



# The New Mexico Maternal Mortality Review Committee: Findings & Recommendations

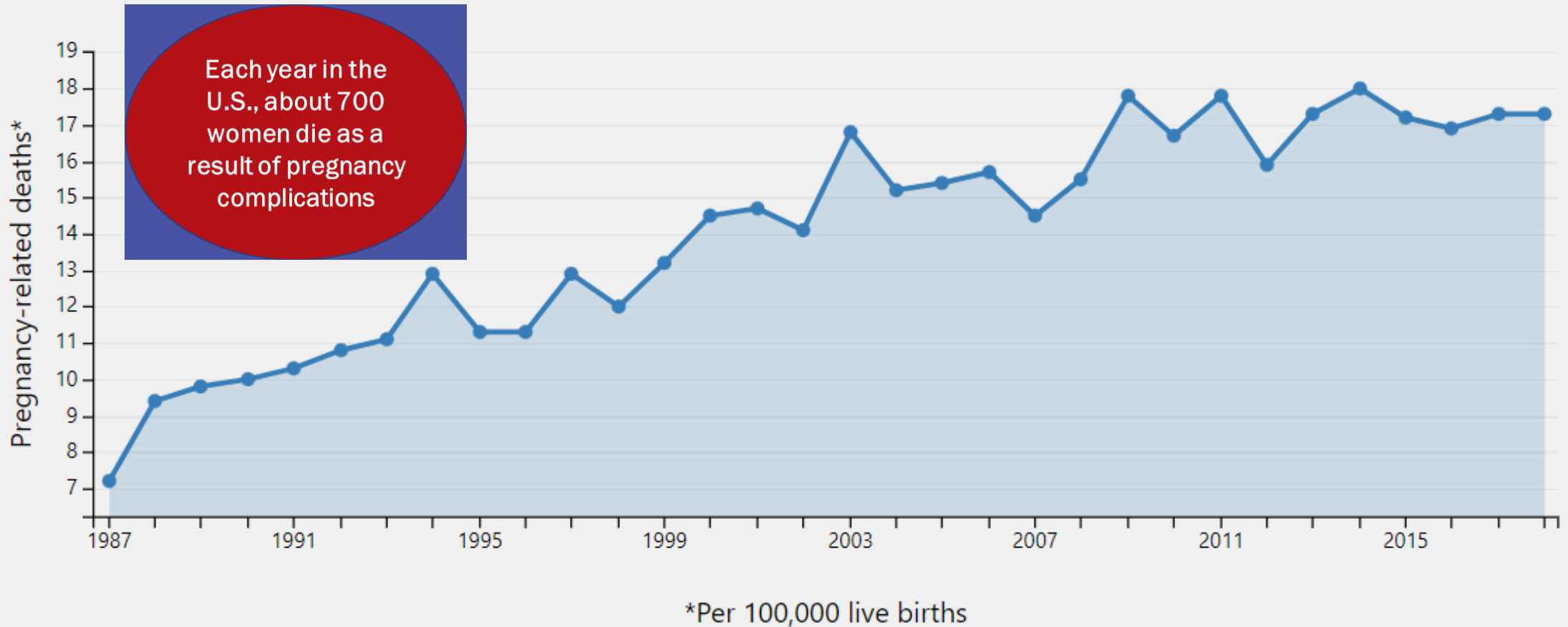
Eirian Coronado, Maternal Child Health Epidemiology  
Abigail Reese, PhD, CNM, Maternal Health Program  
Family Health Bureau, Public Health Division

# Objectives

- Provide essential measures from the most current available national and state level maternal mortality data
- Identify data sources used for analysis
- Present recommendations featured in the inaugural report of the NM Maternal Mortality Review Committee
- Identify accomplishments to date and next steps

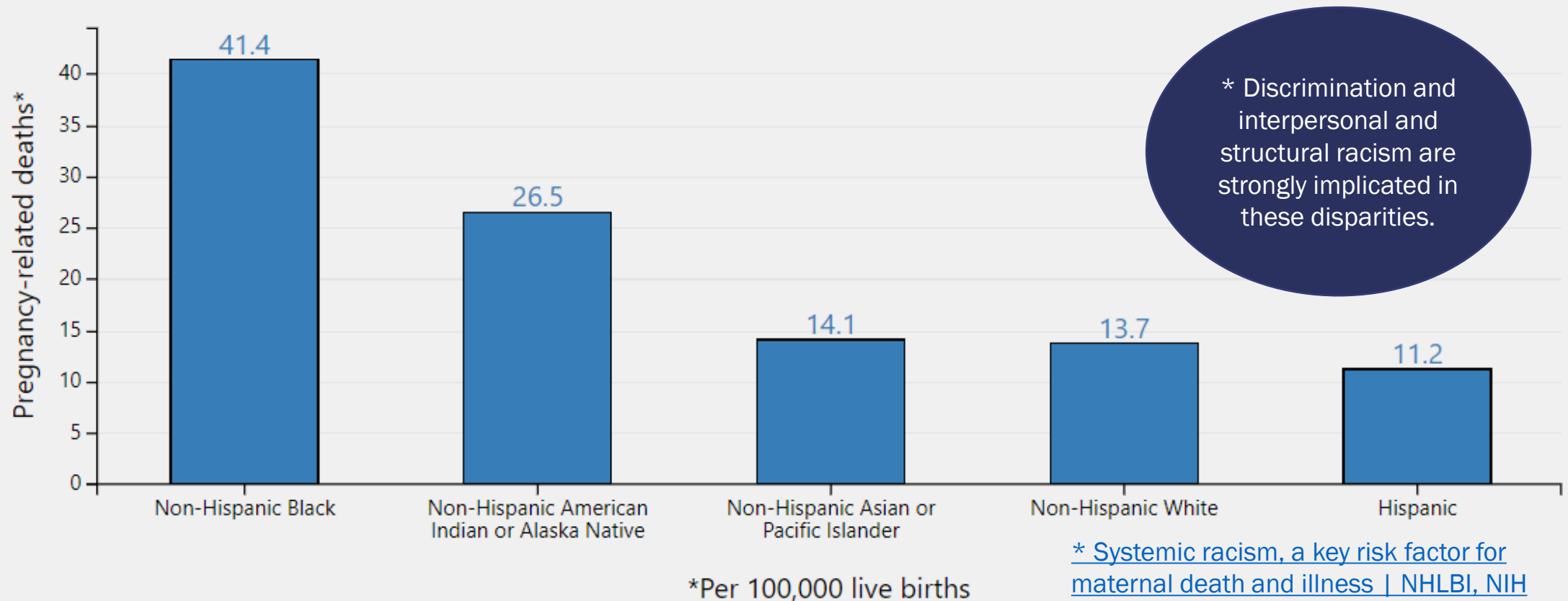
# Maternal Mortality is a National Crisis

