

Rhode Island Pregnancy and Postpartum Death Review Committee (PPDRC)

Known Nationally as Maternal Mortality Review (MMR)

In Rhode Island we acknowledge the breadth of gender identity of individuals who may become pregnant (e.g. transgender, non-binary, and intersex) and named our committee accordingly.

Committee Overview

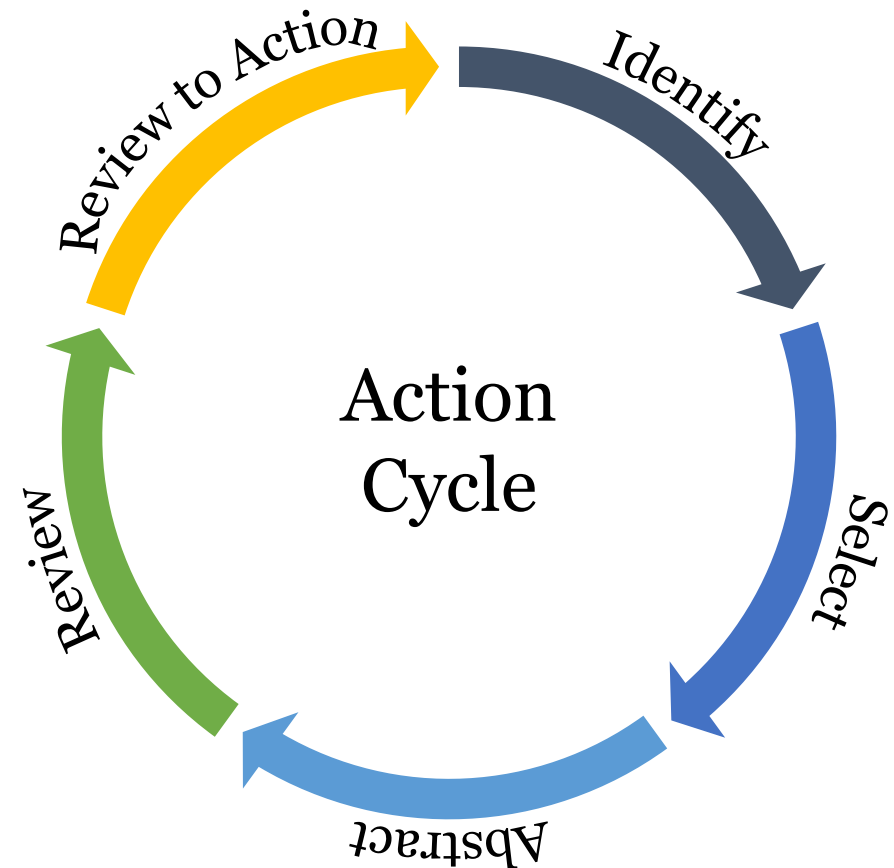
- Rhode Island's Pregnancy & Post-Partum Death Review Committee (PPDRC) is a multidisciplinary committee that reviews deaths that have occurred during pregnancy or within one year of the end of pregnancy.
- The Pregnancy and Postpartum Death review is conducted pursuant to RIGL §23-4-3 and Department of Public Health rules and regulations pertaining to the reporting of selected causes of mortality in Rhode Island.
<http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-4/23-4-3.HTM>
- The PPRC reviews deaths to:
 - ✓ Identify factors contributing to the deaths
 - ✓ Recommend public health and clinical interventions that may prevent future deaths, and also to improve systems of care
 - ✓ Contribute to the state and national knowledge base (CDC's Maternal Mortality Review Information Application / MMRIA)

PPDRC Orientation Participants

- Aidea Downie
- Ailis Clyne
- Andrea Tonski
- Anne Murray
- Ashley Lakin
- Brian Daly
- Collette Onyejekwe
- Danika Wynn
- Deborah Garneau
- E. Christine Brousseau
- Ellen Amore
- Elisabeth Davies-Howard
- James O'Brien
- Jami Star
- Jean Salera-Vieira
- Jennifer Hosmer
- Jerry Fingerut
- John Nisbet
- Keith Scally
- Laurie Chatterley
- Leah Battista
- Linda Nanni
- Liz Tobin-Tyler
- Lucia Larson
- M. Halit Pinar
- Mara Coyle
- Margo Katz
- Martha Kole
- Mary Beth Sutter
- Michelle Palmer
- Mohamad Hamdi
- Monique Depaepe
- Robert Insoft
- Shannon Young
- Sharyn Heinzelman
- Sharon Ryan
- Susan Olson
- Susanna Magee
- Tanya Booker

