NEW MEXICO MATERNAL MORTALITY REVIEW COMMITTEE

NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

WHAT IS THE MMRC?

The Maternal Mortality Review Committee (MMRC) reviews every death of a NM resident occurring during pregnancy or within 365 days of the end of pregnancy.

Committee members determine if deaths were pregnancy-related or pregnancy-associated but not related, and they determine if there had been opportunities to prevent those deaths. They then make recommendations to prevent future deaths.

DEFINITIONS

Pregnancy associated death is the death of a person during pregnancy or within one year of the end of pregnancy from any cause.

Pregnancy-related death is the death of a person during pregnancy or within one year of the end of 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.

A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient/family, provider, facility, system, and/or community factors.

PREGNANCY-RELATED MORTALITY RATIOS

New Mexico - 25.8 deaths per 100,000 births
(2015-2018)

United States - 17.3 deaths per 100,000 births
(2017)

TIMING OF MAATERNAL DEATHS

Among NM pregnancy-associated deaths, 2015-2018:

23% occurred during pregnancy

16% occurred 0-42 days postpartum

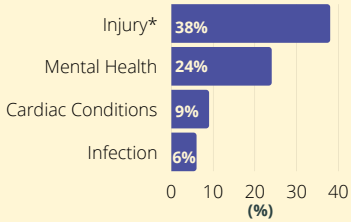
61% occurred 43-365 days postpartum

KEY REPORT FINDINGS

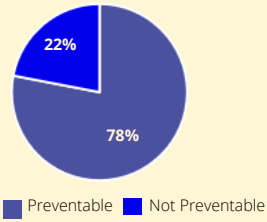
*Pregnancy-associated deaths - **77 total,** 2015-2018*

Contributing factors:
Substance use disorder - 47%
Mental health conditions - 42%
Suicide - 12%

Most Common Causes of Pregnancy-Associated Death



Preventability of Pregnancy-Associated Deaths

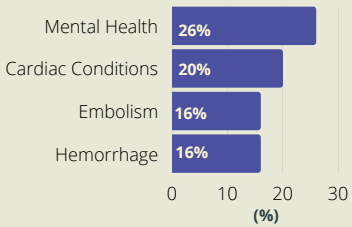


*42% of injury deaths due to motor vehicle crashes, 26% due to overdose

*Pregnancy-related deaths - **25 total,** 2015-2018*

Contributing factors:
Substance use disorder - 40%
Mental health conditions 36%
Suicide - 20%

Most Common Causes of Pregnancy-Related Death



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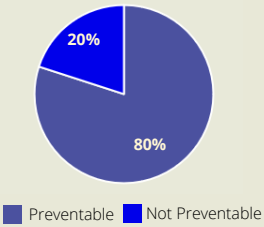

SB-96 LEGISLATION

- Established reimbursement options for members to expand committee participation from diverse experts
- Appointed four members by the Indian Affairs Department and the Office of African American Affairs
- Applied term limits for committee members to ensure a greater variety of participants
- Required training on trauma-informed care and the trauma of death review

PREVENTION ACTIVITIES UNDERWAY

Postpartum Working Group sought expansion of pregnancy Medicaid coverage in NM for full year postpartum;
New patient safety bundle - Alliance for Innovation on Maternal Health (AIM):

- Collaboration with the NM Perinatal Collaborative and Project ECHO to implement maternal safety bundles at birthing hospitals
- Statewide working group on perinatal Substance Use Disorder, implementing best practices in screening, treatment, and trauma-informed care

To learn more about Maternal Mortality Review Committees, please visit our website: https://www.nmmaternalchildhealth.org/maternal-health

For more information, please contact:

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Intimate Partner Violence - 20%
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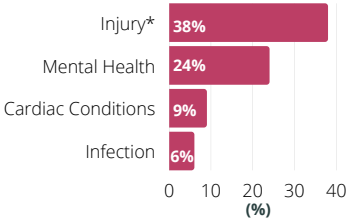

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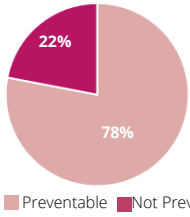

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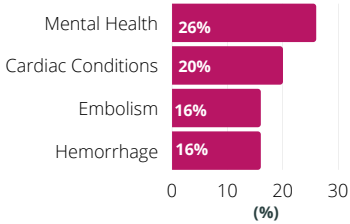

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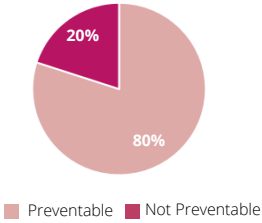

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