## Trends in pregnancy-related mortality in the United States: 1987-2018



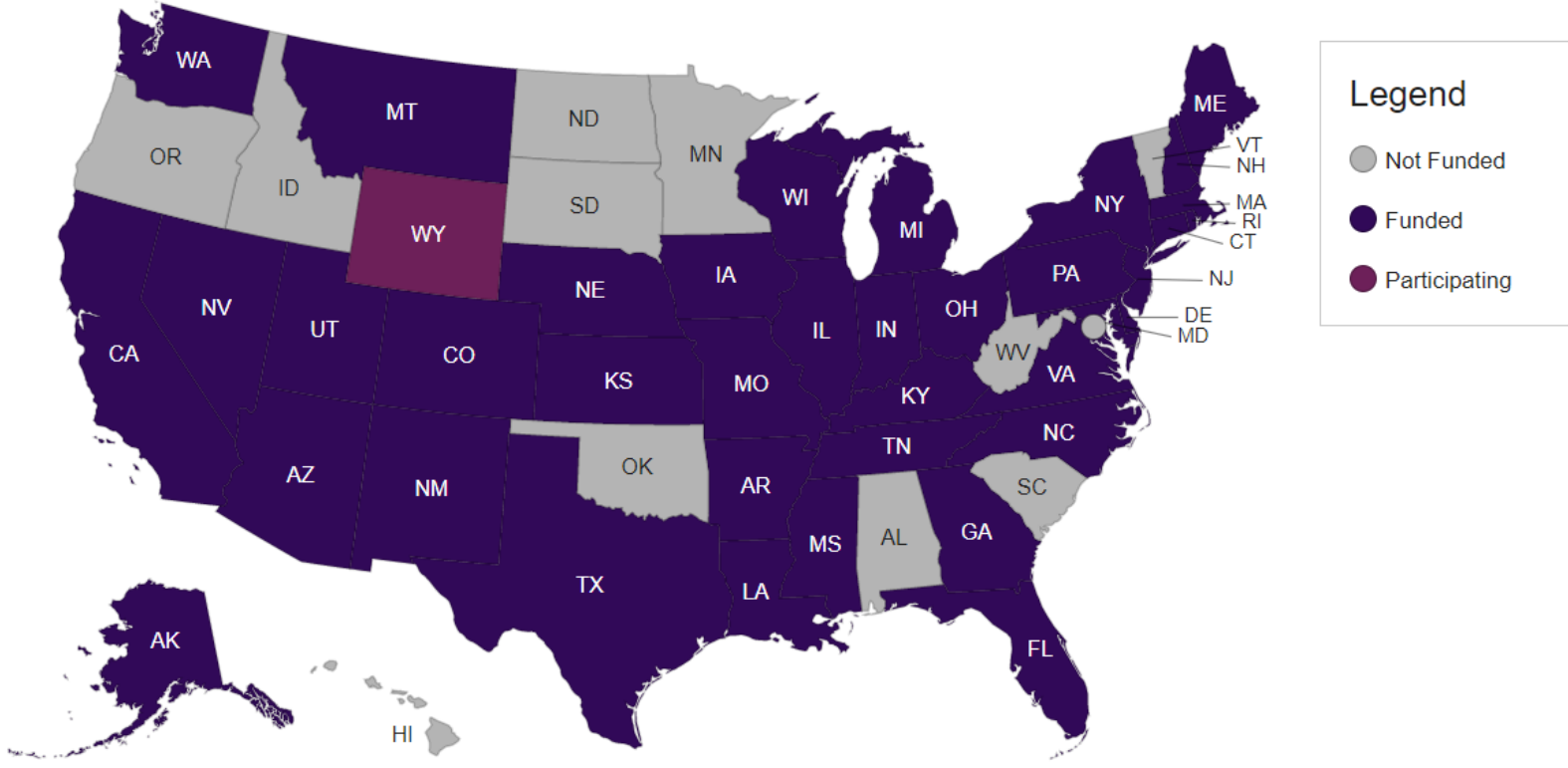
# Black and Indigenous People Disproportionately Impacted

## Pregnancy-Related Mortality Ratio by Race/Ethnicity: 2016-2018



# New Mexico: Engaged in the ERASE MM National Network

States and US Territories Funded Through ERASE MM



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[Enhancing Reviews and Surveillance to Eliminate Maternal Mortality \(ERASE MM\) | CDC](#)



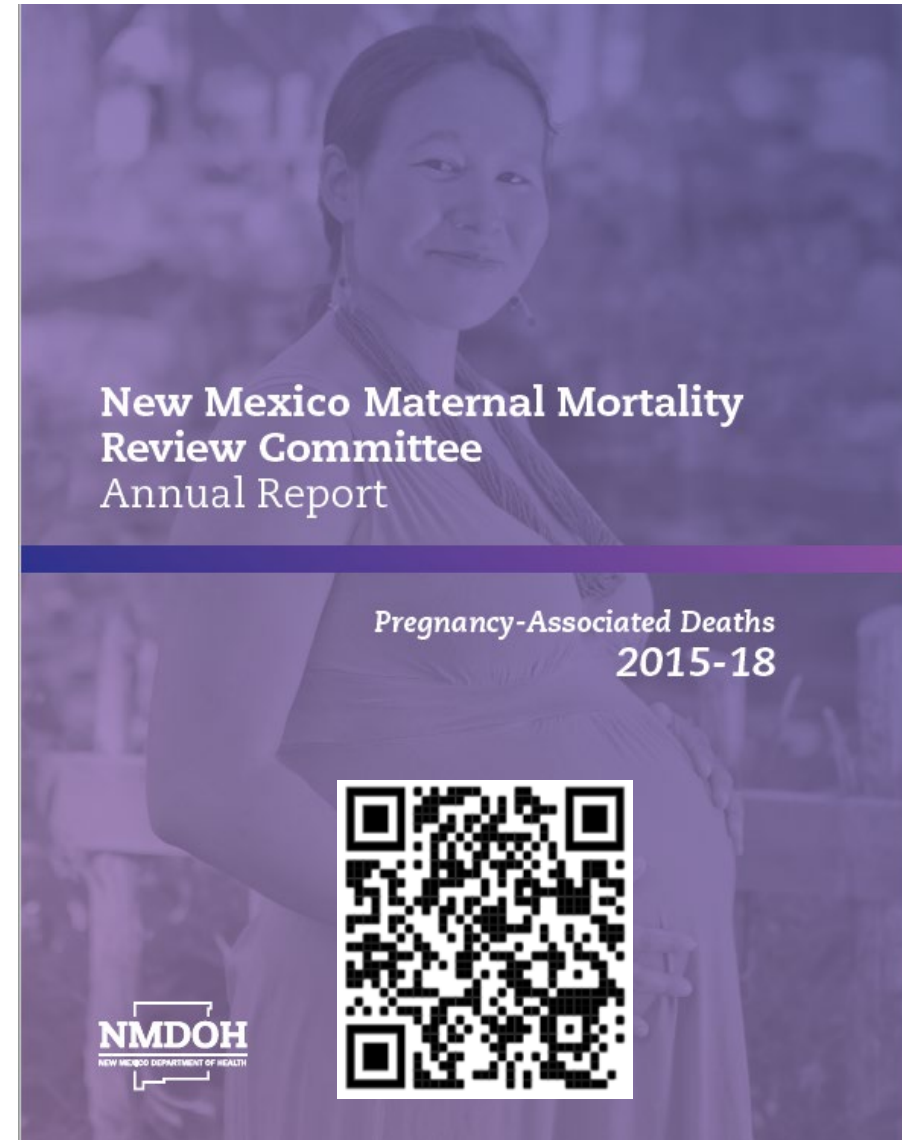
# Maternal Mortality Review Committees (MMRCs):

