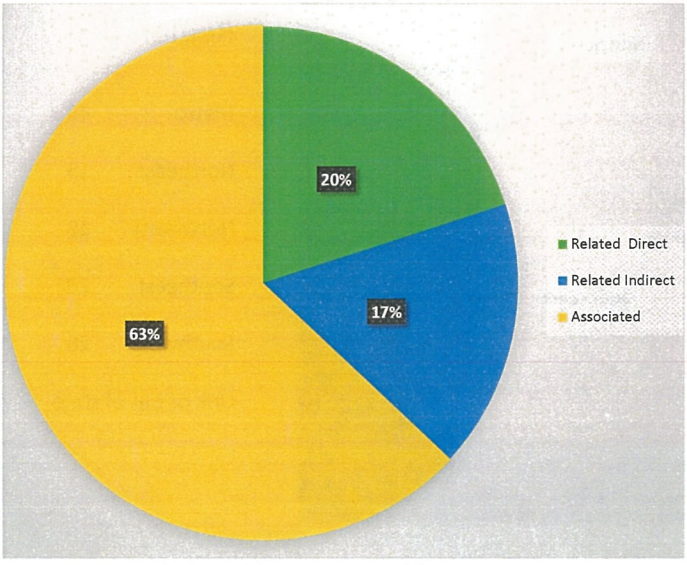
Maternal Mortality Review for State of New Mexico Proposal for legislative action

Sharon T. Phelan MD, FACOG

Chair , New Mexico Section of American College of Obstetricians and Gynecologist

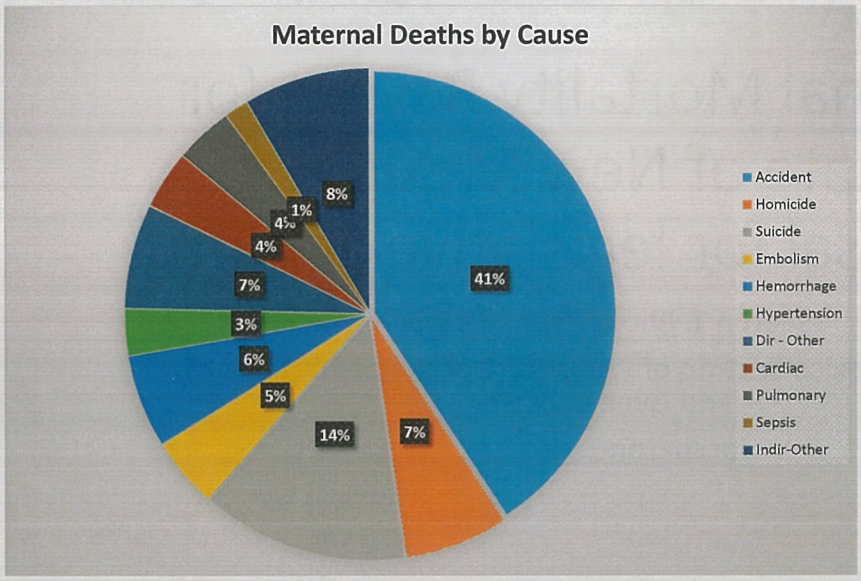
docsharon@aol.com

Maternal Deaths in New Mexico 2008-2014



Pregnancy related deaths:
Direct 27
Indirect 23
Pregnancy Associated deaths:
85

Total: 135 deaths



Raw Numbers

Accidents	53
Homicide	9
Suicide	18
Unknown	5
Embolism	6
Hemorrhage	8
Hypertension	4
Direct Others	9
Cardiac	5
Pulmonary	5
Sepsis	2
Indirect-Other	11

Maternal Deaths per Region

Metro	48
Northeast	15
Northwest	19
Southeast	20
Southwest	26
Unk or out of state	7

