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 woman 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.

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

- Severe bleeding: 25%
- Sepsis: 15%
- Eclampsia: 12%
- Obstructed labor: 8%
- Unsafe abortion: 13%
- Other direct causes: 8%
- Indirect causes: 19%

World Health Report 2005
Loss of Pregnant Women’s Lives

4 Loaded 747s Every Day !!
United Kingdom
Confidential Enquiries

www.cemach.org.uk

*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 Mortality Rates* for the Year 2000

*Per 100,000 live births

15.9 in NYS
23.1 in NYC
9.5 in Upstate

[Map of New York State with highlighted regions]
<table>
<thead>
<tr>
<th>33A</th>
<th>If Female:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Not Pregnant within last year</td>
</tr>
<tr>
<td>☐</td>
<td>Pregnant at time of death</td>
</tr>
<tr>
<td>☐</td>
<td>Not pregnant, but pregnant within 42 days of death</td>
</tr>
<tr>
<td>☐</td>
<td>Not pregnant, but pregnant 43 days to 1 year before death</td>
</tr>
<tr>
<td>☐</td>
<td>Unknown if pregnant within past year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>33B. Date of Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month   Day   Year</td>
</tr>
<tr>
<td>/      /</td>
</tr>
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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)

▲ CHILDREN'S (BUFFALO)
▲ STRONG MEMORIAL (ROCHESTER)
▼ CROUSE (SYRACUSE)
▼ ALBANY MEDICAL CENTER
◆ WESTCHESTER MEDICAL CENTER (VALHALLA)
□ UNIVERSITY (STONY BROOK)
★ LONG ISLAND JEWISH, WINTHROP UNIVERSITY, NORTH SHORE UNIVERSITY (NASSAU COUNTY)
NEW YORK CITY CENTERS/NETWORKS NOT SHOWN
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

Onsite Review
Within 6 to 8 weeks of the occurrence

- Perinatal Medical Record(s)
- Staffing Logs
- Interview(s)

Abstraction Form
<table>
<thead>
<tr>
<th>Question</th>
<th>Coding Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.)</td>
<td>None</td>
</tr>
</tbody>
</table>
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

- PIH = 8 (24%)
- Emb = 8 (24%)
- Hem = 5 (15%)
- Inf = 5 (15%)
- CM = 2 (6%)
- Oth/Ukn = 4 (15%)
Aggregate Data*

- **Obesity**
  - BMI mean = 31.1 (range 19.5 – 53)

- **Mode of delivery**
  - Cesarean Section = 23
  - 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
  - SpO₂
  - 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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