- Require diverse, multidisciplinary expertise to review each death occurring during pregnancy or within one year of a pregnancy to determine:
  - pregnancy relatedness (if death was related to pregnancy)
  - preventability
  - actionable recommendations to prevent future deaths
- 2018 New Mexico MMRC formed
- 2019 joined first ERASE MM cohort (5-year funding)
- 2021 Updated MMRC Statute

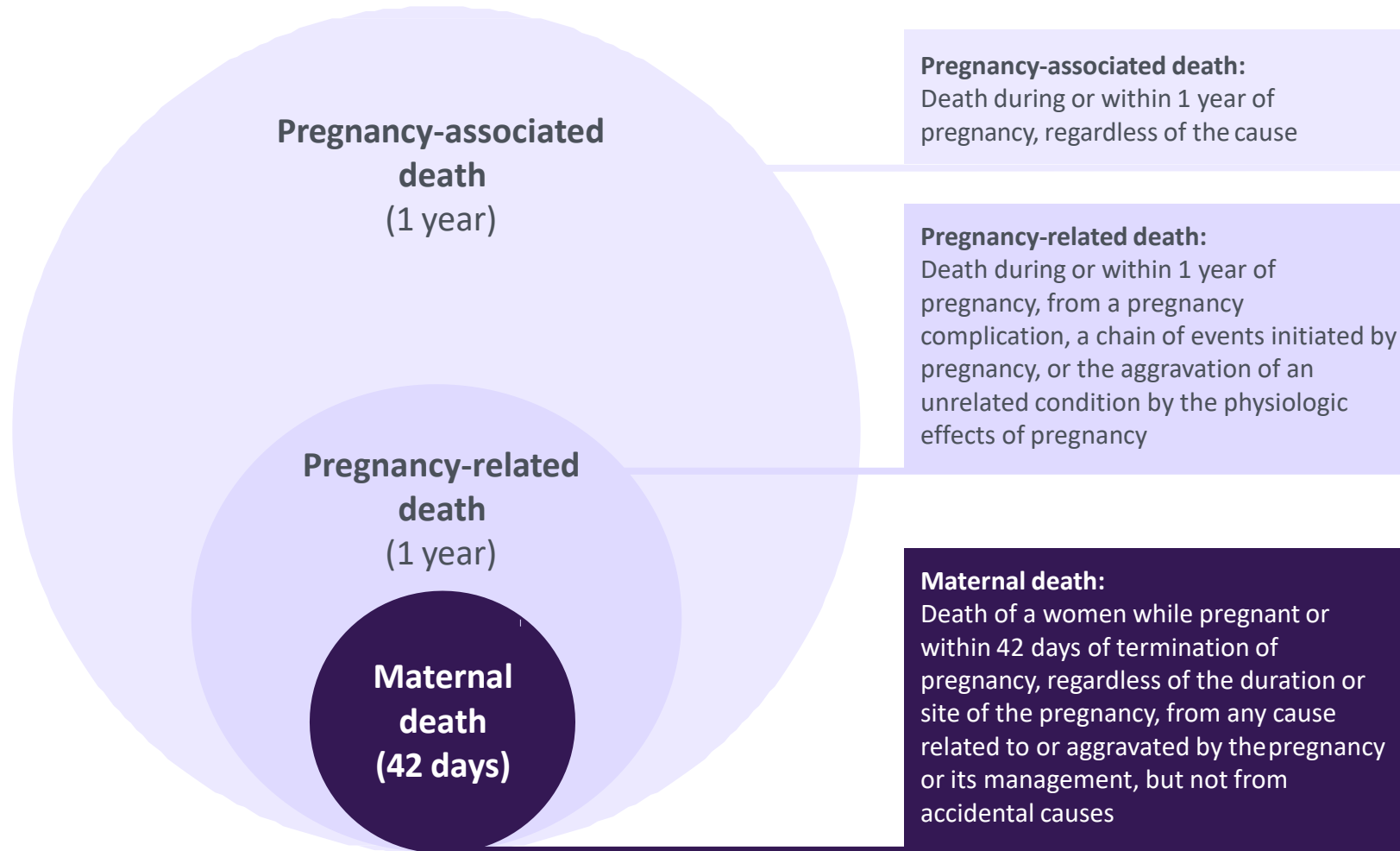


# The Report

- First of its kind for New Mexico
- Represents reviews of every pregnancy-associated death that occurred, 2015-2018
- Identifies committee generated recommendations to prevent mortality at the health systems, community, and policy levels
- <https://www.nmmaternalchildhealth.org/maternal-health>



# Definitions





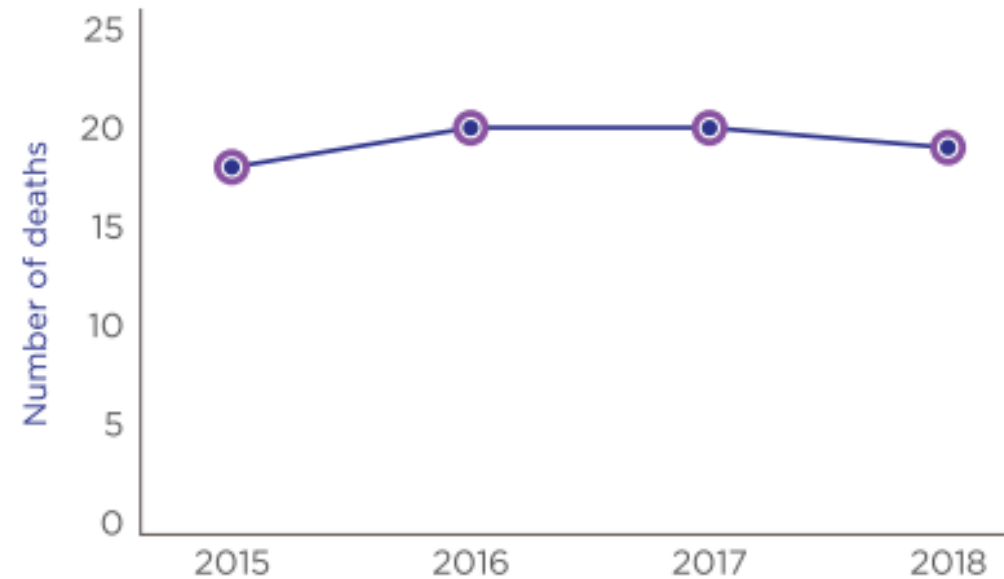
# Data Identification Sources

- Death Records
  - Birthing people (pregnancy box or those linked to birth/fetal record) ages 10-60 years and residents of NM with a death certificate, regardless of state where the death occurred; died during pregnancy or within one year
  - Office of the Medical Investigator and Hospitals may also report directly
- Birth/Fetal Death Records
  - **Two years** of birth and fetal death record data: calendar year of death and prior year
  - Captures births and fetal deaths occurring during the calendar year of death and the year prior to death

