Maternal Overdose Deaths in NC

2018–2020

The North Carolina Maternal Mortality Review Committee (MMRC) was established by state law in 2015. The purpose of the MMRC is to review all maternal deaths of NC residents and develop actionable recommendations aimed at the prevention of future maternal deaths. This fact sheet highlights data for all pregnancy-related deaths that occurred from 2018 to 2020 in North Carolina.

Pregnancy-Related Mortality Ratio (PRMR)

8 **pregnancy-related deaths due to accidental overdose per 100,000 live births**

Source: NCDHHS | Division of Public Health | Women, Infant and Community Wellness section | Maternal Health Branch | NC Maternal Mortality Review Committee

Accidental Overdose is the Leading Cause of:

- **Pregnancy-Related Death**
- **Pregnancy-Associated Death**

#1 CAUSE

Opioids are the most common substance involved in pregnancy-related overdoses

87% INVOLVED OPIOIDS

The majority of pregnancy-related overdose deaths involved opioids

24 pregnancy-related deaths noted **Fentanyl** alone or in combination with other drugs

Preventability

100% **of Pregnancy-related Overdose deaths were deemed preventable**

A death is **preventable** if there was at least some chance it could have been avoided with reasonable changes to patient, family, provider, facility, system, and/or community factors.

Timing of Pregnancy-Related Overdose Deaths

10%
During pregnancy

16%
1-42 days after end of pregnancy
(including day of delivery)

74%
43 days-1 year
after end of pregnancy

A Snapshot of NC MMRC Overdose-related Recommendations

- All health care providers, including obstetricians, should proactively offer Narcan to patients, their family members or community members who accompany them, at every appointment if a patient has a history of overdose, substance use disorder, or narcotics misuse. Educational material about Narcan should be conspicuously displayed in the exam rooms.
- All obstetric providers should use validated screening tools to screen for substance use in each trimester and at the postpartum visit, in accordance with ACOG guidelines, and document the results.
- Emergency departments should have a protocol for a warm hand-off of pregnant and postpartum patients requesting detox or stabilization to a substance use treatment facility, including a clear follow-up process to ensure the patient connects with the facility.
- Hospital systems, insurers, and medical schools should require training for all providers to recognize co-occurring substance use and mental health disorders and connect patients with treatment.

**Note: Please see the full 2018-2020 MMRC report for additional recommendations*

Definition | Pregnancy-related death: A death while pregnant or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. *(Q: "If she had not been pregnant, would she have died?")*

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

ERASE MM
Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

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