STATE OF NEW YORK
DEPARTMENT OF HEALTH

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
1951
WOMEN'S HEALTH CARE PHYSICIANS

Safe Motherhood

Addressing The Crisis in New York State

October 5, 2005

ACOG District II / NY

Learning Objectives

- Review the history of the NYS SMI
- Present a summary of 2004 Maternal Deaths
- Discuss Obstetric – System Recommendations
- Explore some of the Issues

Fundamental Premise of SMI:

An Event As Tragic As
A Maternal Death …

Must **Result in**
Improved Patient Care
and
Professional Enlightenment !!

ACOG/CDC Definitions

Pregnancy-Associated Death

The death of a women **while pregnant** or **within one year of termination of pregnancy**, irrespective of cause.

Pregnancy-Related Death

…irrespective of the duration and site of the pregnancy, from any cause **related to or aggravated by her pregnancy** or its management, but **not from accidental or incidental causes.**

Not-Pregnancy-Related Death

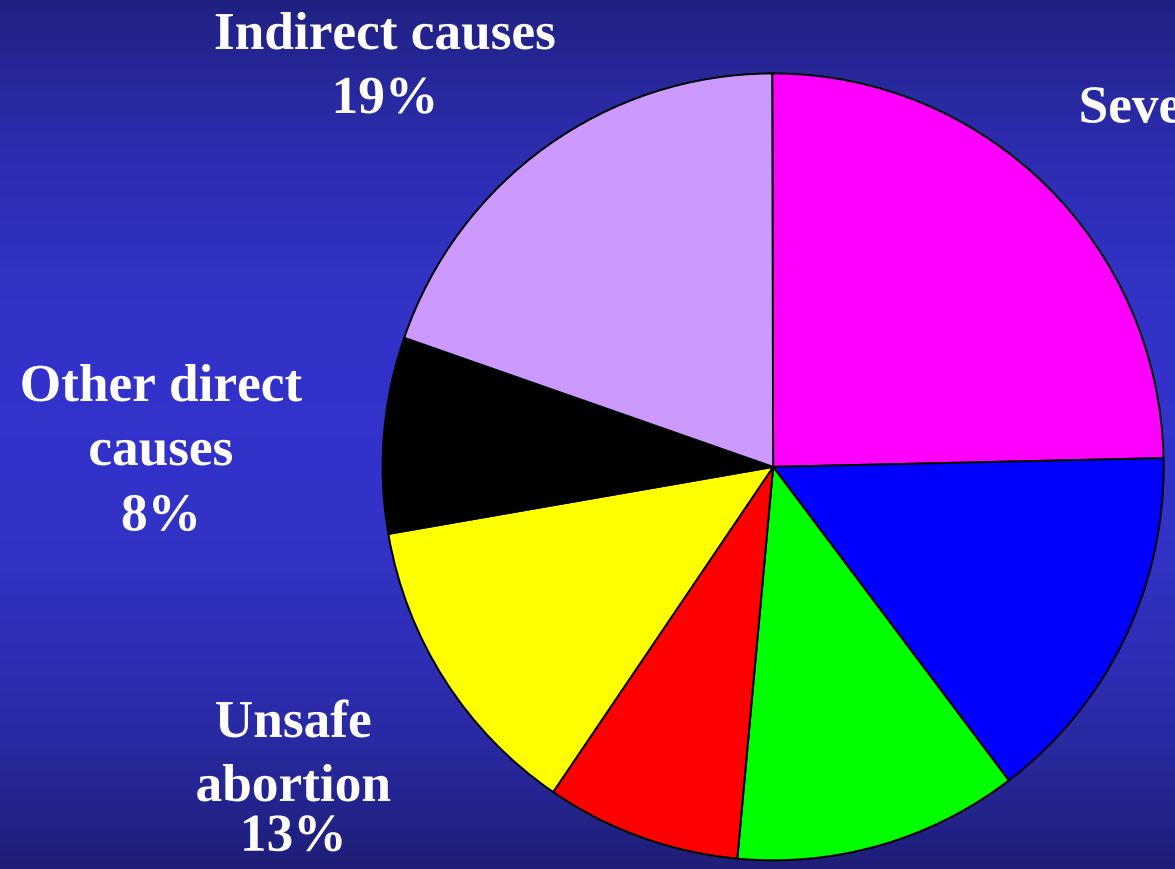
…due to a cause **unrelated to pregnancy**.

Source: Berg, Atrash, Zane, Barlett. Strategies to reduce pregnancy-related deaths: From identification and review to action. Atlanta: Center for Disease Control and Prevention 2001.