# Pregnancy-Associated Deaths in NM, 2015-2018

- 77 pregnancy-associated deaths
- Pregnancy-Associated Mortality Ratio (PAMR) – 79.5 per 100,000 live births

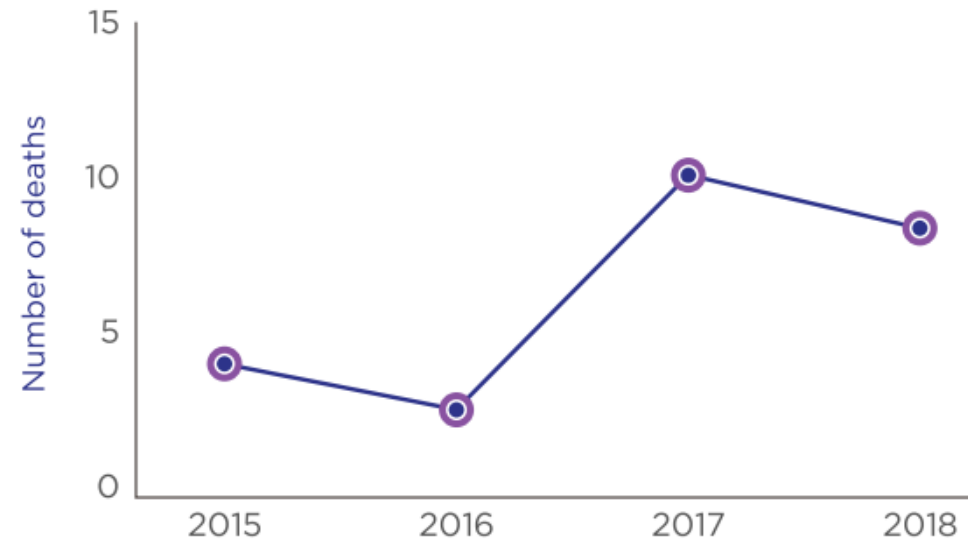
Counts of pregnancy-associated deaths by year



# Pregnancy-Related Deaths in NM, 2015-2018

- 25 pregnancy-related deaths
- Pregnancy-Related Mortality Ratio (PRMR) – 25.8 per 100,000 live births

Counts of pregnancy-associated deaths by year



# Disparity between NM Birth and Death Proportions

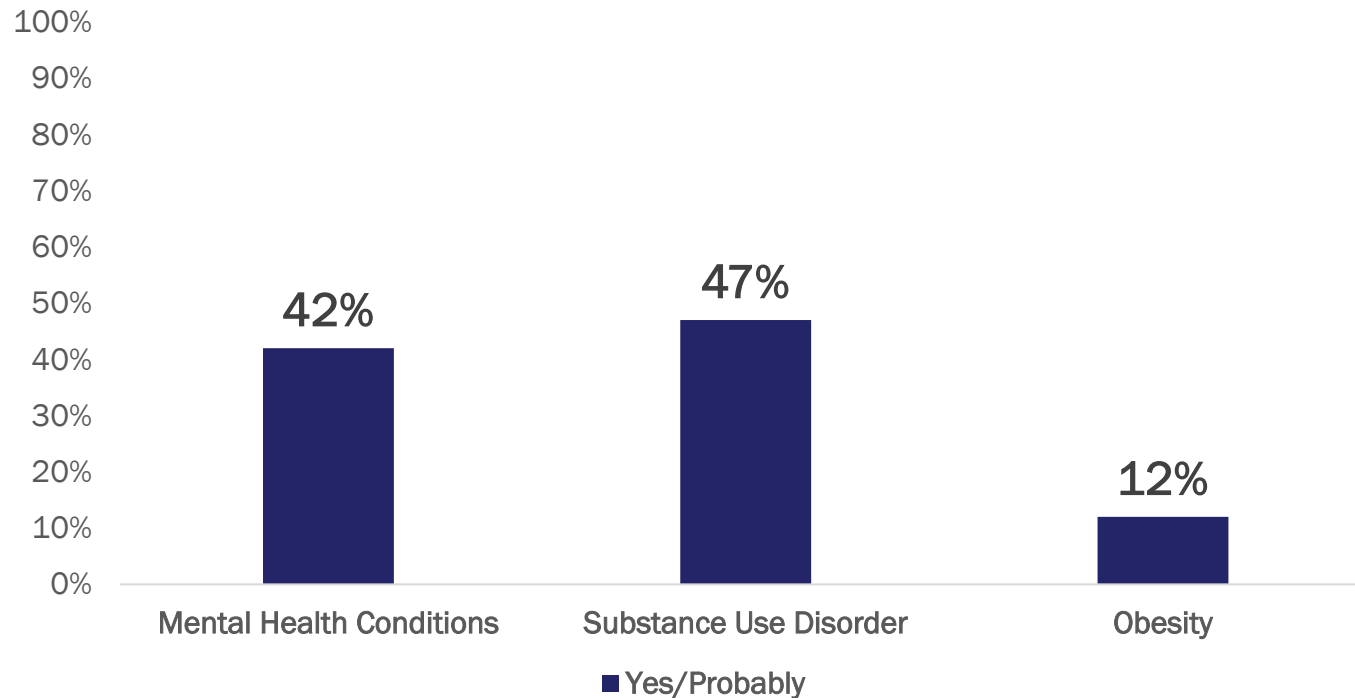
	2015-18 births		2015-18 Pregnancy-Associated Deaths	
	No.	%	No.	%
<b>Marital status</b>				
Married	46,947	48.0	20	26.0
Divorced/Never Married	49,924	51.5	57	74.0
TOTAL	96,871	100.00	77	100.0
<b>Maternal age (years)</b>				
15-19	7,920	8.2	7	9.1
20-29	54,423	56.2	37	48.1
30-34	22,002	22.7	17	22.1
35+	12,557	13.0	16	20.8
TOTAL	96,902	100.0	77	100.0
<b>Race/ethnicity</b>				
non-Hispanic White	27,049	28.0	27	35.1
Black/African-American	1,916	1.9	<3	2.6
AI/AN (Native American)	11,681	12.1	14	18.2
Hispanic/Latina	53,925	55.8	33	42.9
Asian/Pacific Islander	2,060	2.1	.	.
TOTAL	96,631	100.0	76	100.0

Highlighted values indicate concerning discordance between birth and death distributions

