



## Phase II: New York State Safe Motherhood Initiative The American College of Ob/Gyn, District II, New York



The Safe Motherhood Initiative is New York's response to a national effort to improve birth outcomes, reduce pregnancy-related deaths and related racial disparities. The Bureau of Women's Health, New York State Department of Health (NYSDOH), has contracted with the American College of Obstetricians and Gynecologists, District II/NY (ACOG) to conduct hospital reviews to determine causes of pregnancy-related deaths and influence the state's quality improvement activities.

### Safe Motherhood Initiative Overview

ACOG, in partnership with NYSDOH, the Center for Disease Control and Prevention, the Healthcare Association of New York State (HANYS) and the state's Regional Perinatal Centers (RPCs), has identified the following public health objectives for the project:

- Strengthen regionalization of maternity care;
- Provide more effective response to maternal emergencies;
- Improve screening for substance abuse and domestic violence;
- Maximize case ascertainment;
- Improve quality of care;
- Ensure in-depth reviews of maternal deaths;
- Reduce maternal mortality through education of hospital and provider communities.



### ACOG Project

Within the context of the overall Phase II: Safe Motherhood Initiative, ACOG will:

- Develop a data collection system and public health surveillance system to identify, track and reduce pregnancy related deaths.
- Conduct hospital based maternal death reviews in New York State to identify the causes of maternal mortality and provide insight into disparities among populations.
- Provide direction for and education of medical professionals and public health officials that will help prevent and/or treat the leading causes of maternal death discovered during the review process.

### Method

During Phase I, ACOG in conjunction with NYSDOH, HANYS and other collaborative partners, formulated a systematic method to identify and review maternal deaths.

### Identification and Review Process

1. Confidentiality: Under protection of Public Health Law section 206(1)(j), the review team will interview health care providers who had contact with the deceased.
2. Identification: Within three days of the death, a member of the institution (preferably the New York Patient Occurrence Reporting and Tracking System) where the death occurred will complete the maternal death notification form and transmit the form to ACOG. A hospital-based review will be coordinated for all pregnancy-related deaths reported.
3. Review: Within six to eight weeks of the date of occurrence, a maternal mortality review will be conducted by a team composed of the project director acting as team coordinator, two or more RPC representatives including a maternal fetal medicine specialist and a labor and

delivery nurse or nurse coordinator, sub-specialists as necessary (e.g. anesthesiologist, cardiologist, social worker, pathologist, etc.) and the ACOG ob-gyn team leader. If the maternal death occurs at an RPC, ACOG will assign an ad hoc maternal mortality review team comprised of selected experts in the field of maternal fetal medicine.

The team will collect information on the factors that lead to the maternal death using the de-identified maternal mortality abstraction form developed in Phase I. All documents reviewed, i.e., medical records, staffing log records, etc. will remain in the hospital.

4. Analysis: Using information from the abstraction form, interview with health care providers and staffing logs, the review team will identify factors that led to the death.

A de-identified incident report and recommendations will be drafted. ACOG will analyze the incident reports for patterns or similar factors.

5. Action: The review team will submit the final report to ACOG. The ACOG physician consultant, in conjunction with the RPC, will formulate and submit recommendations for quality improvement (i.e. system modifications, revision of protocol, staffing modifications, policy changes, etc.) to the hospital under review.

### ***Meetings***

1. Clinical Review Work Session: ACOG will appoint an expert committee to review all pregnancy related deaths reported in the aggregate. The purpose of the work session will be to identify trends and make recommendations for statewide maternity care.
2. Annual Statewide Maternal Mortality Review Conference: A five-hour continuing medical education program will be conducted to present findings, review maternal death cases, update and instruct ob-gyns and other interested health care professionals statewide in the best practices for prevention and treatment of the leading causes of maternal death.

### **Next Steps**

- A formal letter will be drafted for all RPCs describing the maternal mortality review protocol, review process and requesting RPCs to identify two representatives who will be required to participate in the maternal death review process.
- In forthcoming months ACOG will test the abstraction form.. Full implementation of Phase II is planned for March 2003 under renewed contract by the NYSDOH.

### **For more information contact**

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