CDC's Recommendation: Maternal Mortality Review Committees (MMRCs): The Gold Standard for State Based Data on Maternal Mortality

- Part of an ongoing quality improvement cycle
- Incorporates multidisciplinary expertise, typically staffed by/hosted by public health agency
- Leads to understanding of the drivers of a maternal death and determination of what interventions will have the most impact at patient, provider, facility, system and community level to prevent future deaths



Maternal Mortality Review...

IS

- Ongoing anonymous and confidential process of data collection, analysis, interpretation and action
- Systematic process guided by policies, statutes, rules, etc.
- Intended to move from data collection to prevention activities

IS NOT

- A mechanism for assigning blame or responsibility for any death
- A research study
- Peer review
- An institutional review
- A substitute for existing mortality and morbidity inquiries

National Data: Pregnancy-Related Deaths Occur Up to a Year from the End of Pregnancy



31%

During pregnancy



36%

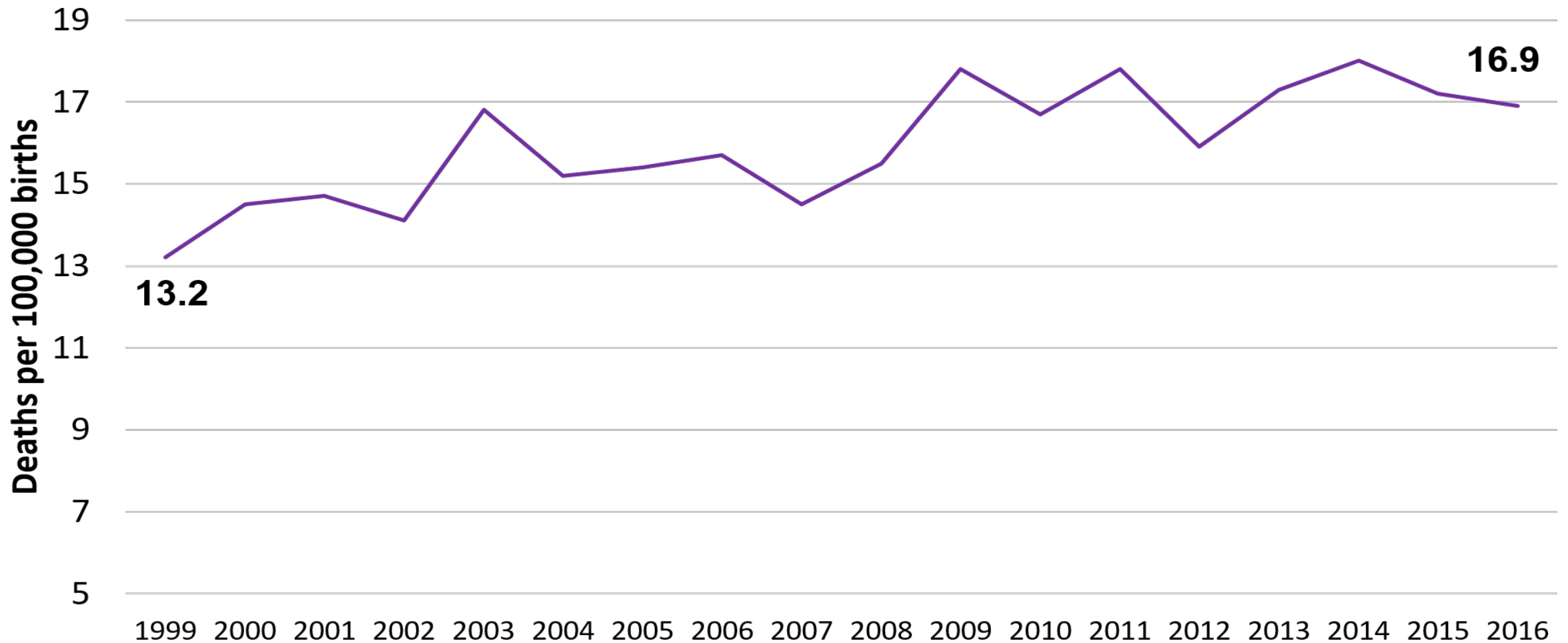
During delivery and
up to 1 week afterward