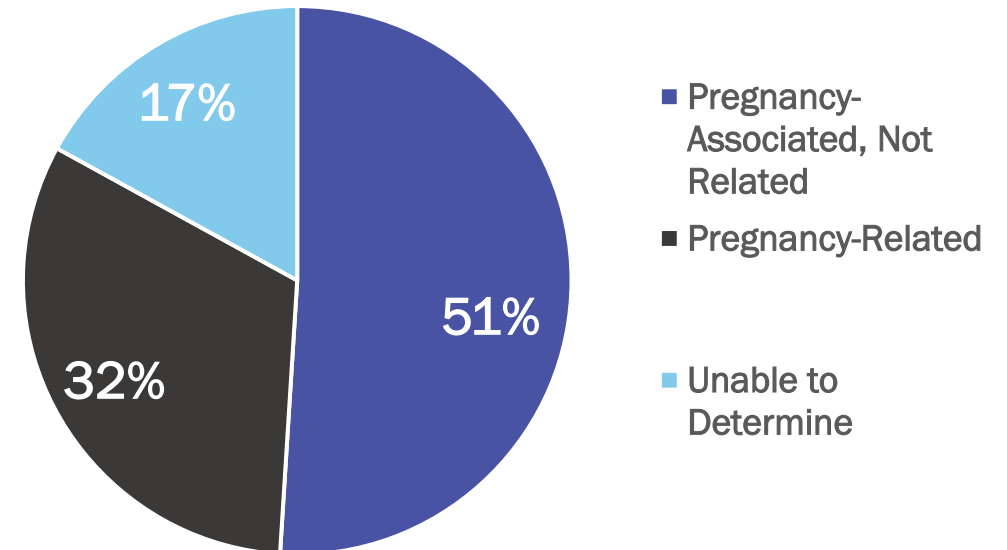
*Investing for tomorrow, delivering today.*

# Pregnancy relatedness and contributing factors in NM Pregnancy-Associated Deaths, 2015-2018 (n=77)

## Contributing Factors to Death

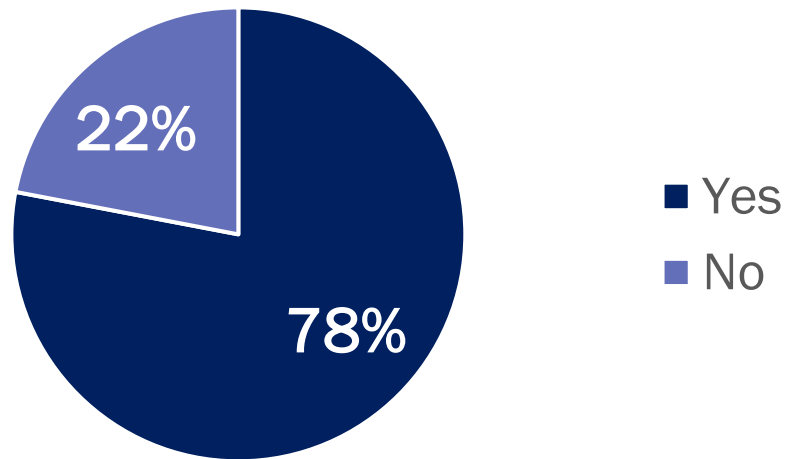


## Pregnancy-Relatedness

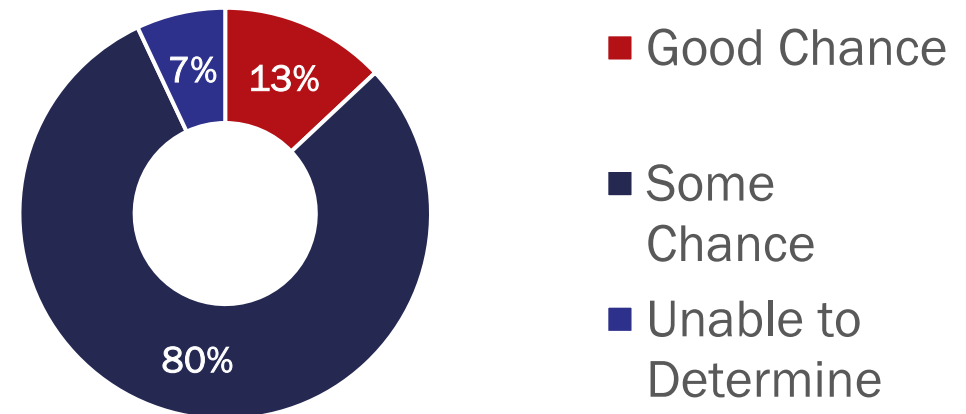


# Preventability of NM Pregnancy-Associated Deaths, 2015-2018 (n=77)

Was the death preventable?



What chance was there to alter outcome of Preventable Deaths?



# More than 2/3 of NM pregnancy-associated deaths occurred after pregnancy (n=77)

## TIMING OF MATERNAL DEATHS

Among NM pregnancy-associated deaths, 2015-2018:



