

122 S. Michigan Ave., Suite 7000 • Chicago, IL 60603-6119 • www.idph.state.il.us

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PERINATAL HEALTH SYSTEM OF ILLINOIS

MATERNAL MORTALITY REVIEW COMMITTEE

April 7, 2010

10:30 A.M.

James R. Thompson Center Room-025- Second Floor 100 West Randolph Chicago, Illinois

MINUTES

Chair: Robin L. Jones, MD

Attendees: Harold Bigger, MD, Louise Simonson, , Trish O'Malley, Patricia Prentice, J. Roger Powell, MD, Cynthia Wong, MD, Jerome Loew, MD, Pat Schneider, CNM, Stacie Geller, PhD.,

Absent: Sarah Kilpatrick, MD, excused, John Gianopolous MD, excused, Kevin Madsen, MD, excused, Deborah Boyle, MD, Andrea Kemp, MD,

IDPH Staff: Charlene Wells, RN, BSN, Mark Flotow

I. Review and Approval of Minutes – December 9, 2009

Minutes of the December 9, 2009 meeting were reviewed. Stacie Geller moved approval of the minutes, Barb Prochnicki seconded. The minutes were approved as written.

II. Report from the Obstetric Hemorrhage Education Project Workgroup: Standards to measure success and Future Education

In order to accurately gauge the success of the program the workgroup needs data from the whole state, some people are not using an excel program. A repeat of the benchmark assessment must be completed by July 1, 2010. At that time

comparison of scores will be done to determine if there is an improvement in overall knowledge of the factors in the assessment.

A letter has been prepared to be sent by the Director along with a revised Hospital Assessment Tool to be completed by all hospitals providing obstetric care. The previous hospital assessment data has been maintained and will be able to be used to provide a valid comparison.

An in-depth review of management of obstetric hemorrhage cases pre and post implementation of the OBHEP project is tentatively scheduled for the University of Illinois and Northwestern. The IRB from University of Illinois has been forwarded to Northwestern.

Ongoing requirements for the OBHEP were discussed, suggestions are as follows:

1. New obstetric staff members must complete all components of the OBHEP program.

2. All hemorrhage cases (3 or more units of blood products received or ICU admissions) become part of the hospital Quality Improvement Process

3. Site visits will require that all cases of three or more blood products received/ICU admissions for the past three years be reported in the Site Visit Manual. Site visit reviewers will request Quality Improvement data related to Maternal Hemorrhage.

4. Hospital Obstetric Education plans must show collaboration with the quality improvement process incorporating the OBHEP standards.

5. The workgroup will develop a 10-15 minute competency to be presented to the MMRC contingent on analysis of the pre and post benchmark assessments.

There was much discussion about how often simulations must be done. The function was compared to other required programs such as NRP etc.

The MMRC was tasked with coming up with suggestions based on discussion with Administrators and hospitals. An estimate can only be made as this information is not evidence based. A suggestion was made that blood estimation be reviewed on an annual basis. Dr. Jones will contact Dr. Madsen and Dr. Boyle to request their participation on the workgroup.

Cases of maternal deaths hemorrhage/amniotic fluid embolism should be reviewed by the MMRC any time they occur.

Motion #1: The MMRC recommends that items 1-5 be forwarded to the Perinatal Advisory Committee for consideration as a requested standard for IDPH.

The motion was made by Cynthia Wong and seconded by Stacie Geller. The motion carried unanimously.

III. Response to Recent Publications Regarding Maternal Mortality

Discussion was held regarding the article by Tegan Culler complimenting the MMRC for its work.

Charlene Wells will contact Ms. Culler for the status of her article and ability to share information.

Discussion was held regarding the article from the Daily Herald. The issue of Cesarean births was discussed and the current factors that precipitate a higher rate in the United States. Causes include an increasing number of advanced maternal age pregnant women, increasing multiple gestation as a result of reproductive technology, reductions in VBAC, pleasing the consumer and a reluctance to do vaginal operative deliveries.

Discussion was held regarding the possibility that Amnesty International was not aware of the State of Illinois process because there has been no data published about the MMRC process. It was felt that until the data regarding the MMRC process and activities becomes published, there will continue to be a lack of understanding about the in-depth analysis of maternal deaths done in Illinois.

Stacie Geller requested that the MMRC pursue authorization from IDPH to publish a descriptive article with access to data that can confirm the validity of the processes being used. The article would confirm that the MMRC has a process, the process has produced the following results and the process is working

Motion #2: That the MMRC request that the Perinatal Advisory Committee ask the Director to respond to the Amnesty International study on the Maternal Death rate in Illinois.

The motion was made by Stacie Geller and seconded by Louise Simonson. The motion was approved unanimously.

Dr. Bigger commented that he has not be able to get data use from the VLBW based on the processes currently used by IDPH.

Charlene Wells stated that she will review the process. Makiya _____, attorney for IDPH discussed the Level III Maternal Death review process that would mandate a outside Network review. She advised that when the Rules come up for the second comment period, the language pertaining to this request be added to the section of the Rule pertaining to the M+M process review.

The process of joint reviews for cases with more than one healthcare facility involved could also be addressed at this time.

Dr. Jones indicated that case reviews would be held as there was no MFM presence at this meeting. Members asked for a calendar of all future meetings. Pat Prentice will forward the IDPH calendar to members.

Old Business:

Nancy Martin is in the process of cataloguing all deaths for 2007-2009. The process for feedback is in place and there will be mandated follow-up directly to Charlene Wells with dates set for letters to be received. Hopefully the entire process will be completed prior to the December meeting.

Dr. Powell asked about the additional meeting requested to look at domestic violence cases. The issue of sharing of information and ex-officio members has not been resolve. It is hope that a solution and suggestion for review will be ready for the June meeting.

New Business

The data base for the MMR is in place and Mark Flotow indicated that there may be a method of improving the process to make the data more user friendly.

This system will allow for accurate data review and data validation.

There being no further business, the meeting was adjourned at 12:16pm