33%

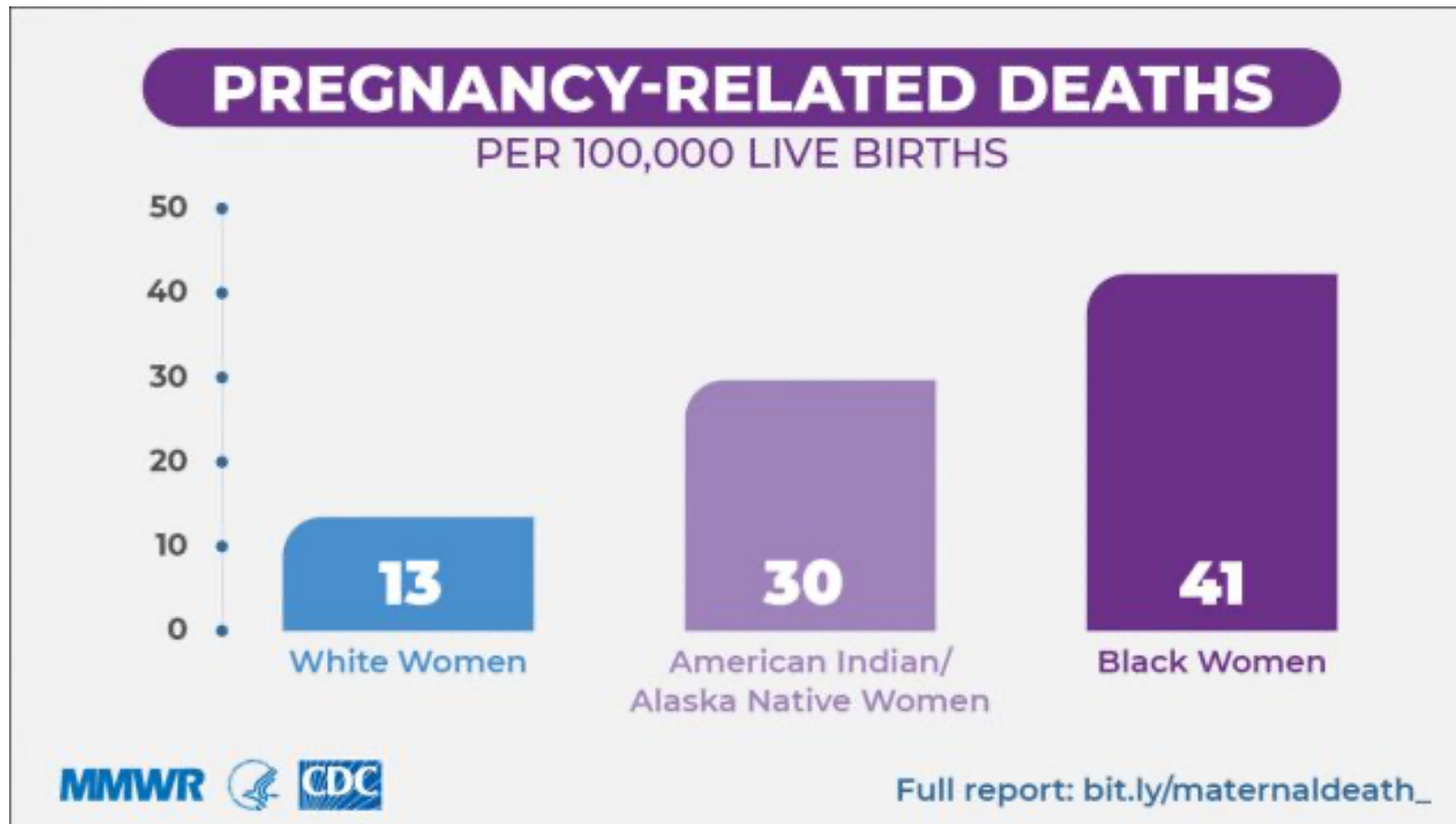
1 week to
1 year after

National Data: Pregnancy-Related Mortality, PMSS, 1999-2015: Not Improving



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

National Data: Native American/Alaska Native and Black Women are 2 – 3 Times More Likely to Die of Pregnancy-Related Causes than White Women