**23%** occurred during pregnancy

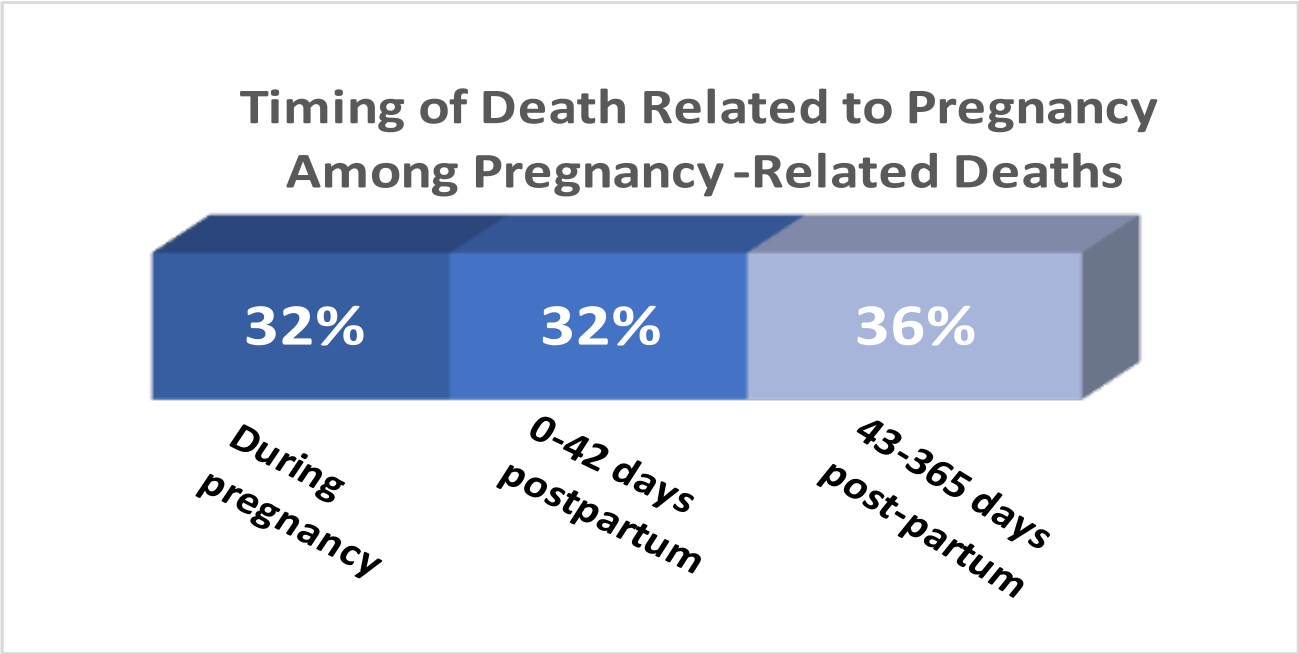


**16%** occurred 0-42 days postpartum



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

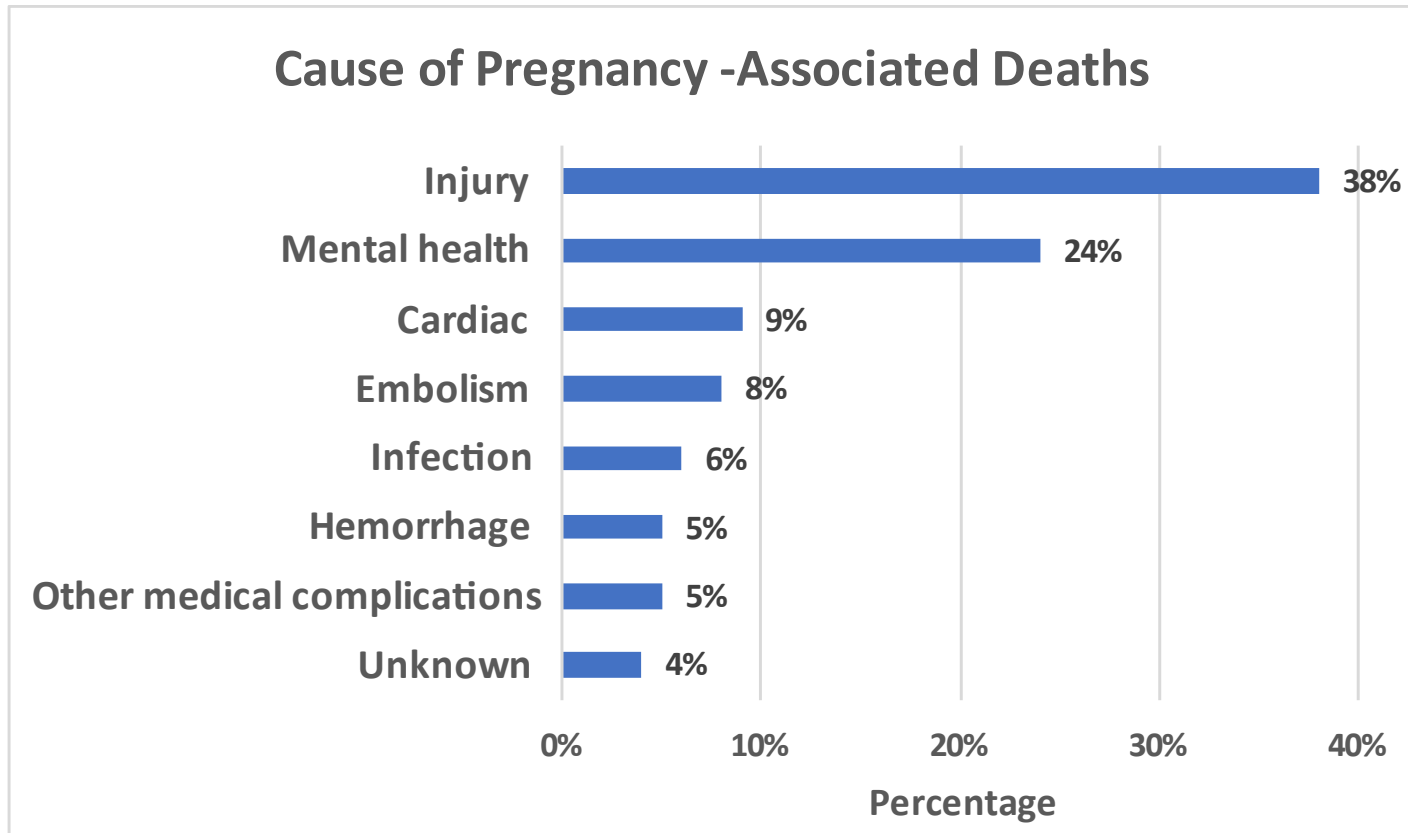
# Sixty-eight percent of NM pregnancy-related deaths occurred postpartum, 2015-2018 (n=25)



Timing was missing (n=2) or unknown (n=14) for 16 (1.6%) pregnancy-related deaths

