complex, emotionally charged issues, such as maternal morbidity and mortality. It is out of that weighted objectivity that valid recommendations for modifying clinical practice can come. I will cite the negative consequences that occur when the available evidence is not consistently embedded in practice.

This message illustrates the negative consequences when clinical providers, health systems, and payers do not utilize these evidence-based practices. The specific concern is the alarmingly high rate of maternal mortality and morbidity in the United States. Each year in America, 50,000 women suffer life-threatening complications (Young, 2018) and 700 of those die (The Editorial Board, 2018) from a natural event that has been going on since the beginning of time—childbirth. If those facts do not shock you, they should, especially when you consider that more than half of these deaths are preventable.

The majority of maternal deaths in the United States are attributed to hypertension and excessive blood loss. Implementing safety procedures that have been known to the health care profession for decades could prevent them. For example, closely monitoring high blood pressure and blood loss are just two low tech and low cost interventions that can alert nurses and physicians when a new mother is on a potential path of becoming seriously ill (Young, 2018).

The steadily rising maternal death rate in the United States is now 26.4% per 100,000 births. (The Editorial Board, 2016) This statistic counters a global trend which shows maternal mortality rates dropping in the developed world. (Tavernise, 2016) Between 1990 and 2015, the number of maternal deaths in Germany, France, Japan, England, and Canada, has been flat or has declined. (The Editorial Board, 2016) All the while, the rate in the United States, which boasts one of the most advanced health care systems in the world, sees maternal morbidity and mortality climbing. In America, maternal deaths suffered by women of color are the key factor driving the increase. (Lost mothers: Maternal mortality rates in the U.S., 2018)

In New York City, home of the country's largest black–white disparity in the maternal death rate, the divide is getting larger. This widening gap is particularly troublesome considering the fact that the city's overall maternal mortality rate has gone down. (Waldman, 2018) Black women in New York City face a higher rate of harm than their white counterparts even when they are college educated, have a normal weight and are affluent. In fact, black women from the city's wealthiest neighborhoods have poorer maternal outcomes than white, Asian, and Hispanic mothers from the city's poorest areas. (Waldman, 2018)

New York City has recently funded $12.8 million to underwrite an initiative to eliminate the black–white disparity in maternal deaths in that city. (Waldman, 2018) The money will be used to improve data collection specific to pregnancy- and childbirth-related deaths, pay for implicit bias training for medical staff at private and public facilities and underwrite a city-wide awareness campaign for the public. In addition, the city has taken steps to improve maternal care in its owned hospitals by offering specific training on how to identify and treat two of the most frequent causes of maternal death—hemorrhaging and blood clots. Another program innovation, the introduction of maternal care coordinators, will target high-risk mothers-to-be with additional assistance to navigate pregnancy, prescriptions and public health benefits. The goal of this comprehensive effort is to reduce by half the number of pregnancy- and childbirth-related complications occurring in New York City during the next five years.

This quality improvement pilot program came on the heels of an NPR series entitled "lost mothers: maternal mortality rates in the U.S." (Waldman, 2018) The series focused on pregnant patients' high hemorrhage rates in a Brooklyn hospital.

Only California, which has implemented many of the gold standard practices outlined in the Alliance for Innovation in Maternal Health Program (AIM), (Alliance for Innovation in Maternal Health) is the exception to this startling trend. AIM is a data-driven national safety and quality improvement program designed specifically to address issues related to maternal health. AIM "safety bundles," an evidence-based list of quality-oriented practices and checklists, helped California bring down maternal complication rates 21% in just 24 months. As a result of implementing this quality improvement methodology designed to tackle the most common problems in childbirth, including heart attack, kidney failure, and blood clots,

significantly fewer California women found themselves on ventilators or scheduled for a hysterectomy after giving birth. (Young, 2018)

While New York City and California are stepping up to address maternal mortality in the short term, several other states have established review committees to investigate the issue, and the U.S. Senate has proposed legislature to provide $50 million in funding to reduce maternal mortality. (Waldman, 2018) In late August, Senator Kamala Harris (D-CA) introduced the Maternal Care Access and Reducing Emergencies (CARE) Act. The Care Access and Reducing Emergencies Act is aimed at addressing and reducing the disproportionate rates of maternal mortality and life-threatening pregnancy complications for African-American women in the United States. With a focus on addressing the racial disparities in maternal mortality, the bill would establish:

- Implicit bias training grants directed to medical schools, nursing schools, and other training programs for health care providers to support implicit bias training.
- Pregnancy medical home grants directed to up to 10 states to establish or operate statewide pregnancy medical home programs. The pregnancy medical home model incentivizes maternal health care providers to deliver integrated health care services to pregnant women and new mothers, with the aim of reducing adverse maternal health outcomes, maternal deaths, and racial health disparities in maternal mortality.

These alarming maternal morbidity and mortality rates point out the importance of science and evidence in shaping public safety advocacy. Using data and research to validate best practices helps health care providers minimize unnecessary care, save money, and move patients into appropriate pathways that produce desired results. (Carroll, 2017) However, statistical significance and clinical significance are not the same. With a substantial cohort, statistical significance can be achieved but simply having a large sample does not necessarily create the clinical significance needed to modify clinical practice. (Carroll, 2017) Knowledge gleaned from data and research calls out for a real-world perspective against which it can be evaluated and acted upon.

Health systems, nurses, providers and insurers appear unable to hardwire the evidence of safety practices related to managing hypertension and blood loss in a highly reliable way. This is an opportunity for nurse leaders to advocate for change based on this evidence. The need to advocate is now. The time for studying maternal mortality has long since passed. Without our leadership, America will continue to be the most dangerous place in the developed world to give birth.

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