

This rule was filed as 7 NMAC 4.5.

TITLE 7 HEALTH
CHAPTER 4 DISEASE CONTROL (EPIDEMIOLOGY)
PART 5 MATERNAL, FETAL, INFANT AND CHILD DEATH REVIEW

7.4.5.1 ISSUING AGENCY: New Mexico Department of Health, Public Health Division, Family Health Bureau
[01/01/98; Recompiled 10/31/01]

7.4.5.2 SCOPE: These regulations shall apply to the operations of the New Mexico maternal mortality review team, fetal and infant mortality review team, child fatality review team *and any other team which is deemed necessary by the department* and their policies and procedures, confidentiality provisions, management of records, dissemination of findings and recommendations; and to the public and private entities from whom data, information or records are requested for the purpose of mortality or fatality review.
[01/01/98; Recompiled 10/31/01]

7.4.5.3 STATUTORY AUTHORITY:

A. The regulation set forth herein is promulgated by the secretary of the department of health by authority of the Department of Health Act, Section 9-7-6.E. NMSA 1978 and the Public Health Act, Section 24-1-3 NMSA 1978, specifically Section 24-1-3. C. NMSA 1978, which states: *"The department has authority to: investigate, control and abate the causes of disease, especially epidemics, sources of mortality and other conditions of public health;* and Section 24-1-3. F. NMSA 1978, which states: *"The department has authority to: establish programs and adopt regulations to prevent infant mortality, birth defects and morbidity;* and Section 24-1-3. H. NMSA 1978, which states: *"The department has authority to: provide educational programs and disseminate information on public health."* The administration and enforcement of these regulations is the responsibility of the public health division of the department.

B. Related statutes and regulations: New Mexico law provides for other statutes and regulations that support or limit the statutory authority of the department to regulate the review of maternal, fetal, infant or child deaths.
[01/01/98; Recompiled 10/31/01]

7.4.5.4 DURATION: Permanent
[01/01/98; Recompiled 10/31/01]

7.4.5.5 EFFECTIVE DATE: January 1, 1998, unless a later date is cited at the end of a section or paragraph.
[01/01/98; Recompiled 10/31/01]
[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.4.5.6 OBJECTIVE: The purpose of the retrospective case review of death in the maternal, fetal, infant and child population in New Mexico by a multidisciplinary team of experts is to reduce future rates of such deaths by identification of prevention factors, risk reduction factors and/or systems failure factors and the dissemination of such information to policy makers, providers, communities and to the public.
[01/01/98; Recompiled 10/31/01]

7.4.5.7 DEFINITIONS:

A. "AAP" means the American academy of pediatrics
B. "ACOG" means the American college of obstetricians and gynecologists.
C. "CYFD" means the New Mexico children, youth and families department.
D. "Child fatality review" or "CFR" means a review that includes all reported deaths of children due to fatal injury or other undetermined cause from birth through 24 years of age, or a specific age range as determined appropriate by a special panel.

