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**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
MATERNAL MORTALITY REVIEW COMMITTEE**

April 10, 2013

10:30 a.m. – 1:00 p. m.

Michael Bilandic Building

160 North LaSalle Street

Chicago, Illinois

5th Floor, Room 502

Robin L. Jones, MD, Chairperson

Minutes

1. Review and Approval of Minutes- December 12, 2012: The minutes of December 12, 2012 were reviewed. Barb Prochnicki motioned approval, Trish O'Malley seconded; the minutes were approved as written.

2. Obesity Workgroup Update **Deborah Boyle, MD**
Dr. Boyle was unable to be here today, this agenda item was tabled.

3. Research and Publications **Stacie Geller, PhD**
Cynthia Wong, MD
Harold Bigger, MD

Cynthia Wong reported that a paper providing a more detailed description of the Obstetric Hemorrhage Education Program is ready for publication. The article reflected the pretest/post-test results and analyzed the learning that took place by type of knowledge and the discipline of the groups of healthcare providers. Nurses made the greatest improvement. The article is being brought forward for publication. Dr. Wong will approach Simulation in Healthcare for possible publication.

The data analyzed from the pretest (Benchmark Assessment) and post-test (six months after the education was completed) in general has validity. The primary concern is to be able to link knowledge with outcomes but there is no process to currently allow for this knowledge.

Shirley Scott indicated that some networks have not submitted their two year post competency network.

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Hospital assessment surveys; the preprogram assessment of 2007 and post program assessment of 2009 are being analyzed and a baseline defining the changes will be made available.

Dr. Bigger stated that IRB's are ready for submission. The Maternal Mortality Review Committee is requesting that the Illinois Department of Public Health allow use of the MMRC data for the following objectives:

1. To produce an Annual Report that will outline the activities of the MMRC and provide trends in Maternal Death
2. Allow participation by sharing the report with agencies such as the CDC and Perinatal Collaboratives. This will allow Illinois to participate in national databases.
3. Comparing data between first level review and MMRC reviews

Dr. Bigger also presented a journal article from 1952 by Charles Newberger, Md indicating that Illinois reviewed maternal death since 1937. The study presented in the article were from 1948-1952. Deaths were reviewed by physicians going directly to hospitals and abstracting medical records. Preventability was assessed.

Pat Prentice discussed the presentation of medical record data. Case Assessment data will be provided for cases as discussed in December. Some cases presented to the MMRC do not have an Maternal Mortality Review Report as the case was not able to be determined in a first review and was directly sent to the MMRC.

Jerome Loew discussed the general nature of first reviews as there is not standard that mandates abstracts or conduct of a first review other than the data fields on the MMR.

Dr. Bigger stated that not all maternal deaths would be considered sentinel events depending on the timing and the relationship to the pregnancy. However, all cases from conception to one year post partum are expected to be reviewed.

Access to the EMS records and police records is still a concern, sometimes limiting the ability to thoroughly review a case.

Nancy Martin discussed the concern of receiving charts from hospitals that subcontract with copy services. Charts are often disorganized.

Mark Flotow will be speaking regarding the Departments need to send a letter and checklist to all Illinois Birthing Hospitals.

4. Maternal Death Reports from IDPH

ALL

Discussion was held regarding the need to get information from the MMRC reviews back to Perinatal Centers and Network hospitals.

Motion: #1

Proposal:

1. MMRC Case Assessments and the original Maternal Mortality Review prepared by the Perinatal Center and Hospital will be returned to the Illinois Department of Public Health. (Charts from IDPH will be shredded to comply with the Medical Studies Act)
2. The Illinois Department of Public Health will return the MMRC Case Assessment and the original Maternal Mortality Review to the appropriate Perinatal Administrator under a “For Your Eyes Only” traced communication.
3. Follow-up communication will occur between the Perinatal Center and the hospital in a protected setting.
4. The MMRC’s role is to make the recommendation – not to receive further reports as to Perinatal Center/Hospital actions on the recommendations.
5. Starting in 2013, Case Assessments will be completed at the time of the meeting and sent to the Illinois Department of Public Health where they will be forwarded to the Perinatal Center under a “For Your Eyes Only” traced communication within three weeks of the meeting.

