Maternal Morbidity and Mortality Surveillance in Canada - Where We Are and Where We Are Not

Webinar, February 20, 2019
Your Facilitators

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On Today’s Call…

Dr. Barrett will:
Provide a summary of the Society of Obstetricians and Gynaecologists of Canada (SOGC) initiatives related to Maternal and Mortality

Joanna Noble will:
Share various recognition of clinical deterioration resources available on the CPSI website

This will be followed by a Q and A
Maternal
Mortality and Morbidity in Canada

Dr. Jon Barrett
Dr. Jocelynn Cook, PhD., MBA
Chief Scientific Officer
Objective

• To Provide a summary of the SOGC initiatives into Maternal and Mortality
Disclosure

- Received Financial Support from Ferring and Smith and Nephew
Maternal Mortality

• The maternal mortality ratio (MMR) is one of the main indicators of a country’s health. This ratio is reported and compared globally, within and across sectors.
  – **MMR**: Pregnancy-related deaths per 100,000 live births.

• The recommended definition is based on work in other countries, such that data and trends can be compared and contrasted, with the goal of capturing all pregnancies.
  – **Maternal Death** - The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.
What’s Happening in Canada?

- In Canada, maternal mortality is an infrequent event with devastating consequences for women, their families and care providers.
  - The Public Health Agency of Canada (PHAC) reported variation in pregnancy related mortality between 5.1 and 11.9 per 100,000 deliveries (1999/2000 to 2014/2015).
Maternal Mortality and Severe Maternal Morbidity Surveillance in Canada

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Abstract

The Canadian Perinatal Surveillance System has provided a comprehensive review of maternal mortality and severe maternal morbidity in Canada, and has identified several important limitations to existing national maternal data collection systems, including variability in the detail and quality of mortality data. The Canadian Perinatal Surveillance System report recommended the establishment of an ongoing national review and reporting system, as well as consistency in definitions and classifications of maternal mortality and severe maternal morbidity, in order to enhance surveillance of maternal mortality and severe maternal morbidity. This review

la surveillance de la mortalité maternelle et de la morbidité maternelle grave. En utilisant des articles et des études d'analyse ayant examiné la mortalité maternelle en général (par opposition avec la mortalité maternelle associée à des stratégies de prise en charge ou à des pathologies particulières), les classifications, la terminologie et les statistiques comparatives portant sur la morbidité grave et la mortalité maternelles ont été analysées et utilisées pour évaluer les lacunes des méthodes passées et actuelles de collecte de données et pour chercher des solutions visant à répondre au besoin d'établir un système national amélioré et uniforme de surveillance de la mortalité maternelle et de la morbidité maternelle grave au Canada.
Maternal Mortality in Canada

- Existing Canadian data sources have been shown to under-ascertain and misclassify maternal deaths, leading to underestimation of Canada’s MMR, and limited understanding of the causes of maternal deaths.

- Canada does not have a national enquiry process and has not set targets for maternal mortality reduction.

- Provinces and territories are critical leaders in the measurement of maternal mortality in Canada and some have existing processes in place to measure, report and to provide recommendations, to varying degrees.
  - Despite this, there is little standardization across jurisdictions and no accurate national picture.
SOGC Updates (2010)

• The World Health Organization’s 2010 report indicated a rise in maternal mortality in Canada.

• This prompted the Society of Obstetricians and Gynaecologists of Canada (SOGC) to work with partners to review national maternal mortality surveillance.

• A Committee on Maternal Mortality and Severe Morbidity was formed in August 2010 with the mandate to make recommendations for measurement.
  – The Committee found that national maternal health surveillance faces serious barriers relating to data access, coverage, timeliness and completeness.

• Since 2010, there have been significant shifts in the demographics of the child-bearing population in Canada.
  – A new set of contributing causes of maternal mortality that the existing system was not designed to measure, and was unequipped to analyze.
If at first you don't succeed then skydiving definitely isn't for you.