- E. "Community based review" means the review that takes place in the community where the death occurs, is staffed by Team members approved by the department and may involve follow-back interview with informed consent to surviving family, providers of care or other relevant persons.
- F. "Coordinator" means the person designated by the department to administer and manage the day to day operations of the review teams.
- G. "Confidentiality" means the protection of the privacy of the decedent, the decedent's family, and any information pertaining to the fatality.
- H. "Department" or "DOH" means the New Mexico department of health.
- I. "Department designee for MCH death review" means the department staff person, usually an epidemiologist, authorized to receive information regarding deaths that fit the criteria for MMR, FIMR and CFR.
- J. "Death investigation" means the investigation of a death by appropriate authorities for the purpose of establishing the manner and cause of death.
- K. "Expert" means a person by whose training and present work-related activities or professional licensure has the requisite knowledge to review case information and contribute to an assessment of prevention factors, risk reduction factors and/or systems failure factors. The expert is bound by confidentiality policies and statute, and must be recognized by the department.
- L. "Fetal and infant mortality review" or "FIMR" means a review including all reported deaths of fetuses (death prior to the complete expulsion or extraction from the mother of a product of human conception, fetus and placenta, irrespective of the duration of pregnancy), and infants (any death at any time from birth through one year).
- M. "MCH" means public health practice concerned with maternal and child health.
- N. "Maternal mortality review" or "MMR" means the review of all reported deaths of the following: pregnant women who die from any cause during pregnancy, or who die within one calendar year of pregnancy termination.
- O. "Multidisciplinary team" means a team of experts comprising, but not limited to, the disciplines essential to death review, such as medicine, nursing, social work, law enforcement, mental health, public health, education, domestic violence, and child advocacy.
- P. "OMI" means the New Mexico office of medical investigator.
- Q. "PHD" means the public health division of the department.
- R. "Prevention factors" means the circumstances, events, exposures or products that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and/or educated for the prevention of future such death(s).
- S. "Retrospective case review" means the gathering of case information and analysis of information after the manner and cause of death have been registered with vital records and health statistics. Retrospective case review is not a death investigation process. It is a public health function concerned with assessment, prevention, risk reduction and/or systems improvements.
- T. "Risk reduction factors" means the circumstances, events, exposures or products that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and/or educated for the prevention of future such death(s).
- U. "Secretary" means the secretary of the department or his/her designee.
- V. "Special panel" means a group convened on a permanent or temporary basis for the MMR, FIMR or CFR Team, to review an aggregation of deaths by selected categories to increase the power of analysis and interpretation by reviewing several cases of a similar manner or cause of death.
- W. "State level review" means the process whereby statewide quantitative and qualitative data, gathered either at the state level or by a local community death review team, are analyzed and used for development of public policy, public health recommendations, and/or implementation of prevention measures.
- X. "System failure factors" means the community-based circumstances, events, resources including the lack thereof, and provider policies that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and or educated for the prevention of future such death(s).
- Y. "Team" means one of the state or community level MMR, FIMR or CFR teams.
- Z. "UNM" means the university of New Mexico.
- AA. "VRHS/NM" means the department entity responsible for vital records and health statistics in New Mexico.

[01/01/98; Recompiled 10/31/01]

7.4.5.8 PROGRAM ADMINISTRATION: MMR, FIMR, and CFR are administered by the public health division in the department in collaboration with the OMI of UNM. MMR, FIMR and CFR are coordinated by the MCH death review coordinator in the office of MCH epidemiology.
[01/01/98; Recompiled 10/31/01]

7.4.5.9 EXECUTIVE OVERSIGHT BOARD: An executive oversight board will comprise department representatives designated by the secretary including but not limited to the office of the DOH chief medical officer, office of general counsel, offices of the PHD director, VRHS/NM, family health, MCH epidemiology; and a designated representative of OMI, ACOG and CYFD.
[01/01/98; Recompiled 10/31/01]

7.4.5.10 MEMBERSHIP: The members of maternal mortality review team, the fetal and Infant mortality review team and child fatality review team will be state or local experts in their field and appointed by the department. Members are selected to achieve a culturally diverse, multidisciplinary team that may include but is not limited to representatives of the following disciplines: medicine and selected subspecialties, nursing, nurse-midwifery, forensic medicine, mental health, social work, specialists in child abuse and neglect, public health epidemiology, law enforcement, the judiciary, prosecution, traffic safety, education, child advocacy, grief intervention and support, domestic violence, health education, survivor or parent support groups. Membership will include representation from federal (military and Indian), state and local entities. Membership is voluntary and team members or special panel members shall not be remunerated by the department.

A. State level teams are organized for MMR, FIMR and CFR and are responsible for initial and/or final review of all cases, aggregate analysis of statewide data, and the identification and preparation of reports or other documents to address statewide and or local systems improvements, prevention, and risk reduction factors. State level teams are responsible for training, support and consultation to community level teams.

B. Community level teams shall be organized with training and support of state level teams, and shall abide by state level regulations, protocols and policies. The formation of community level teams shall be contingent upon available resources including consultation by specialists in appropriate disciplines. The purpose of a community team is to bring case review to the local level where identification of problems and development of interventions for systems improvements, risk reduction or prevention can take place

C. Special panels: Special ad hoc panels may be organized in response to any identified profile or cluster of fatalities that are identified by a team and the department, the OMI, or other appropriate entities as approved by the executive committee.