This proposal fits the process described by other states as discussed at the CDC. Many states have not yet made individual hospital recommendations from their MMR Committees. The Illinois MMRC will abide by the Illinois Medical Studies if this proposal is adopted and the Illinois Perinatal Rule does provide for protected reviews under the Morbidity and Mortality stipulations.

Pat Prentice moved approval of Motion #1, seconded by Shirley Scott. The motion was unanimously approved by the MMRC.

Nancy Martin discussed the current direct causes of maternal death and Obstetric Hemorrhage as a cause of death has declined. It was suggested that someone write this up, preferably someone from the Obstetric Hemorrhage Education team.

The most frequent current causes of death include those involving cases needing resuscitation and those with the diagnosis of pre-eclampsia and eclampsia

Discussion was held regarding about how the MMRC can educate around specific disease conditions. Cynthia Wong suggested there are ways to encourage improved ways of dealing with cardiac arrests during obstetric events.

Judith Hibbard suggested looking at all causes of death and define those that would benefit from education. She mentioned earlier diagnosis of cardiomyopathy.

MOTION #2: The MMRC will establish two workgroups to review Maternal Resuscitation and Pre-Eclampsia/Eclampsia. The recommendations of these workgroups will be brought back to the MMRC.

Cynthia Wong moved approval of the motion, Barb Prochnicki seconded. The motion was unanimously approved. Persons interested in participating in the workgroups are asked to e-mail Pat Prentice.

4. CDC/AMCHP Maternal Mortality Review Initiative Robin L Jones, MD

Robin Jones discussed the CDC Maternal Mortality Initiative Meeting March 19-12, 2013

The Meeting Focused on the following:

- ▶ Goal: Develop recommendations and standards to strengthen existing and guide development of new maternal death review processes within States
- ▶ Objectives: Document linkage process from data access to software and algorithms; document abstraction, review and recommendations that could serve as templates for all states; assess capacity and challenges for translating review into action and document examples of successful translation into public health improvements
- ▶ Currently 14 States and one City are participating as well as the CDC, ACOG, AMCHP, AWHONN, ASTHO, HRSA, Merck for Mothers, NAPHSIS and SMFM

The Expected Outcomes are:

- ▶ A “Best Practices” guide will be developed and made available to other entities starting a review process
- ▶ Existing state and city reviews could use the guidelines to strengthen their reviews
- ▶ Standardized information across reviews enables data to be assessed at regional and national levels
- ▶ Compilation of review findings successfully translated into actions that address common challenges experienced by reviews will be made available.

The CDC Guide for Maternal Mortality Reviews will be structured as follows:

- ▶ Introduction – an overview of state based maternal death reviews in the United States and the scope of those reviews
- ▶ Case Ascertainment – definition, data sources, vital records, data linkages, strategies and barriers to complete case counts
- ▶ MMR panel membership – who should be on a Maternal Mortality Review Committee
- ▶ Case Summaries – Data sources, Format and content
- ▶ Assessment of Preventability
- ▶ Evaluation and Recommendations
- ▶ Action implementation
- ▶ Appendices to include examples of

- State statutes or other vehicles that define maternal death
- Requirements for reporting, forms processes
- Data sources used and access to information
- Forms for presenting cases - abstracts
- Forms for assessing cause of death and preventability
- Process of recommendations

Illinois has made significant contribution to the process and future plans including:

- ▶ Illinois is advanced in many areas of Maternal Mortality Review as the Department of Public Health has accomplished the following:
 - A State Rule defining Maternal Death and mandating reporting and document production
 - A Maternal Mortality Review Committee defined by State Rule
 - Complex reporting and review forms with a data base to record results
 - Perinatal Regionalization mandates first level reviews and reports
 - An excellent structure (personnel) for determining accuracy in determining cases within the state and beyond
 - Recommendations from activities have resulted in complex educational processes and mandates for care supported by the Illinois Legislature

Robin Jones mentioned the response from the CDC and other states regarding the Obstetric Hemorrhage Education Project.

Paula Melone discussed the use of the OBHEP within Trinity health and offered to share the corporate project

5. MMRC Case Reviews and Recommendations

Trish O'Malley made a motion to close the meeting, Barb Prochnicki seconded. The meeting was closed at 12:09 pm.

Jerome Loew made a motion to open the meeting at 1:16 pm. Harold Bigger seconded.

The meeting was adjourned 1:20 pm.