NC Department of Health and Human Services

# NC Maternal Mortality Review Committee

Sarah R. Conte, DNP, MSN, RN
Maternal Health Nurse Consultant
NCMMR Coordinator/Lead Abstractor

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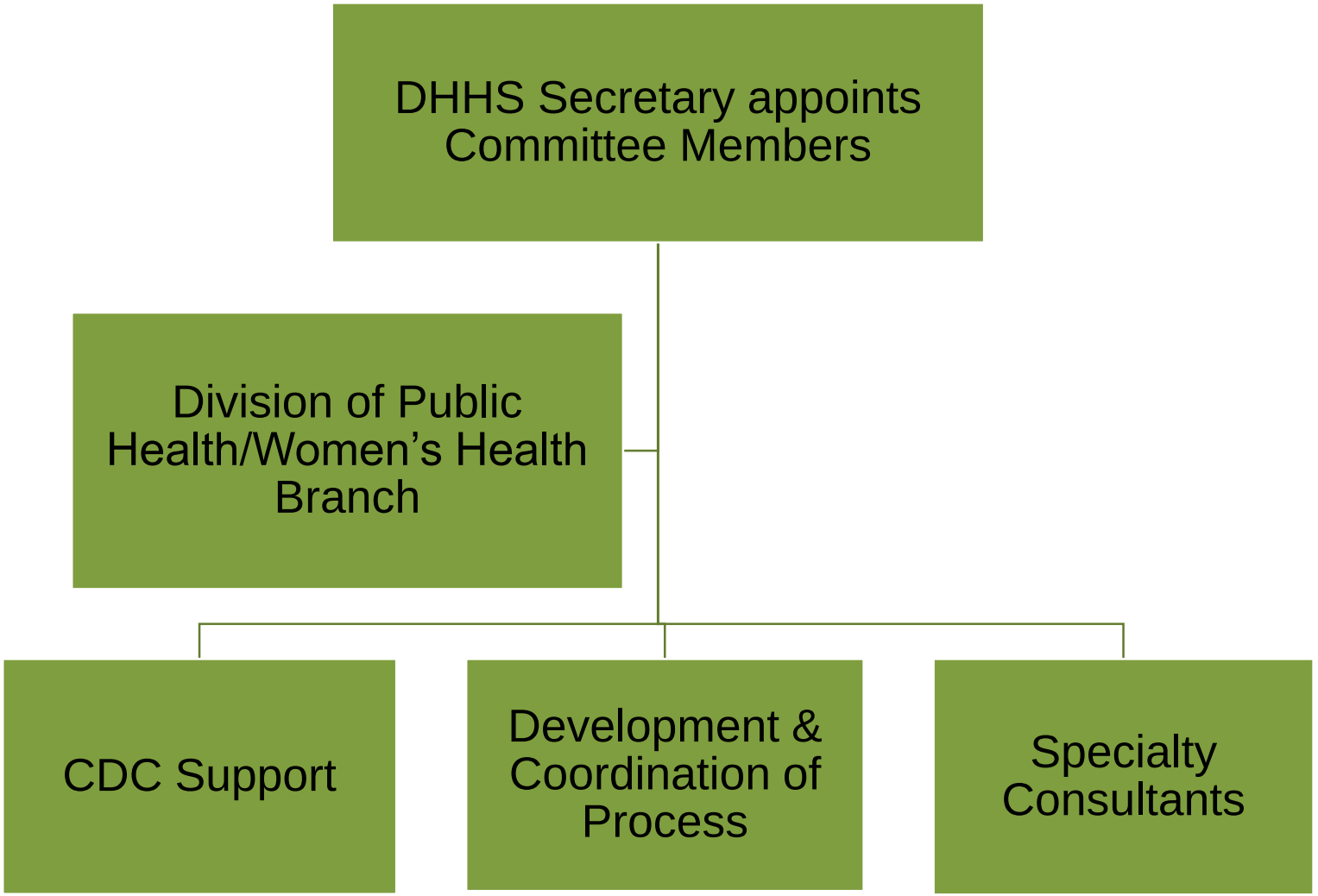
# §130A-33.52. The Maternal Mortality Review Committee; membership, compensation.