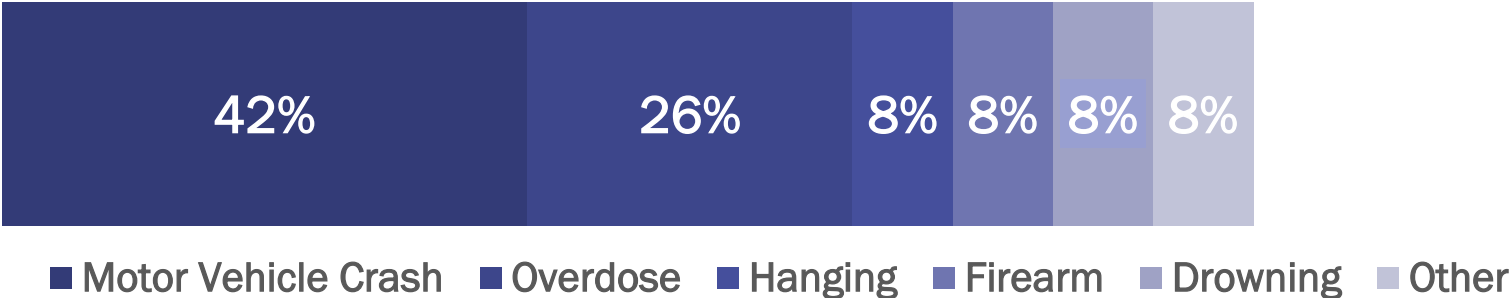


# Most Frequent Underlying Causes of NM Pregnancy-Associated Deaths, 2015-2018 (n=77)

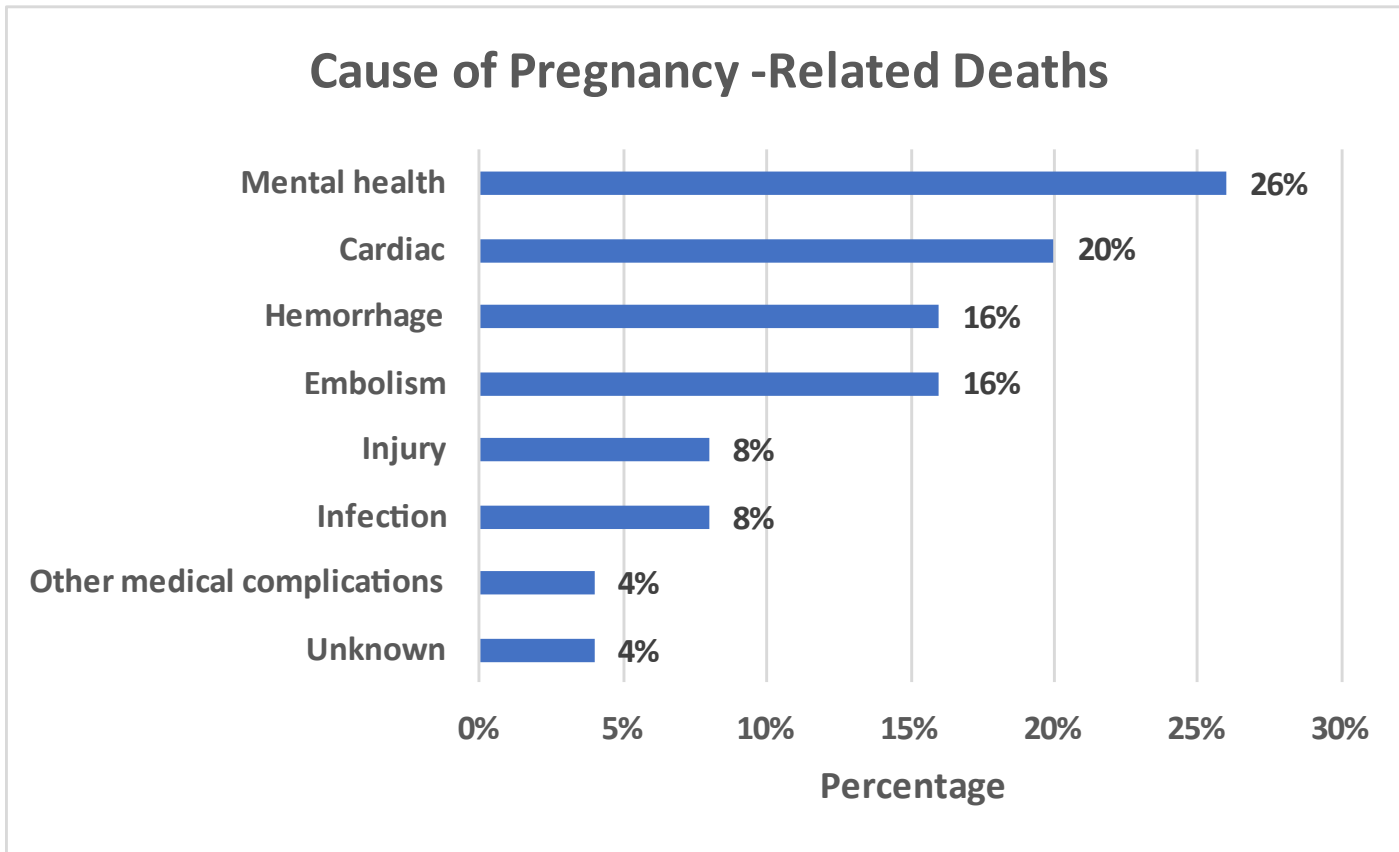


# Mechanism of Injury and mental health in pregnancy-associated deaths, NM 2015-2018 (n=77)

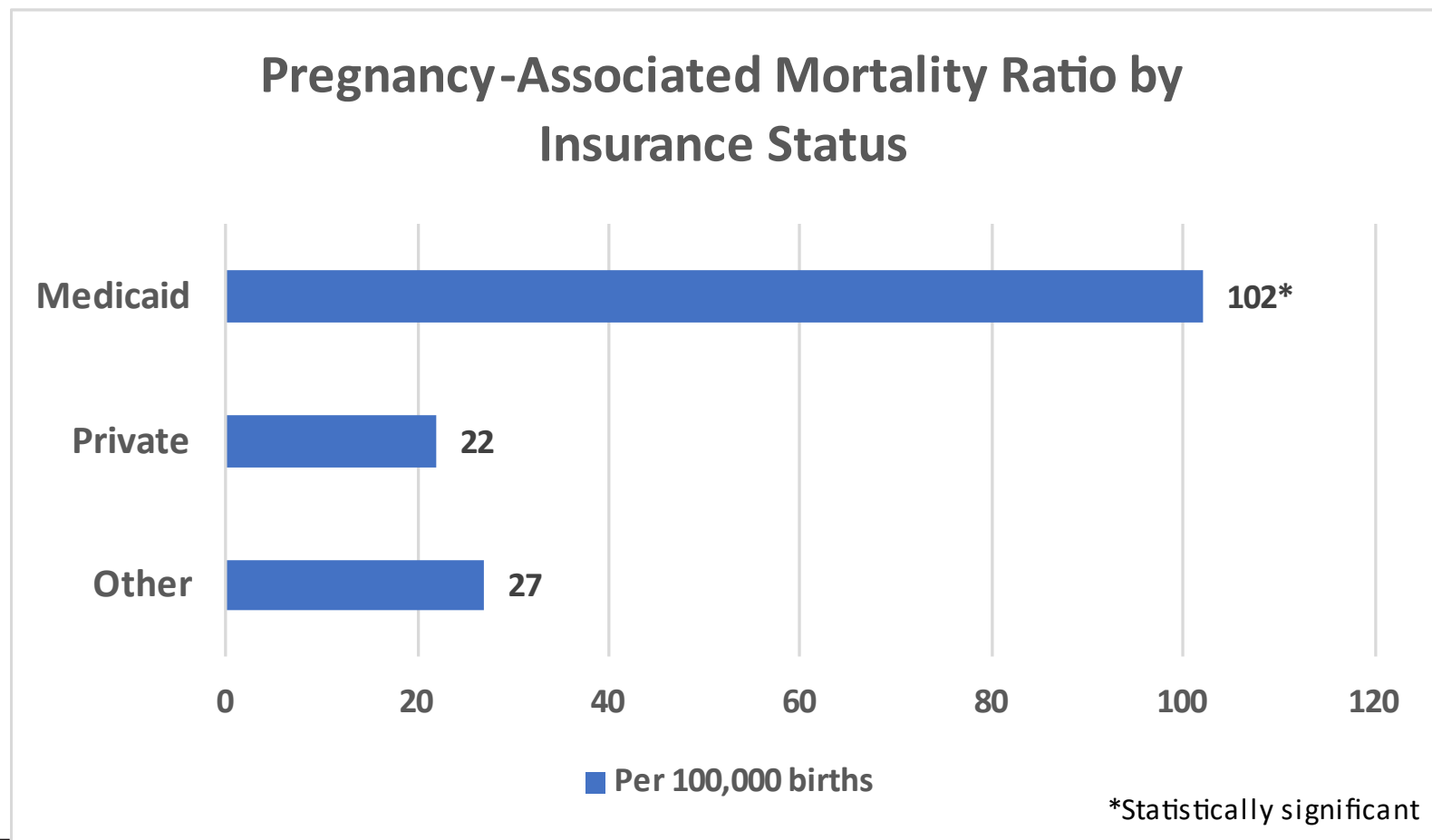
Mechanisms of injury for injury and mental health pregnancy-associated deaths



