Maternal Mortality Review Committee Report Nevada, 2018-2020 (Nevada Revised Statutes 442.767)

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Maternal, Child and Adolescent Health Section

Division of Public and Behavioral Health

Department of Health and Human Services

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Table of Contents

Dedication

The Nevada Division of Public and Behavioral Health (DPBH) notes with deepest sympathy and respect this report is dedicated to the memory of those who have died in pregnancy or within one year of pregnancy, and to their families and loved ones surviving an incalculable loss.

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Background

The purpose of this report is to meet the duties of the Maternal Mortality Review Committee (MMRC) as outlined in NRS 442.767 and provide insight into demographic characteristics and causes of death associated with pregnancy-associated deaths from December 2018 through 2020. This report includes two resources, the Office of Analytics of DHHS *Severe Maternal Morbidity Report, Nevada, December 2018 - 2020* and *Maternal Mortality Report, Nevada, December 2018 - 2020* which also provides data on pregnancy-related deaths from the Centers for Disease Control and Prevention (CDC) Pregnancy Maternal Surveillance System (PMSS). Both reports highlight Nevada disparity data on severe maternal morbidity and maternal mortality across race, ethnicity, geography, insurance status, education, age, as well as prenatal and delivery characteristics such as prenatal care initiation, adequacy of prenatal care, parity, method of delivery, plurality, and chronic disease. Differences in pregnancy-associated death rates, counts, disparities, geographic distribution, and causality are seen between 2018 and 2019 maternal mortality data and preliminary 2020 data, and PMSS pregnancy-related data reveal patterns of disparate burden, as well. Preliminary 2020 data must be read with caution and are subject to change, and PMSS time periods and type of mortality are different from the pregnancy-associated death data from 2018-2020 in the *Maternal Mortality Report, Nevada, December 2018 - 2020*.

Race and ethnicity disparity data in both reports are of particular concern in relation to differential burden of maternal mortality and severe maternal morbidity (SMM). Identification of disparities, including implicit bias and racism, is an initial crucial step in creating evidence-based interventions to reduce all contributing factors at the individual, societal and political levels. Ending all preventable maternal mortality and SMM in the state is a key goal of MMRC efforts.

Establishment of the Nevada Maternal Mortality Review Committee

Assembly Bill 169 of the 80th Legislative Session established the Nevada MMRC granting additional authorities and protections for a statewide MMRC, codified in Nevada Revised Statutes (NRS) 442.751 through NRS 442.774, inclusive. The MMRC was established within the Nevada Department of Health and Human Services (DHHS). The Committee is required to: (1) review incidents of maternal mortality and severe maternal morbidity (SMM) in Nevada; (2) disseminate findings and recommendations concerning maternal mortality and SMM to providers of health care, medical facilities, other interested persons and the public; (3) publish timely reports consisting of data relating to maternal mortality and SMM, descriptions of incidents reviewed by the Committee, and recommendations to reduce maternal mortality and SMM in Nevada. The Committee is entitled to any records deemed necessary to perform duties and to petition the district court for a subpoena to compel the production of such records and information acquired by. Records of the Committee are confidential and not subjected to subpoena. A call for interest was placed via the Maternal and Child Health Advisory Board and shared widely. The Director of DHHS appointed the statutorily required twelve MMRC members representing diverse expertise and geographic areas within Nevada.

The Nevada MMRC conducts ongoing, comprehensive, multidisciplinary reviews of maternal deaths to help determine factors contributing to maternal mortality and SMM and identify public health and clinical interventions to improve systems of care and prevent mortality and morbidity.

Outcomes expected include: timely, accurate, and standardized information available about deaths during pregnancy and the year after the end of pregnancy, including opportunities for prevention; increased awareness of the existence and recommendations of the MMRC among the public, clinicians, and policy makers; implementation of data-driven recommendations; widespread adoption of patient safety bundles and/or policies reflecting the highest standards of care; reduction in maternal mortality, SMM and related disparities; and improvement in population health for women of reproductive age (e.g., reductions in hypertension, coronary heart disease, substance use, and other chronic diseases).

Maternal Mortality and SMM Incidents Reviewed

The Nevada MMRC convened four times in 2020, with the initial meeting being a Centers for Disease Control and Prevention (CDC) training and orientation to state and national maternal mortality and severe maternal morbidity data in February of 2020. Case abstraction takes roughly 20 hours per death review and can easily exceed this time period. Requested records can take time to be fulfilled and a single case may generate numerous records requests to capture as much information as possible to ensure a complete abstraction. The Committee reviewed five maternal mortality cases in 2020. Decision data are limited to ensure the identity of those whose deaths were reviewed are protected given the small sample size. As record requests become routine and are shared more quickly and abstraction and the MMRC case review process familiarity increases, efficiencies will be gained resulting in increased numbers of case reviews.

MMRC Recommendations

MMRC recommendations to reduce maternal mortality and SMM in Nevada are expected to increase with additional maternal mortality incident review. At this point in time, the Committee has identified recommendations to improve care in Nevada and recommendations to improve the work of the Committee.

Two contributing factors to maternal mortality at the systems level which could have a large impact in preventing maternal mortality were identified by MMRC members. First, the Committee identified the need to provide adequate drug treatment options to pregnant women. The Committee recommends educating providers on Nevada's substance use disorder treatment options which already exist for pregnant women and removing barriers to care. The second relates to substance use in pregnancy and the identified need as a society to address the social determinants of health. At the provider level, the utility of recommending the use of a suicide screen in addition to the antepartum and postpartum depression screen was discussed. Finally, a recommendation for outreach promoting the importance of prenatal care and preventing delays in prenatal care was identified.

The Committee identified two recommendations to improve the function of the committee. First, the statutory language is a barrier to accessing Cancer Registry data. The Committee recommends considering legislative action to remove the barrier to receive these records for case abstraction. Second, the Committee identified the lack of family interviews and data regarding the social determinants of health as a barrier to making recommendations from the cases. The Committee recommends considering securing dedicated funding to ensure full data collection.