- Legislation passed 12/2015

- The Maternal Mortality Review Committee was established in the Department. The purpose of the committee is to reduce maternal mortality in this State by conducting multidisciplinary maternal death reviews and developing recommendations for the prevention of future maternal deaths.

# Overview of Development



## Committee Membership Composition (9)

- Representing Perinatal Care Regions I - VI
  - Forensic Pathology
  - Maternal Fetal Medicine/Academician (3)
  - Nurse Midwifery
  - Perinatal Nursing
  - Social Work
  - Vacancies (2)

## Specialty Consultants

- Representing Perinatal Care Regions I - VI
  - Cardiology
  - Family Medicine (providing Obstetrical Care/Delivery)
  - Injury Prevention
  - Neurology
  - Pharmacy
  - Psychiatry
  - Women's Anesthesiology

## Milestones

- Development of forms/processes
- Coordination of Information Technology (IT)
  - CDC & NC DHHS
- Statewide outreach
  - Healthcare systems, private obstetrical providers, public healthcare entities, Community Care of NC (CCNC), law enforcement agencies, emergency medical services, pharmacies
- Data entry into CDC's Maternal Mortality Review Information Application (MMRIA)
- Continued development of committee's process/focus through recommendations from CDC and literature

# Process Cycle

SCHS - Case ascertainment

WHB – Nurse Coordinator/Lead Abstractor; State LCSW; Committee Chair screening of categorized cases

Data entry into MMRIA

Sub-Committee briefing of cases

Full abstraction of cases determined by Sub-Committees to be brought forth for full committee review

# Case Ascertainment of Pregnancy-Associated Cases from SCHS

- **Step I**
- **Sources and criteria for identifying possible cases**
  - Death Certificate Cause(s) of Death
  - Hospital Discharge ICD 10CM Coding
  - Death Certificate Pregnancy Check Box
  - Vital Statistics Linkage (death and birth records)
  - Healthcare system discharge or emergency department records

# Case Ascertainment of Pregnancy-Associated Cases from SCHS (continued)

- **Step II**
- **Confirmatory sources of pregnancy at time of death**
  - Obituaries
  - Social Media
  - Media/News Reports
  - Medical Examiner Confirmation – NEW to 2016 data (confirmation of pregnancy within a year of death is forwarded to the Committee)

# Case Categorization

## ➢ 2016

- Categories of death
  - Strong likelihood of pregnancy-related
  - Possible likelihood of pregnancy-related
  - Homicide
  - Suicide
  - Motor Vehicle Accident
  - Accidental Drug Overdose
  - Pregnancy Check Box Only
  - Medically unrelated to pregnancy
  - Did not meet criteria of inclusion

