New Mexico Maternal Mortality Review Update

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Presented at NMPC Meeting 5-11-18

Definitions

- A **Pregnancy Associated Death** is a death during a pregnancy or any time up to 1 year (365 days) after completion of the pregnancy, regardless of cause.
- A **Pregnancy Related Death** is a death during a pregnancy or any time up to 1 year (365 days) after completion of the pregnancy due to any cause related to or aggravated by the pregnancy or its management.

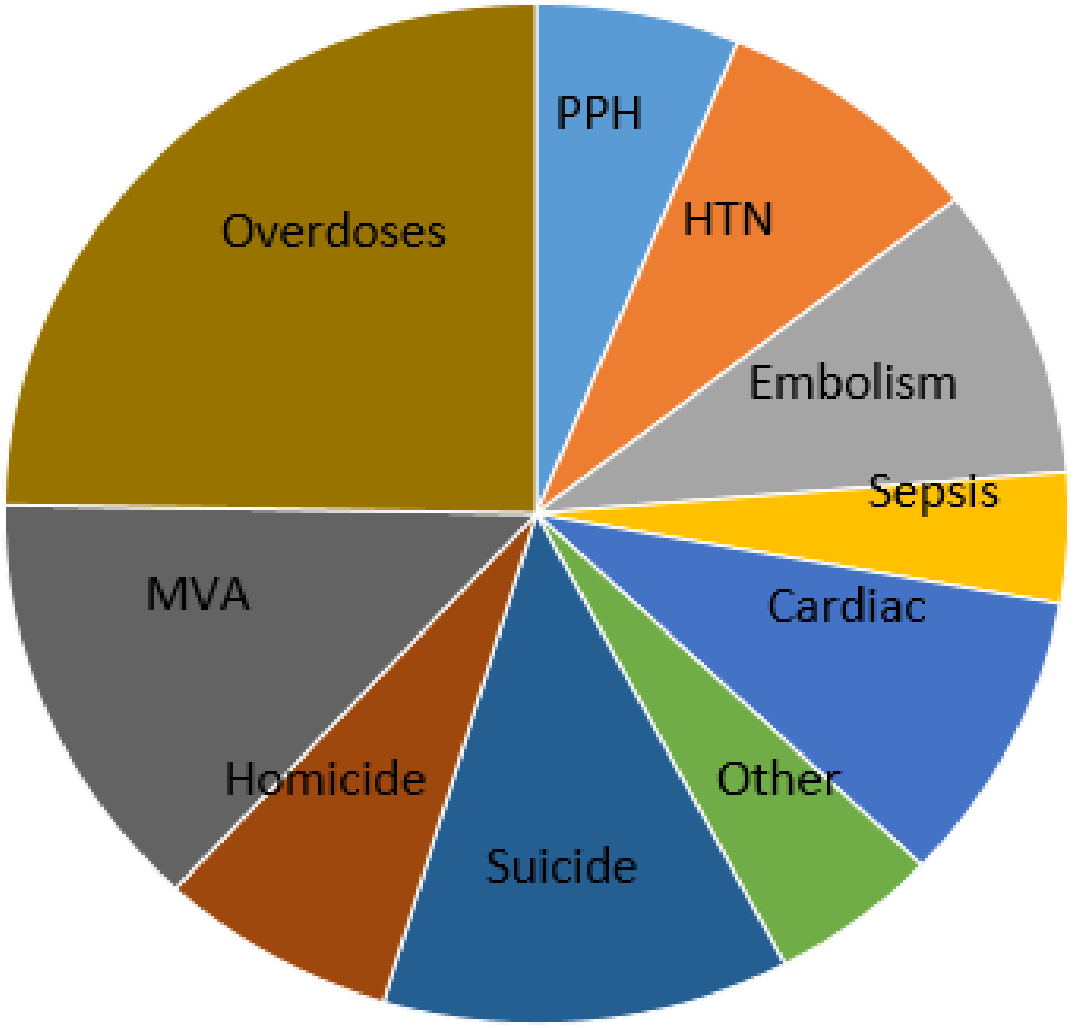
Timeline

- 1998 – DOH regulations created to do MMRC
- 1999-2012 – Couple of renditions of the committee work but not sustained
- 2015 Bill introduced in NM Senate to create MMRC – did not get out of committee
- 2016 – NM MMRC Task Force convened to discuss barriers to a NM MMRC and help to draft bill to legislate the need for an MMRC
- 2017 – Senate bill introduced by Senator Rodriquez. Eventually passed legislature but vetoed by Governor
- 2017 – NM Dept of Health supporting the bill in concept and with the encouragement of leadership, proceeded forward with NM MMRC
- 2018 – Could not get bill re-introduced in short session will try again in 2019