Sobering Statistics

- UNICEF estimates > 600,000 deaths/year
- Quality indicator of Maternal-Child Health
- United States data
  - 99% reduction in risk of death
    - In-hospital birth
    - Blood banking
    - Antibiotics

Worldwide Causes of Maternal Deaths



World Health Report 2005

Loss of Pregnant Women's Lives

4 Loaded 747s Every Day !!

United Kingdom

Confidential Enquiries

www.cemach.org.uk

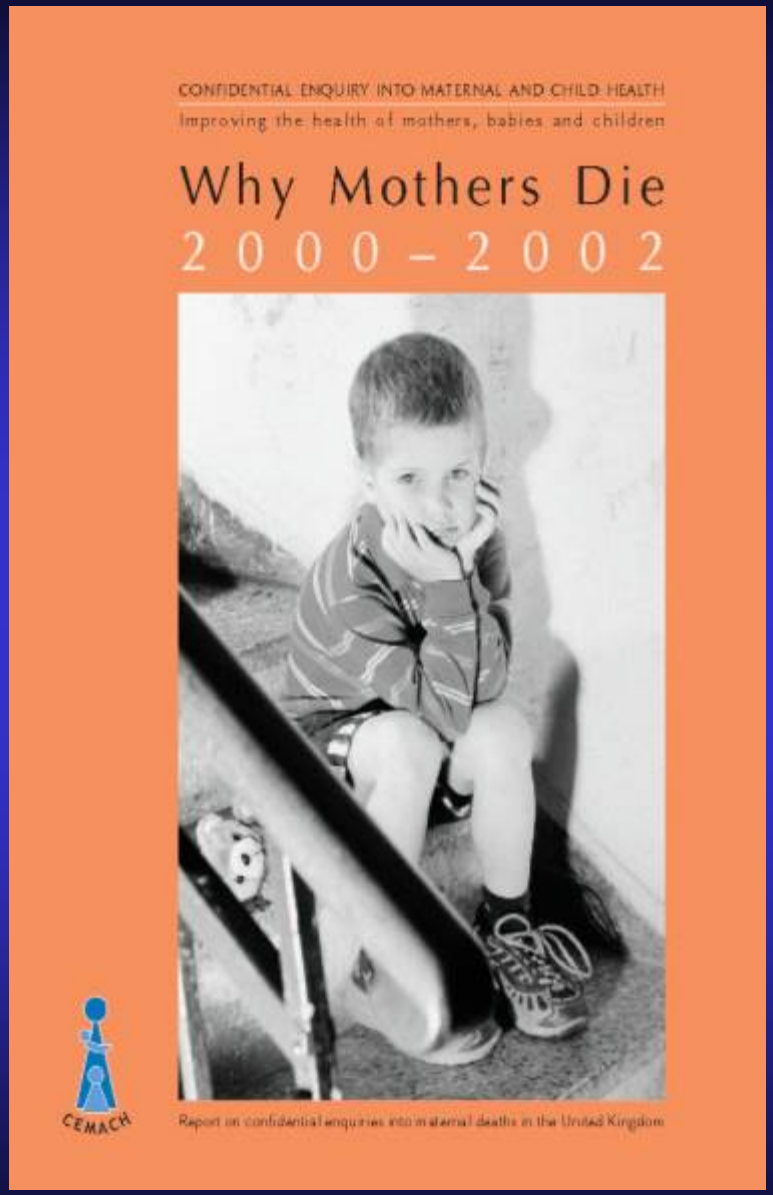
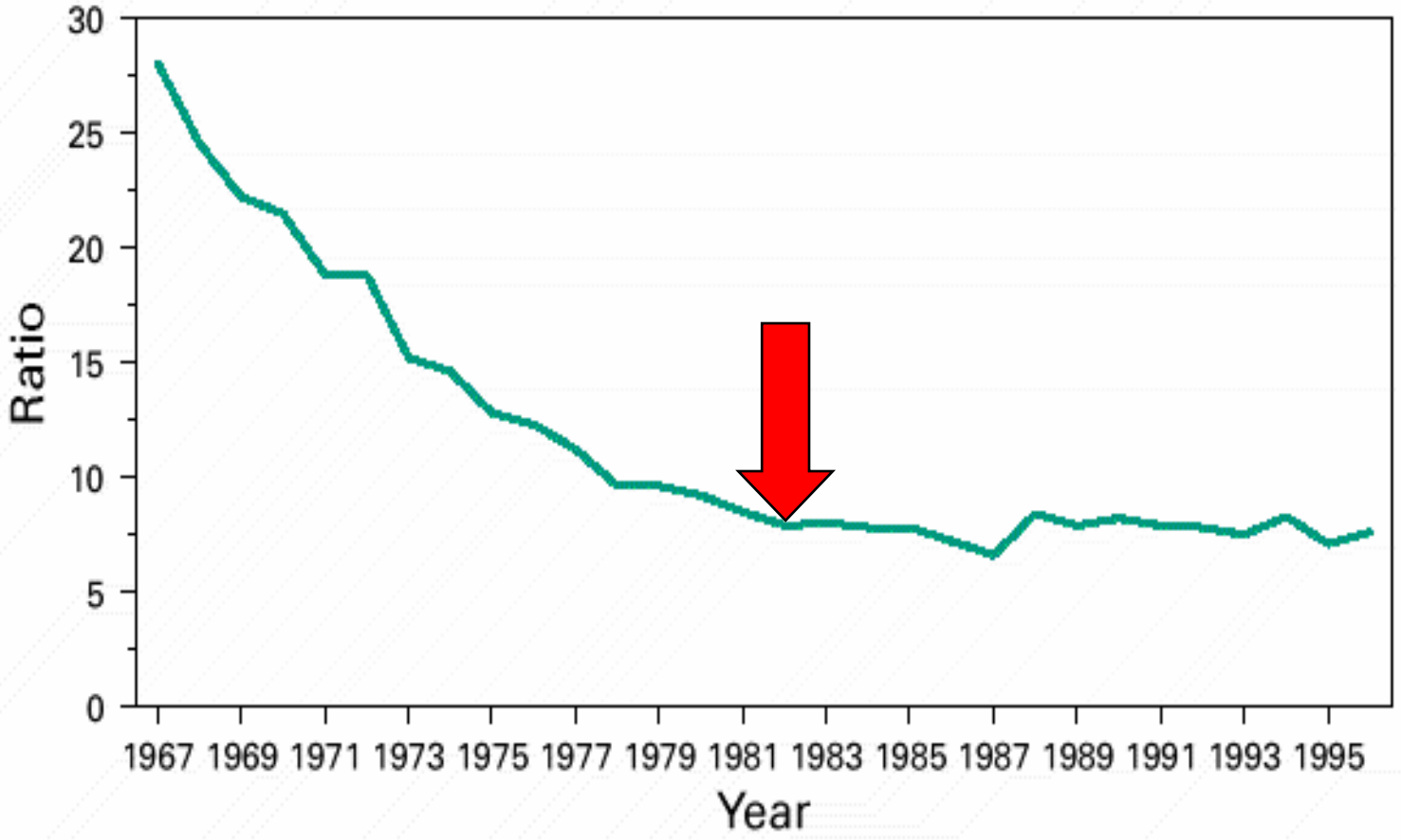
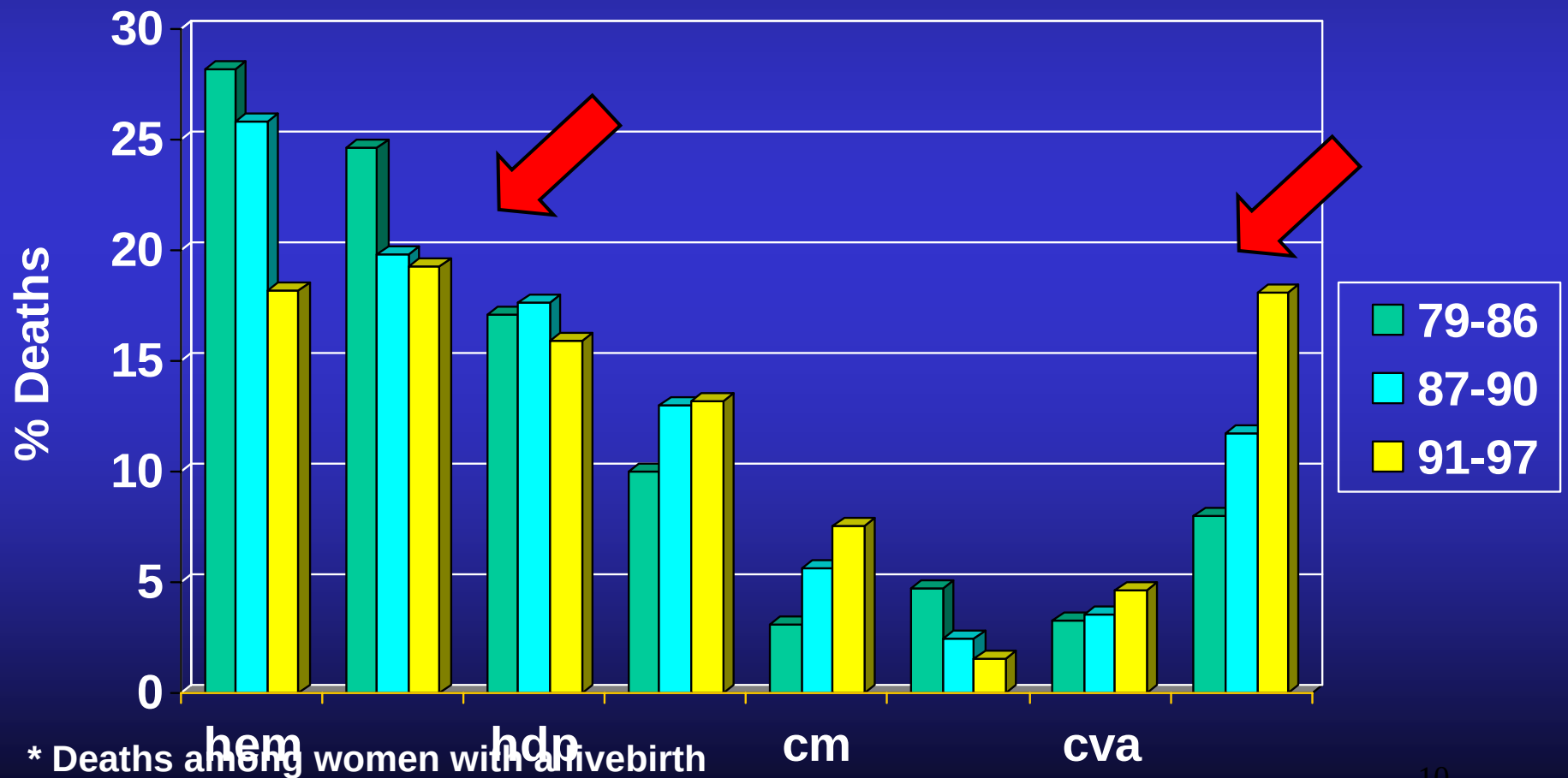


