Illinois Maternal Morbidity and Mortality Report

Frequently Asked Questions

On October 24, 2023, the Illinois Department of Public Health released Illinois' third Maternal Morbidity and Mortality Report. The report identifies statewide trends in maternal deaths and provides recommendations to help prevent maternal mortality. In addition, the report provides data on common maternal morbidities present at delivery including obesity, hypertension, diabetes, mental health conditions, and substance use disorder. It also provides data on a group of potentially life-threatening, unexpected maternal conditions or complications that occur during labor and delivery called "severe maternal morbidity" or SMM.

Table 1 briefly describes the various indicators in the report, including the years provided.

Indicator	Years Provided	Stratified Data Provided	Trend Data Provided
Maternal Mortality			
Pregnancy-associated deaths	2015-2022	No	Yes
Pregnancy-related deaths	2015-2020	Yes: 2018- 2020	Yes
Maternal Morbidity at Delivery			
Obesity	2010-2020	Yes: 2018-2020	Yes
Hypertension	2010-2020	Yes: 2018-2020	Yes
Diabetes	2010-2020	Yes: 2018-2020	Yes
Mental health conditions	2018-2020	Yes: 2018-2020	No
Substance use disorder	2018-2020	Yes: 2018-2020	No
Severe maternal morbidity	2018-2020	Yes: 2018-2020	No

Below we answer some frequently asked questions about the report and the data it contains.

1. **What is the difference between pregnancy-associated and pregnancy-related deaths?**

   A pregnancy-associated death is the death of a woman during pregnancy or within one year of the end of a pregnancy **from any cause;** these are deaths that are temporally associated with a pregnancy. A pregnancy-related death is the death of a woman during pregnancy or within one year of the end of a pregnancy **from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy**. Pregnancy-related deaths are a subset of pregnancy-associated deaths; all pregnancy-related deaths are pregnancy- associated but not all pregnancy-associated deaths are pregnancy-related; for example, a woman who dies in a car crash six months postpartum is pregnancy-associated (by time since they were six months postpartum) but not pregnancy-related (being pregnant or postpartum did not cause the car crash).

2. Why is there such a lag in providing maternal mortality data?

There are three main reasons why there is a delay in releasing Illinois maternal mortality data. The first is that to abide by the set definition of pregnancy-associated and pregnancy-related deaths, the state must monitor and identify all deaths within one year of pregnancy, thus at least one year's time needs to pass. For example, to identify all deaths that occurred following 2019 births, those who gave birth in December 2019 need to be followed for one year (through December 2020). The second reason is that the maternal mortality review committee process is robust and it takes time to identify deaths (from multiple sources), request records, and compose case review abstracts, accompanied by the coordination of the committees to meet to review and discuss the deaths. Lastly, maternal mortality is a rare event so combining at least two calendar years' worth of data enables better estimates and an understanding of overall needs in maternal health and for public reporting purposes.

3. Why is the national maternal mortality data more current than Illinois data?

The National Vital Statistics System (NVSS) releases maternal mortality statistics annually based on data provided via death certificates. Deaths related to pregnancy are identified via a standardized check box on the death certificate. Only deaths that occur while pregnant or within 42 days of the end of pregnancy are counted. NVSS uses a shorter time frame and includes only one source of information to identify deaths, thus the data can be summarized and analyzed more quickly.

Link to most recent report: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm

The Centers for Disease Control and Prevention (CDC) conducts national pregnancy-related mortality surveillance based on vital records information (death records, birth records and fetal death records) collected in the Pregnancy Mortality Surveillance System (PMSS). The CDC counts all deaths while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy. The PMSS also used media searches and public health reporting processes to identify deaths and may review other sources of information (such as medical records) if available. Because the PMSS uses a longer time frame (one year) and includes data linkages, it has a slower reporting time than NCHS. However, it uses a team of medical epidemiologists rather than a multi-disciplinary review committee so reporting time is faster than data generated by state-level maternal mortality review committees.

Link to most recent PMSS report: https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

The data released by NCHS and PMSS have different definitions, identification methods, data sources and methodology than the maternal mortality review committees. When it comes to

maternal deaths, the data produced by the maternal mortality review committees is considered gold standard as it provides the most detailed and complete data and undergoes rigorous review to understand the cause of death and if indeed the death was pregnancy-related. It is also conducted at the state-level providing additional context to the deaths being reviewed.

4. Can the Illinois data be compared to other states?

Each state conducts its maternal mortality reviews a little bit differently and although information provided by reviews is generated by consensus among committee members, there is still room for subjectivity. Thus, there is slight variation from state to state. Recent efforts of the Centers for Disease Control and Prevention's ERASE MM Program have focused on providing technical assistance to states in attempts to make maternal death reviews and data collection more standardized. Every few years, the researchers at the CDC access information entered by states into the shared Maternal Mortality Review Information Application (MMRIA) system and summarize data for all available states.

Link to most recent multi-state report using maternal mortality review committee data: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

5. Why is county-level maternal mortality data not available?

Maternal deaths are a rare event. For many counties and areas of the state, the data cannot be released due to low counts which affect the stability of rates and may comprise the privacy of the deceased and their families.