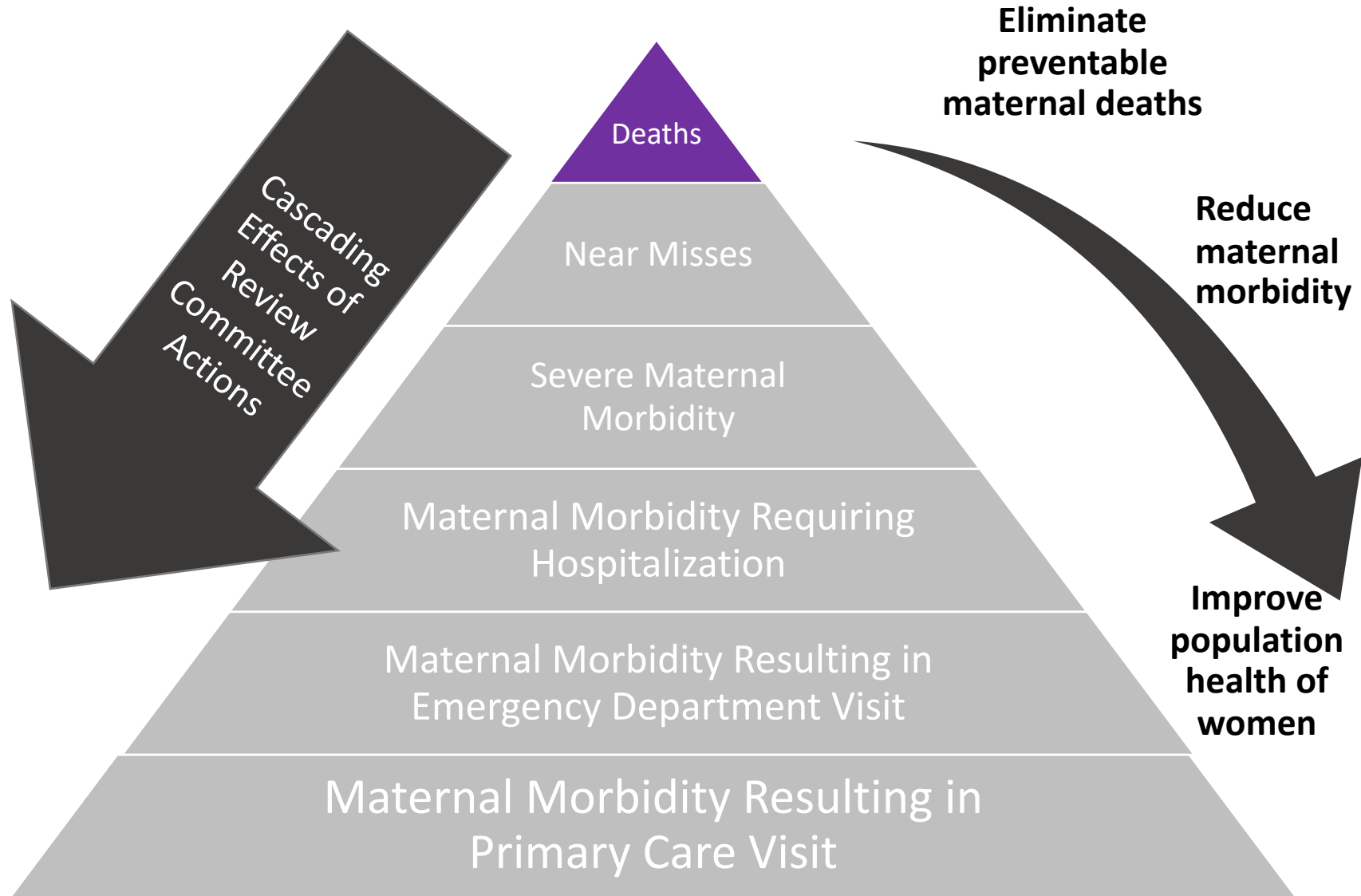
Rhode Island Data

PMSS data show that in 2012-2016, there were < 10 pregnancy-related deaths in Rhode Island.

PMSS data reports a combined 13 pregnancy associated or pregnancy-related deaths in RI for 2012-2016

Small numbers in RI make it difficult to highlight relevant disparities found nationally.

Impact



Thank you!

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