FIGURE 1. Maternal mortality ratio*, by year — United States, 1967–1996



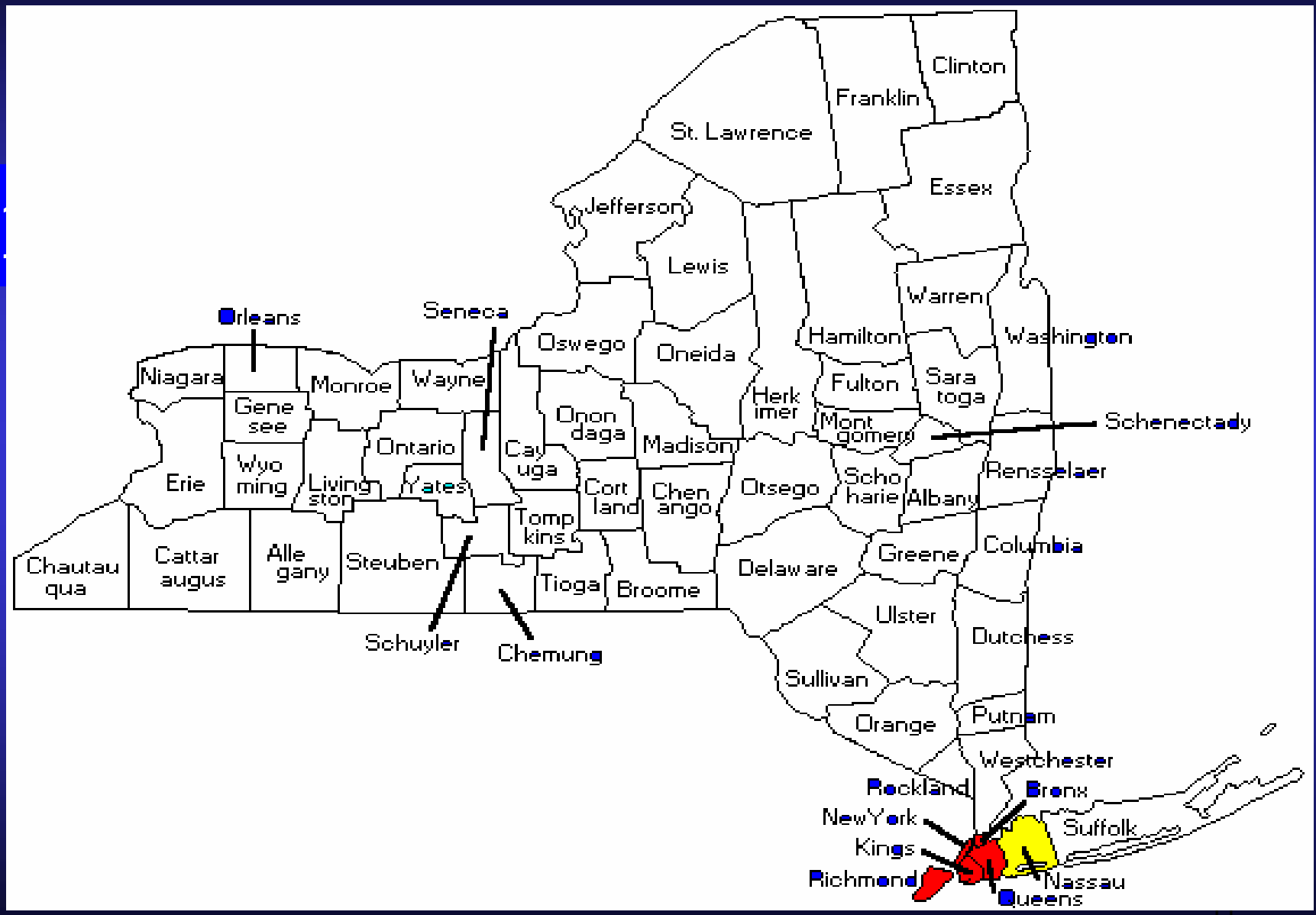
*Number of maternal deaths per 100,000 live births The term "ratio" is used instead of rate because the numerator includes some maternal deaths that were not related to live births and thus were not included in the denominator.