D. Maternal mortality review: The organizational membership of MMR shall seek to include, but not be limited to, representatives of the New Mexico section of ACOG; the New Mexico academy of family practice; the New Mexico hospital and health service association; the New Mexico association for women's health, obstetrics, and neonatal nursing; the New Mexico department of health, public health division; the New Mexico chapter of the American college of nurse midwives; the New Mexico vital records and health statistics entity; the Indian health service; the New Mexico office of the medical investigator; tertiary center perinatologists (institutions designated as level III neonatal intensive care unit); and community obstetricians and family practitioners.

E. Fetal and infant mortality review: The organizational membership of FIMR shall seek to include but not be limited to representatives from New Mexico units of the American academy of family physicians; the American academy of pediatrics; the American anthropological association; ACOG; the American college of nurse midwives; the New Mexico hospital and health service association; the MCH Title V entity of the department; the New Mexico vital records and health statistics entity; the association of state and territorial health officials; the college of American pathologists; the march of dimes birth defects foundation; the association for women's health, obstetric and neonatal nurses; and the society of perinatal obstetricians.

F. Child fatality review: The membership of CFR shall seek to include but not be limited to representatives of the following organizations and interest areas: law enforcement; prosecution; the medical and mental health communities; tribal governments; tribal social service agencies; military bases; a domestic violence program; a grief intervention program; the New Mexico traffic safety bureau; the New Mexico sudden infant death syndrome program; a child advocacy group; the unit responsible for the investigation and prevention of child abuse and neglect in CYFD; public health epidemiology, the New Mexico vital records and health statistics entity; the MCH Title V entity in the department; a representative from OMI; a representative of the New Mexico not even one project, and a representative from the public school system.

[01/01/98; Recompiled 10/31/01]

7.4.5.11 CASE IDENTIFICATION: Deaths of New Mexico residents which are registered with VRHS/NM will serve as the denominator or source file for MMR, FIMR and CFR. Deaths of non-residents which have occurred in New Mexico may not always be included.

A. MMR case identification: Deaths that meet criteria for maternal mortality review will be reported by OMI to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for MMR including a linked birth, death and fetal death file, will be reported by VRHS/NM to the department designee.

B. FIMR case identification: Deaths that meet criteria for fetal or infant mortality review will be reported by VRHS/NM to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for FIMR will be reported by VRHS/NM to the department designee.

C. CFR case identification: Deaths that meet criteria for child fatality review will be reported by OMI to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for child fatality review will be reported by VRHS/NM to the department designee for MCH death review.

[01/01/98; Recompiled 10/31/01]

7.4.5.12 DATA COLLECTION: The department designee shall receive case identifiers from OMI and VRHS/NM and shall prepare the file for review by ascertaining what supplementary records are needed for a comprehensive case review. Case data and information are then requested from the relevant sources.

A. Non-federal sources: Relevant sources for FIMR, MMR, CFR review include but are not limited to: OMI records; providers of medical, health, nutrition and mental health care; emergency department records; emergency transport records; hospital records; records of applicable law enforcement agencies; other public safety service records such as those maintained by fire departments; records of providers of social work care including child protective services; day care records; school-based records; motor vehicle crash reports.

B. Federal sources: Deaths meeting criteria for MMR, FIMR and CFR which have occurred on military reserves or Indian reservations will require collection of case information from relevant federal agencies including but not limited to the federal bureau of investigation (FBI); the bureau of Indian affairs (BIA), the Indian health service (IHS), military and tribal police, and military and tribal social services.

C. Forms: A standard form to request information of private or public entities shall be used and which states the authority of the department with the signature of the chief medical officer of the department. The form shall be prepared, signed and dated by the department designee or the coordinator.

D. Collection of information by interview: Case review may include interviews with the decedent's family, care providers, and other relevant persons. These interviews will be conducted only with the informed consent of the interviewee.

E. Partial collection of information: In death review data collection where case information is sequestered, privileged, or confidential, the department will request information as required on the data form from appropriate agencies. Such deaths may be deferred for review until such time as the case file may be available for review.

[01/01/98; Recompiled 10/31/01]

7.4.5.13 CONFIDENTIALITY OF RECORDS, PROCEEDINGS AND FINDINGS: MMR, FIMR and CFR involve the use of highly confidential case files which are protected by statute(s), regulation(s), departmental protocol, and policy.