Maternal Deaths in NM by race and age

	% of Maternal Deaths	Deaths/100,000 live births (US rates)	% of NM Population
White: non-Hispanic	24%	14.9 (14.1)	38%
White: Hispanic	55%	25.5 (11.3)	48%
Black	?	83.0 (40.2)	2.6%
Native American	18%	23.7 (25.1)	10%
Asian	?	0 (10.6)	1%

Age Distribution of deaths

< 20 : 18 (13%) 20-29 : 73 (54%) 30-39: 36 (27%) 40+ : 8 (6%)

Problems with **current** NM MMR approach

1. Small numbers
   - Raises concerns of confidentiality in the process
   - Need to aggregate date over many years to find trends or need to compare with other similar rural states to verify trends and system issues
   - Severe morbidity reviews may help since 10-20X more common
2. Health Care Delivery complex with multiple stake holders
   - Need multiple groups represented to identify issues
   - More individuals involved with raw data more concerns of confidentiality

Problems with **current** NM MMR approach

3. Data Accessible
   - Access to only birth certificates, death certificates and autopsy/OMI records are not enough to accurately determine systems issues for improvement
   - Hospitals and providers unwilling to share information without clear protection from discovery
   - Need a law not a regulation to provide this.

4. No requirement to report to stakeholders regarding data, actions taken, or improvements achieved.

Can anything be done if there is more data?

- YES!!!
- Example of patient delivering at Hospital A being transported to Hospital B and eventually dying at Hospital C from hemorrhagic shock –Patient bled to death.
- Members of Hospital C and ACOG members presented a lecture and simulation at Hospital B with attendance by staff of both A and B on managing PPH
- In following year 2 similar cases happened at same region - both survived with minimal long term complications.

The Joint Proposal for the Maternal Mortality Review Process for the State of New Mexico

1. The legislation would require DOH to create and maintain this review process. (Since the members of the MMR will be volunteers, the cost will be minimal for DOH staff activities) LS1
2. Confidentiality –
    1. The process will be considered peer review for patient safety and will not be discoverable for legal or disciplinary actions.
    2. To minimize access of identified data, there will be a small group of individual providers who will be responsible for looking at the actual data and abstracting it into a standardize (CDC recommended) de-identified data collection tool
    3. This will minimize the identification of individual providers, patients and hospitals and place focus on more regional/state systems issues
    4. All committee members will sign a confidentiality agreement

The Joint Proposal for the Maternal Mortality Review Process for the State of New Mexico

3. Data Collection –
    1. Hospitals, providers and law enforcement will be required to share information with abstractors include prenatal care, hospitalization, and report from the scene.
    2. Hospitals will be encouraged to quickly share the cases of maternal mortality that occur in their institutions so problems and solutions can be identified more promptly.
    3. Have the potential for sharing de-identified data via a CDC platform with other states and regions.
    4. Have the potential for expanding into Severe Maternal Morbidity reviews as defined by the CDC (ICU admission or 4 unit transfusion).
4. Membership – will include representatives from the major hospital systems, the various obstetric provider organization, Perinatal Collaborative, Nursing, HSD and insurance organizations, I.H.S, DOH, and others

Slide 9

LS1 Linda Siegle, 10/23/2016

The Joint Proposal for the Maternal Mortality Review Process for the State of New Mexico

5. Review Process

1. An abstractor will complete the de-identified review form by reviewing the actual patient records
2. The full committee at their quarterly meeting will review the abstracted data and determine if the death might have been preventable and what would have be done to prevent a re-occurrence
3. The appropriate member groups will then work to implement the recommendations – i.e. patient, provider, or systems education
4. Committee will monitor implementation of recommendations and impact
5. Yearly report will be compiled of de-identified data (rolling aggregate of 5 years to help with maintaining confidentiality) and submitted to the DOH

Summary

- We must have a more robust MMR process
- The Provider organizations are behind this and will do the work
- The legislature will provide the statutory authority to enable a comprehensive maternal mortality review.

New Mexico has unique challenges in providing health care to its residents due to distances, economics, legal status, and cultures. We can not just ignore these challenges.