US Trends in Cause of Pregnancy-Related Death* by Year

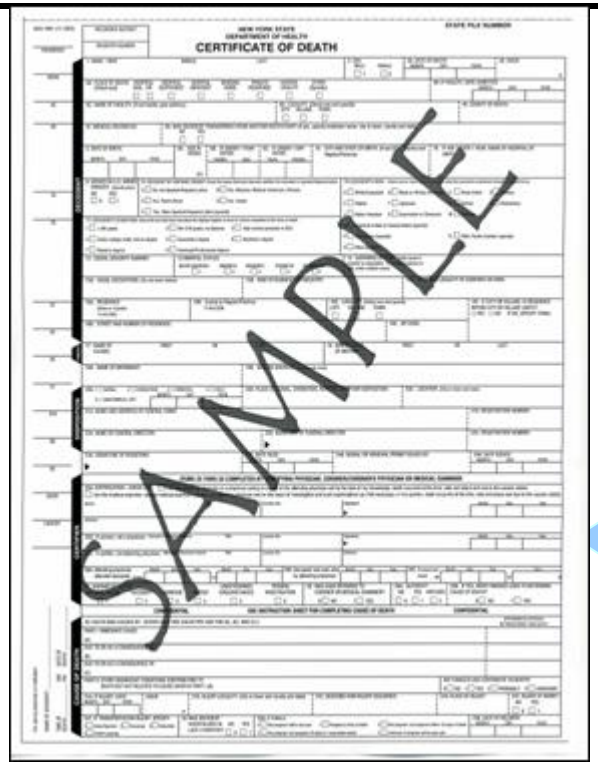


* Deaths among women with alivebirth

A Regional Look at Maternal



33A If Female:	**33B**. Date of Delivery
☐ Not Pregnant within last year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within past year	Month Day Year _____/_____/_____



Boxes 33A & 33B are on the **bottom of the death certificate**

Approximately one-half of all maternal deaths are considered to be preventable!!

