

# NEW MEXICO MATERNAL MORTALITY REVIEW COMMITTEE



## 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 MATERNAL DEATHS

Among NM pregnancy-associated deaths, 2015-2018:



**23%** occurred during pregnancy



**16%** occurred 0-42 days postpartum



**61%** occurred 43-365 days postpartum

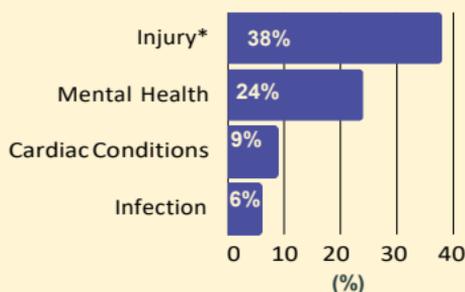
# KEY FINDINGS



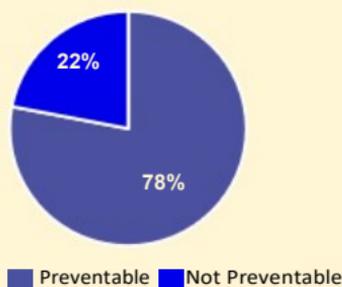
## Pregnancy-associated deaths - 77 total, 2015-2018

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

### Most Common Causes of Pregnancy-Associated Death



### Preventability of Pregnancy-Associated Deaths

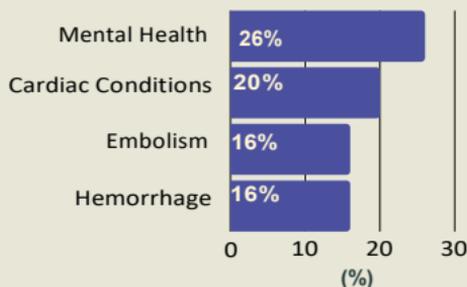


\*42% of injury deaths due to motor vehicle crashes, 26% due to overdose

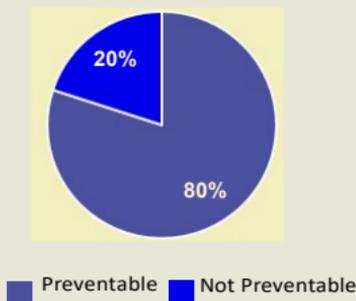
## Pregnancy-related deaths - 25 total, 2015-2018

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

### Most Common Causes of Pregnancy-Related Death



### Preventability of Pregnancy-Related Deaths



## SB-96 LEGISLATION

- Established reimbursement options for community members to support participation from diverse backgrounds
- Four members appointed by Indian Affairs Department and 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 for full year postpartum.
- New Mexico's commitment to the 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

**DOH to release a report on maternal deaths in New Mexico and their contributing factors, including recommendations for prevention this Fall.**

For more information, please contact:

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