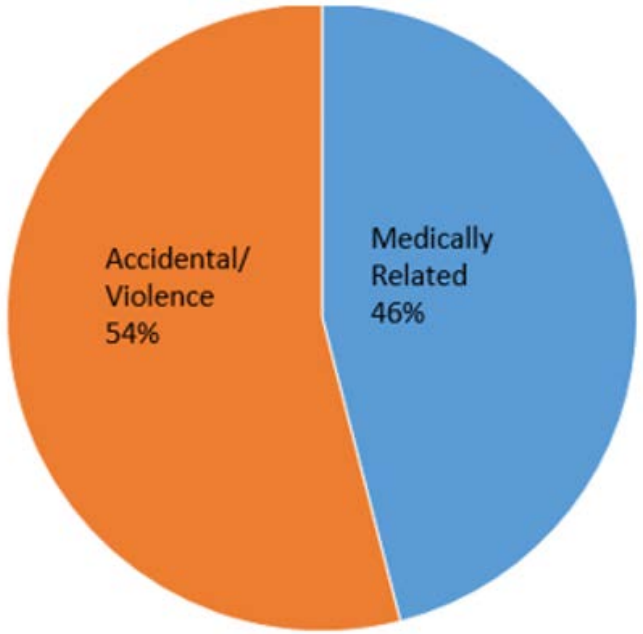
What data is available so far

- Deaths from 2010-2014 were identified by either
  - “O” death codes
  - Linked infant birth and maternal death certificates
  - Check in box on death certificate stating pregnant at time of death or within 1 year of end of a pregnancy & verified
- 97 maternal deaths were identified.
- Data abstracted from birth/death certificates.
- No review of hospital, OMI or police reports done
- No review by abstractors or committee members to verify cause of death and preventability

Aggregate data from 2010-2014 (n=97)



Death Certificate stated cause of Death



Aggregate data from 2010-2014 (n=97)

Distribution of Maternal Deaths by:

Ethnicity/Race

White	31%	Hispanic	47%
Native American	20%	Other	2%

Age

<20	15%	20-29	57%	30+	28%

Timing of Death

Pregnant	7%	PP days 0-7	20%
PP days 8-42	20%	PP days 43+	53%

MMRC Review of Maternal Deaths 2015

- Cases Identified by DOH and verified by abstractors
- Total of 19 possible maternal deaths identified
- 3 MMRC meetings scheduled for Committee in 2018
- Hospital and clinic records are requested
- Medical records abstracted into data base
- De-identified summaries to be presented to MMR to determine accuracy of cause of death, whether preventable and recommendations for prevention

Membership of MMRC Committee

- Clinical Chair – obstetric provider
- Administrative Chair – DOH Director
- DOH personnel – MMR Coordinator, Epidemiologist and Lead abstractor
- Medical Specialties – OB-GYN, MFM, FP, EM, Psychiatry, Anesthesiology/Critical Care, Pathologist and Medical Examiner
- AWHONN
- ACNM
- Representatives from NM Perinatal Collaborative, NM Hospital Association, Mental Health worker, Ob epidemiologist, and Experts as needed.

What do we do with our small numbers?