CDC Opinion

The Initiative is…

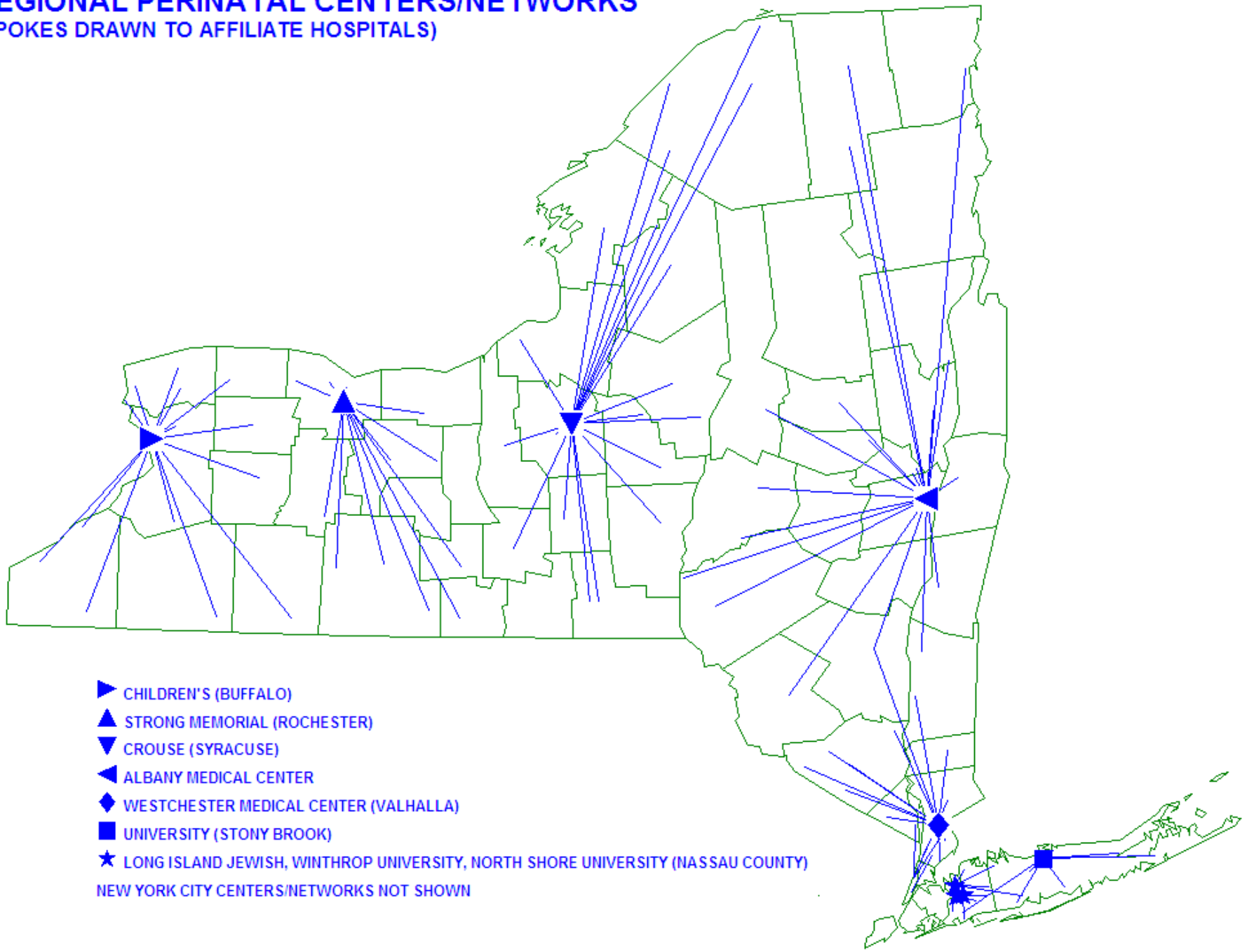
New York's response to prevent maternal deaths & reduce racial disparities.

Project Design

- Patterned after the Confidential Enquiry
- Developed with NYS/District II
- Funded by NY State Health Department
- Protected by Public Health Law 206 (1)(j)
- ACOG Partners with RPCs – Expected to Perform Quality
- On-site death review teams

