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

- Overdoses
- MVA
- Homicide
- Suicide
- Other
- Cardiac
- Embolism
- Sepsis
- HTN
- PPH

Accidental/Violence 54%
Medically Related 46%
### 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 database (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
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.