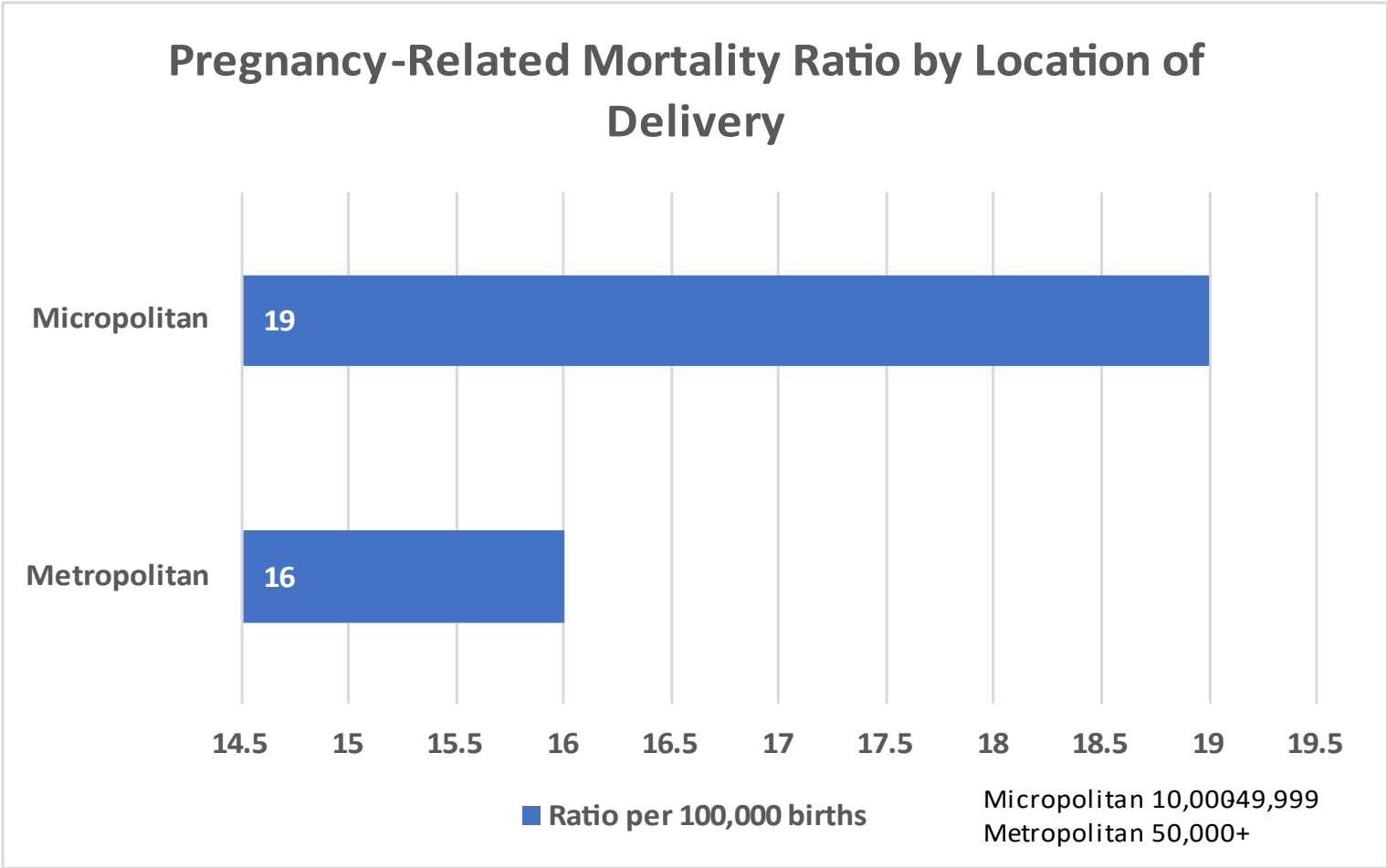
# Most Frequent Underlying Causes of NM Pregnancy-Related Deaths, 2015-2018 (n=25)



# Deaths per 100,000 live births (PAMR) by insurance status during pregnancy- NM 2015-2018 (n=77)



# Deaths per 100,000 live births (PRMR) by population density- NM 2015-2018 (n=25)



# Mental health conditions and substance use in NM pregnancy-associated deaths

*Substance use disorder (SUD) and mental health conditions were major contributors to pregnancy-associated death in New Mexico. The NM MMRC determined that **substance use was a contributing factor in nearly half of both pregnancy-associated and pregnancy-related deaths. Mental health conditions contributed to over one-third of pregnancy-associated (42%) and pregnancy-related (36%) deaths.***

*NM MMRC priority recommendations highlight the urgent need for policy and practice changes to address gaps in treatment capacity and coordination to save lives.*

# MMRC Priority Recommendations

1. Expand Medicaid eligibility for a full year postpartum
2. Increase access to perinatal mental health services
3. Increase access to Substance Use Disorder (SUD) treatment for pregnant and parenting people
4. Increase resources for care coordination among perinatal, mental health and SUD treatment providers
5. Incentivize hospitals and other perinatal care providers to engage in ongoing quality improvement
6. Increase resources and support for Intimate Partner Violence



# Accomplishments to Date

- Expansion and diversification of MMRC members and expertise
- Promulgation of Rule to accompany 2021 statute
- Establishment of formal collaboration with the Black & Indigenous Coalition and other partners
- Initiation of collaboration with HSD-Medicaid
- Release of inaugural report for baseline analysis and recommendations



# Next Steps

- Implement MMRC governance structure outlined in NMAC
- Establish a clear mechanism to track implementation of prevention initiatives and progress
- Staff roles to enhance MMRC capacity related to informant interviews and abstracting
- Continue to onboard new members to fill vacancies and maintain diverse expertise
- Continue to develop collaboration with NM Medicaid and community-based thought leaders and service providers to prevent future deaths

# Questions?

Abigail Reese, PhD, CNM

Please note my new email address:

[Abigail.reese@doh.nm.gov](mailto:Abigail.reese@doh.nm.gov)

Maternal Health Program Manager

*she/her/hers*



*Accredited since 2015*

Family Health Bureau / Public Health Division

2040 S. Pacheco St.

Santa Fe, NM, 87505

ph:(505) 476-8866

cell: (505) 231-6817

fax:(505) 476-8898

[www.nmhealth.org](http://www.nmhealth.org)



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