REGIONAL PERINATAL CENTERS/NETWORKS

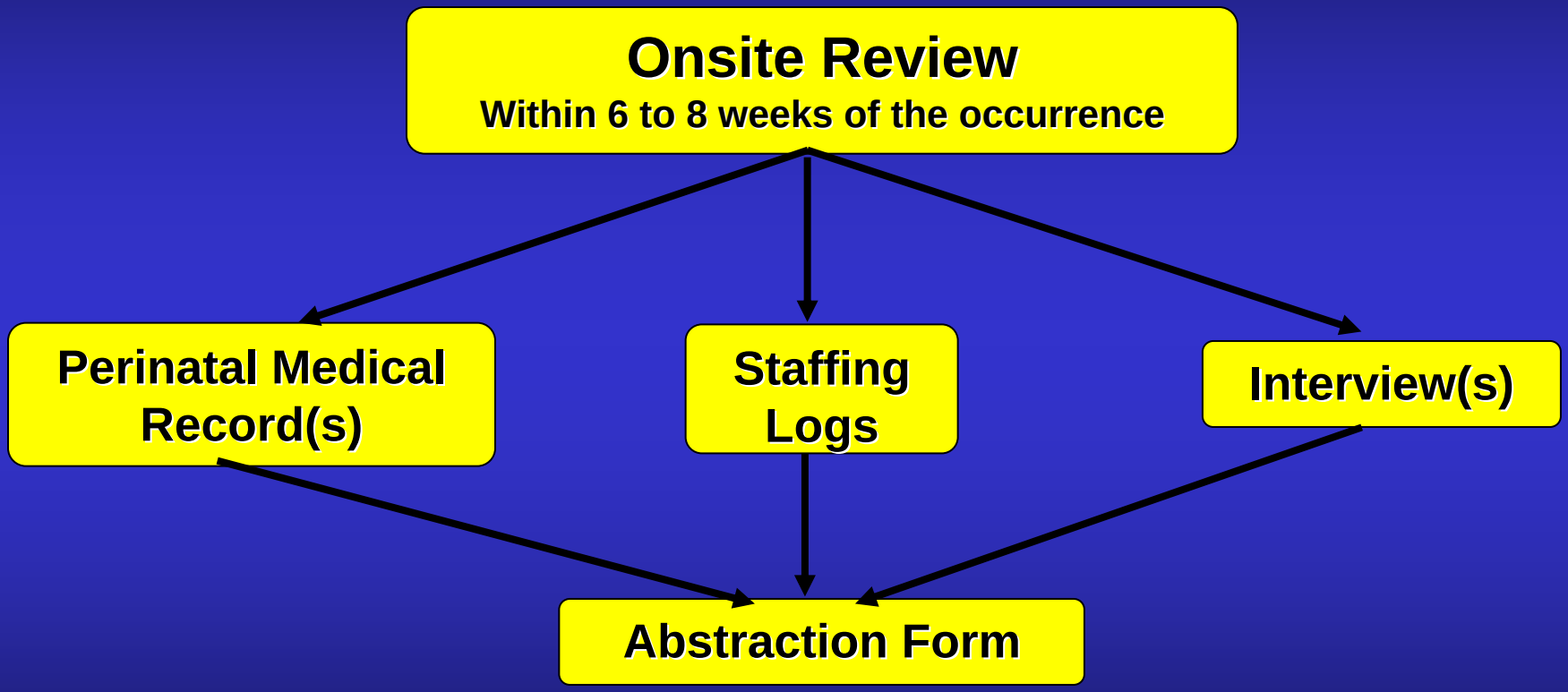
(SPOKES DRAWN TO AFFILIATE HOSPITALS)



Public Health Law § 206(1)(j)

Authorizes the Commissioner of the NYSDOH to conduct "medical audits which have as their purpose the reduction of morbidity and mortality"

Maternal Death Protocol



Recommendations

Question	Coding Instructions
90.Written recommendations for improvement of care in the areas reviewed. *(e.g., system modifications, revision of protocol(s), staffing modifications, policy change(s) etc.*	None

Safe Motherhood Initiative

Cumulative Project Totals: August 2003 – June 2005

Total Number of Maternal Deaths Reported to the SMI 37

12 cases were reviewed by an external review organization of the NYC Health and Hospitals Corporation

Total Number of On-site Reviews by SMI 21

4 deaths did not meet criteria for review

Aggregate Data*

21 Deaths Reviewed by SMI

- 85% occurred downstate
- 76% occurred in minority women
- 70% were under 35 years of age
- 70% had c-section deliveries
- 64% occurred within 1 week of delivery