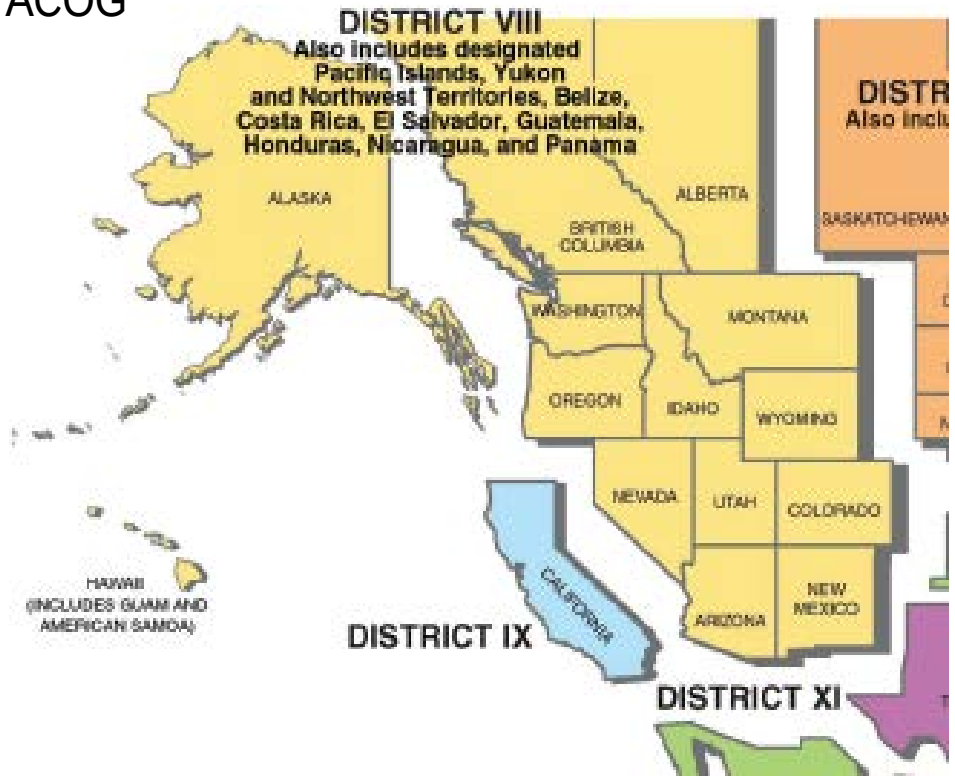
- Necessary to aggregate 5+ years to have adequate sample size to make any conclusions or trend success of interventions.

And / Or

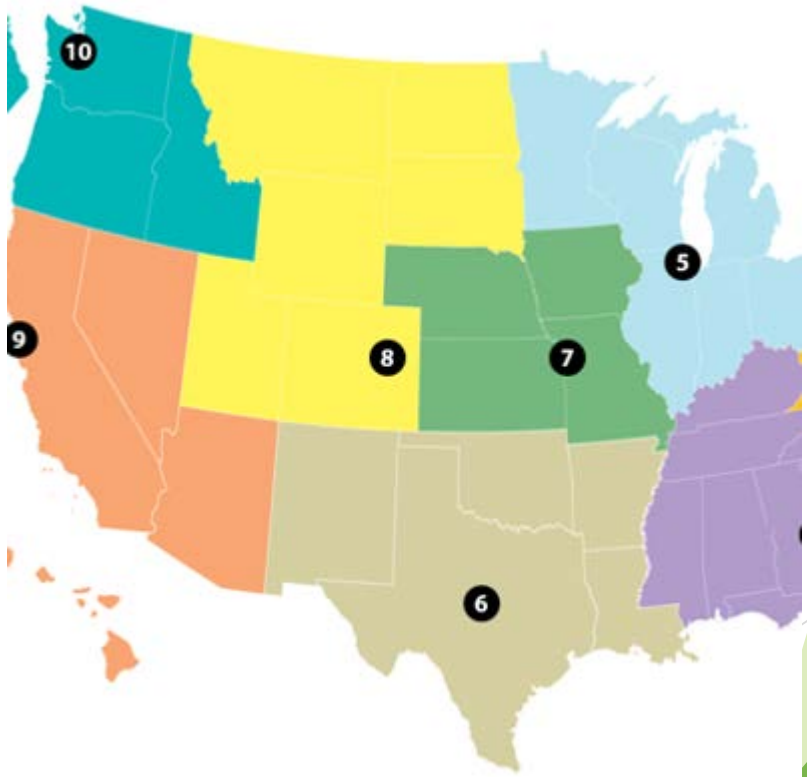
- Use the CDC data base (MMR interactive application – MMRIA). Collects data from multiple states in same format, using same definitions, and will be able to compile de-identified data by larger groups to achieve adequate sample size for determining trending in causes and impact of interventions across a region.

Possible ideas for regional reports

ACOG



HRSA



Regional approach

Would allow enough data from similar areas to look at questions such as

- What are the causes of death/severe morbidity for the rural population
- How do overdoses, motor vehicle accidents and violence impact the rural populations
- Do diverse racial/ethnic groups have different patterns of maternal deaths
- Have our interventions had a positive impact on Maternal mortality in our state or regionally.

What is on the agenda for 2018?

- Re-introduce legislation to have Maternal Mortality review and Severe Maternal Morbidity trending be required.
- Evaluate asking for money from legislature to help support the efforts of DOH and committee members
- Utilize the MMRIA data base and be included in the next CDC publication
- Determine cause, preventability and recommendation for each 2015 death
- Utilize the NM Perinatal Collaborative as the resource for implementing and coordinating interventions