Steven Wright
In October 2016, the SOGC hosted a planning workshop in Ottawa.

- “Measuring Maternal Morbidity and Mortality in Canada”

Outcomes of this workshop:
- Reviewed data sources for measurement of maternal morbidity and mortality in Canada.
- Created a list of key indicators of maternal morbidity and mortality in Canada.
- Identified best practices, gaps and challenges related to surveillance of maternal morbidity and mortality in Canada.
- Brought together National and International experts and key stakeholders related to measurement of maternal morbidity and mortality in Canada.
Key experts wrote a review article in the JOGC highlighting there was no systematic mechanism in place to synthesize and report maternal morbidity and mortality data in Canada.

This paper updated the Canadian context and provided an up-to-date review of the literature, practices and approaches that can form the foundation for the development of approaches and systems to capture data on maternal morbidity and mortality in Canada that is essential to improve outcomes for mothers and their babies.
SOGC Updates (2017)

- In June 2017, the SOGC hosted a face-to-face meeting with key experts (PHAC, CPSS, BORN, UK and US experts) on “Measurement of Maternal Morbidity and Mortality”. Outcomes were:
  - Received an update on the UK and US surveillance systems.
  - Reviewed progress to date with partnerships.
  - Formed the Maternal Mortality Steering Committee.

- Over the last year, the SOGC’s Maternal Mortality Steering Committee has met every 6-7 weeks to discuss updates, work plans and timelines on activities related to maternal mortality.
  - Committee includes individuals from the SOGC, CPSS, PHAC, and MOREob.

- Met with the Chief Public Health Officer to receive support on maternal mortality activities.
SOGC Updates (2018)

• The SOGC hosted a two-day National Maternal Mortality Workshop on March 27-28th, 2018 in Toronto.

• Participants included: key Canadian expert clinicians, researchers, policy makers, and International experts. They outlined the requirements and processes for accurate and reliable measurement of maternal mortality in Canada.

• This meeting involved the sharing of current practices around maternal mortality reporting from different provinces and territories across Canada, as well as from the United Kingdom and the United States.

• The opportunities and challenges around the implementation of a national reporting system were discussed, and a consensus emerged regarding next steps for putting such a system in place.
SOGC Updates (2018)

• Outcomes of the National Maternal Mortality Workshop:
  – It was agreed upon that all provinces and territories should use the same definitions related to maternal mortality
  – It was decided that a National Consortium on Maternal Mortality should be created, as well as a National Confidential Enquiry System on measuring and reporting on maternal mortality (to support provinces and territories who want to report their own data, but ultimately to produce a national report that is specific for regional differences and challenges)
    • *The ultimate goal is to eliminate all future preventable deaths*
  – The use of the minimum dataset and associated reporting templates (MMRIA and MMBRACE) are currently being reviewed by four provincial perinatal programs
  – Adequate financial resources are necessary for the development and sustainability of a national system for measurement and reporting on maternal mortality
### Going Forward

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<th>Development of an online database infrastructure</th>
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<td>Establishment of a national minimum dataset</td>
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<td>Implementation of a comprehensive governance and oversight structure</td>
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<td>Obtaining consensus on a data-sharing/contribution process, including adherence to privacy legislation and OCAP principles, from provinces, territories and Indigenous partners</td>
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<td>Development of Best Practices for Maternal Mortality Review and Reporting, including follow-up</td>
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<td>Development of recommendations arising from reviews, and action plans for dissemination and monitoring</td>
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<td>Holding a consensus meeting among all parties to agree on the target for a specific targeted reduction in preventable deaths within 7 years.</td>
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THANK YOU!

Questions?
Joanna Noble – A Glimpse of the CPSI Website

www.patientsafetyinstitute.ca

Canadian Patient Safety Officer Course
June 3rd - June 6th, 2019 (Ottawa, ON)
Register Now

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Archive

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Any questions?