# Case Categorization (continued)

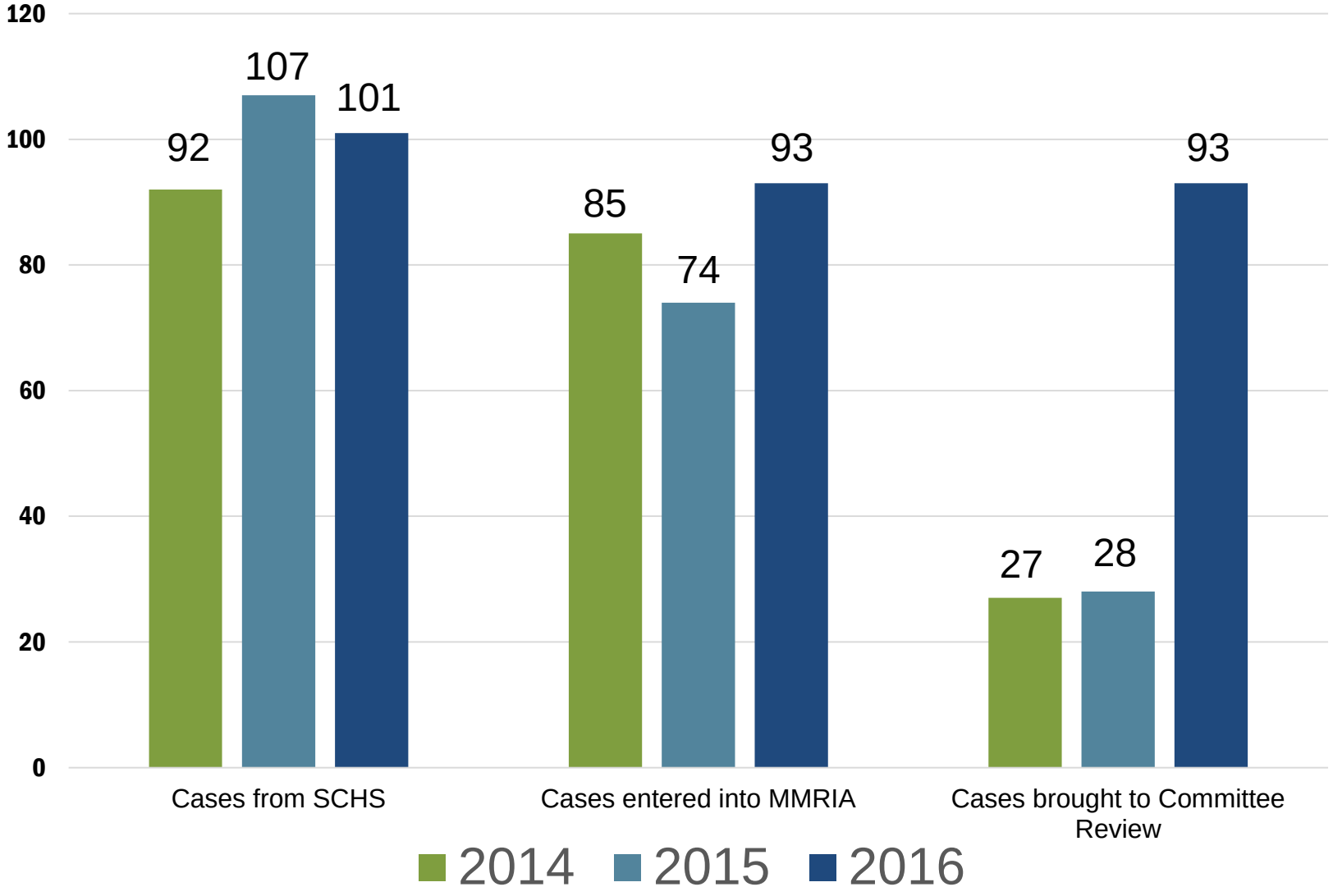
- **2017**
  - No change in case categorization

- ***2018** NEW CDC recommendations
  - Continued use of categories, but further categorized by
    - Pregnant at the time of death; Not pregnant, but pregnant within 42 days of death
    - Not pregnant, but pregnant 43 days to 1 year before death

# Case Screening

- **2016 - 2017**
  - **2014 Data**
  - Case screening conducted by Dr. Margaret A. Harper, Sentinel Researcher/Committee Chair & Nurse Coordinator/Lead Abstractor
- **2017 - 2018**
  - **2015 Data**
  - Case screening conducted by Nurse Coordinator/Lead Abstractor
  - Physician Committee member(s)
- **2018 - 2019**
  - **2016 Data**
  - Case screening conducted by Nurse Coordinator/Lead Abstractor, State LCSW, Committee Chair, Sub-Committee(s)

# Cases Reviewed



# Questions