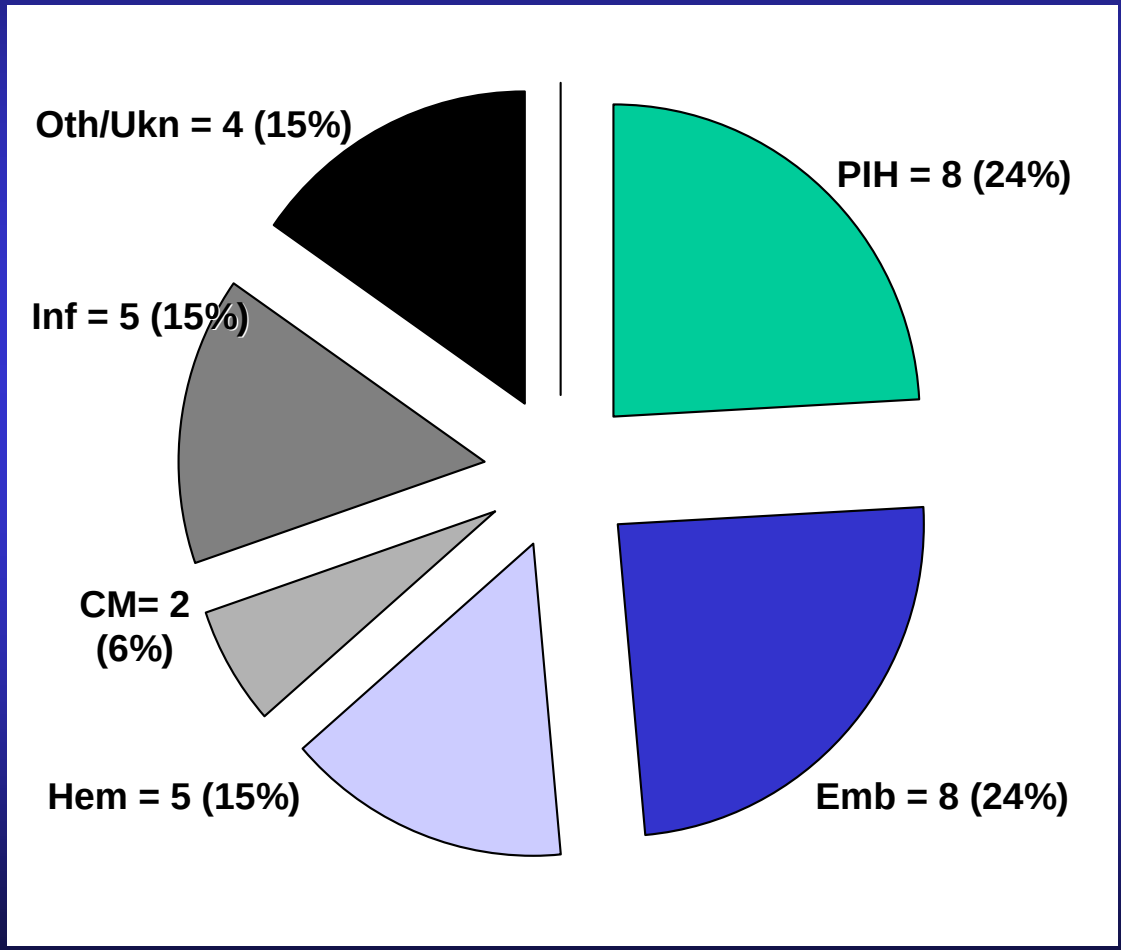
*8/03 – 6/05

SMI – Review of 2004 Data

51 cases identified

- 25 notifications to the SMI
  12 identified by HHC Internal Audit
- 26 hospital discharge notifications

2004 Data



Aggregate Data*

- Obesity
  - BMI mean = 31.1 (range 19.5 – 53)
- Mode of delivery
  - Cesarean Section = 23
    - Primary = 11
    - Repeat = 12
  - Vaginal = 7
  - TOP = 1
  - Undelivered = 2

*8/03 – 6/05

Aggregate Data*

- English as primary language
  - Yes 15 (46%)
  - No 9 (27%)
  - Unknown 9 (27%)
- Race
  - African-American 10 (30%)
  - Caucasian 8 (24%)
  - Other 9 (27%)
  - Unknown 6 (18%)

* 8/03 – 6/05

Issues - Medical

- ICU Management
- Care Coordination
  - Vacation, Midwives, etc.
- Blood product availability
- Staffing
  - Medical and Nursing
- Training and Experience
- MFM & other coverage
- Recovery Room Protocols
- Anesthesia evals in L&D
- Magnesium management
- Consultation issues
  - Routine vs. Requested
  - Timely vs. Available
- Emergency Drills
- ACLS experience
- Timely transfer

Issues - Systems

- Scribe for emergencies
- Charting
  - Availability
  - Legibility
- Laboratory procedures
  - Failure to notify
  - Repeat testing requirement
- Availability of diagnostic studies
- Equipment
  - SpO_2
  - Cell-Saver
  - Surgical instruments
  - Crash Cart
- EMS and ED Triage

Issues – Support Services

- Grief Management
- Translation Services 24/7
- “Early Attending Involvement”
- Transporter Issues

Issues Identified

- Medical Care – recognition and transfer
- Blood bank – Policy and Procedures
- EMS protocols & ED process
- Availability of Diagnostic studies
- Translation Services
- Consulting issues – willingness and adequacy
- Grief Counseling for Family and Staff

What Do We Suggest ??

- Review your institutional Policy and Procedures
- Consider Prevention Strategies
- Establish Emergency Drills
- Confront Cultural Competency
- Admit Your Limitations

Remember:

It’s The Patient That Really Matters!!!

For more information contact

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THANK YOU

FOR ALLOWING

US TO SHARE THIS

WITH YOU TODAY