A. Confidentiality of Information from VRHS/NM: Access to data constituting vital statistics as defined in the New Mexico Vital Statistics Act, Section 24-14-1, et seq. NMSA 1978, shall be in accordance with the Act and applicable department regulations.

B. Open records: All information and records accessed or in the possession of the MMR team, FIMR team, CFR team, or a special panel are confidential in accordance with the New Mexico Inspection of Public Records Act, Sections 14-2-1, et seq. NMSA 1978 and applicable law.

C. Member confidentiality statement: All members shall receive a training orientation regarding applicable statutes, protocols, and the rules for confidentiality. Each member is required to sign a confidentiality statement, the intent of which is to protect the confidentiality and privacy of the decedent, the decedent's family, and other individuals, agencies or providers cited in the case file. The confidentiality statement shall be signed by a

team member prior to participation in case review and signed annually thereafter on July 1st or the first review session held for the state fiscal year. Experts invited for a special panel are to sign the confidentiality statement prior to participation in a case review.

D. Breach of confidentiality: Anyone who breaches confidentiality shall be subject to legal liability including, but not limited to, the provisions of the Vital Statistics Act at Sections 24-14-27 NMSA 1978 and 24-14-31 NMSA 1978.

E. Review team findings: The findings and recommendations of the MMR, FIMR, and CFR teams with respect to prevention, risk reduction or systems failures are the property of the department. They are based on retrospective case review. The process by which findings are derived is different from the understanding and judgment of a provider or any other person present at the time of caring for the decedent prior to the death. Findings and recommendations are prevention-oriented rather than investigatory. The opinions expressed are based upon an aggregate of information which has been compiled from a variety of sources post-mortem, and which was not available to any single provider at the time of death.

F. Closed meetings: Team meetings are not subject to the Open Meetings Act, Sections 10-15-1 through 10-15-4 NMSA 1978. Records of the team shall be confidential pursuant to the provisions of the Inspection of Public Records Act and Section 24-1-20 NMSA 1978 of the Public Health Act. Individuals who are not members of the team or special panel will not be allowed to be present at case reviews unless the individual is approved by the presiding chair with the consent of the panel or team, and that individual signs the confidentiality agreement.

G. Reports of findings: Statistical studies and research reports based upon the confidential information may be published, but they will not identify decedents, their families, or provide any other information that can be extrapolated to ultimately identify these individuals. Data will be published in the aggregate.

H. Follow-up to at-risk circumstances: In the event that a team or special panel finds that there are circumstances that may place others at risk for injury or untoward exposure, the department on behalf of the team or special panel shall inform the appropriate federal, state and/or community entity in accordance with procedures and protocols established by the department.

[01/01/98; Recompiled 10/31/01]

7.4.5.14 SECURITY OF RECORDS:

A. Statistical information: Information from forms completed by any of the teams or its special panels will be entered without personal identifiers into a data base dedicated solely to MMR, FIMR and CFR, and will be accessed only by the team coordinator, the department designee for MCH death review, and the individual who is responsible for data base management and data entry. Personal identifiers include first, middle, and last name, and the street address of decedent or other persons, including providers.

B. Administrative information: The review forms with personal identifiers will be kept in a secure, locked location which can be accessed only by the department designee for MCH death review, the coordinator, and the individual responsible for data base management and entry.

C. Management of case documentation during review session: Team members are prohibited from leaving case reviews with any identifiable written review information that is related to cases under review, those cases which have been reviewed, and those cases which will be reviewed. All materials held by anyone other than the coordinator of the review team, the department designee for MCH death review, an OMI representative, or the designee of any of the aforementioned individuals will be collected and destroyed by the presiding chair of the team reviewing the case.

[01/01/98; Recompiled 10/31/01]

7.4.5.15 DISSEMINATION OF INFORMATION: Non-identified, aggregate data and descriptive risk information will be disseminated by the MMR, FIMR or CFR team in annual reports, epidemiological bulletins to providers, informational releases to the public regarding preventable risk, and special reports to the New Mexico legislature and other appropriate groups.

[01/01/98; Recompiled 10/31/01]

HISTORY OF 7.4.5 NMAC: [RESERVED]