IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
MATERNAL MORTALITY REVIEW COMMITTEE
October 8, 2014
10:30 a.m. – 1:00 p. m.
James R. Thompson Center
9th Floor, 031 Conference Room
100 West Randolph Street
Chicago, Illinois

Robin L. Jones, MD, Chairperson
Minutes

Chair: Robin L. Jones, MD

Attendees: Shirley Scott, Jerome Loew, J. Roger Powell, Nancy Martin, Kevin Madsen, Harold Bigger, Frank Nagorka, Michael Socol, Pat Prentice, Gary Loy, Joan Briller, Stacie Geller, Robert Gessner, Pat Schneider, Paula Melone, Deborah Boyle, Abby Koch

Absent: Cynthia Wong, Trish O'Malley, Robert Abrams, Brenda Jones, - all excused

IDPH Staff: Charlene Wells

Guests: Robyn Gude, Deb Rosenberg

1. **Review and Approval of Minutes- June 11, 2014:** The minutes were reviewed. Stacie Geller moved approval and Jerome Loew seconded the motion. The minutes were approved unanimously. Abby Koch was introduced as a new member of the MMRC. She works with the Center on Gender Studies at the University of Illinois School of Public Health.

2. MMRC Case Reviews and Recommendations All

Harold Bigger moved that the meeting be closed for review at 10:45, approved. Case review was done and a motion from Roger Powel and seconded by Nancy Martin opened the meeting at 1140 am

3. Resuscitation Task Force Members

Dr. Cynthia Wong initiated the task for as she saw the opportunity to improve the education around pregnancy related resuscitation. SOAP guidelines were circulated to the membership.

4. Maternal Mortality Review Forms Members

Brenda Jones was unable to attend the meeting but is in agreement that complete charts be mandated and that a statewide form and process be required for primary reviews

National standards are now suggesting that all maternal death cases should be reviewed by a physician. Members asked about cases deemed clearly unavoidable cases by clinical standards. Limited resources and a focus on clinical issues have limited the number of cases available for review in Illinois; however each case has a review by the Perinatal Center and a Maternal Mortality Review Form submitted.

Suggestion was that some reviews should be outside of the MMRC. Charlene stated we may need to expand our focus. State Legislators should have a report that is able to identify trends for all maternal deaths and categorize by disposition

Kevin Madsen stated that reviews need to focus on preventability and accountability when reporting to IDPH; trend analysis is our ultimate charge. Currently without a standard there is no requirement for abstracting and cases may come for first review with no documentation that the hospital or facility has done any oversight.

Robin L. Jones stated ideally we would review every case. Currently, we are not able to accomplish this and avoidable factors may be missed. Based on this mandate from the state we need to include cases deemed unavoidable on first review. The MMRC is only doing this in hemorrhage cases and those deemed amniotic fluid emboli cases at present.

Jerry Loew stated that hospital should be evaluating all maternal death reviews as sentinel events and review should be conducted with the proper depth.

Deborah Boyle noted that Perinatal Centers all have the ability to assure that abstracts are their responsibility.

The MMRC established a checklist to assure all data was presented to IDPH but this is rarely used. Standard abstracting practices, forms and conditions for review have been mandated by the PAC from the MMRC. This will require mandates from IDPH that the process must be employed. Formats may differ for homicide, suicide and accidents but all cases must be reviewed.

Brenda Jones will present some forms for consideration at the next meeting.

5. AAMCHP Every Mother Initiative Stacie Geller

Deb Rosenberg, Abby Koch. Brenda Jones Stacie Geller, Gary Loy Rob Abrams, Cindy, Mitchell, Rob Gessner and Nancy have all agreed to work on this Initiative.

The goal is to obtain this grant for 15 months under the auspices of the office of Women's Health at IDPH death to review "out of hospital deaths". Some of the non-clinical factors that will be examined include, Domestic Violence, Motor Vehicle Accidents, Substance Abuse, Suicide and Homicide.

The initial meeting for this project will be held in Oklahoma on November 18, 2014, Six states including, Florida, Oklahoma, Missouri, Illinois and Utah are involved

Preventability lectures with Megan Harper will be presented

Abby Koch indicated the process is designed to turn focus into action to determine how many of the "out-of-hospital" deaths are pregnancy associated. To date review forms have been geared toward the clinical factors. This grant will provide ways to reach out to the broader community to address the problem of Maternal Death.
State is looking for not just the non-clinical

Deb Rosenberg noted that Illinois and the MMRC is recognized as doing state of the art work. Maternal Health has risen to the CDC, AMCHP, and HRSA agenda. There is also going to be a focus on severe maternal morbidity. Illinois will be involved from many perspectives.

6. **OB Hemorrhage Competency Requirements - Robyn Gude**

Robyn Gude is the Chair of the Grantee Meeting and requested to be placed on the agenda to discuss the administrators concern about whether the same ten competency questions needed to be used every two year to fulfill the requirements of the Obstetric Hemorrhage Education project. Shirley Scott indicated that the questions are a good assessment of response and knowledge. but acknowledged that hospitals develop their won competencies according to their need

Paula Melone wants to adapt program the OBHEP stating it is becoming outdated. New concepts are coming in. Perinatal Educators are asking for the ability to update.

Hospitals need to retain the responsibility for the quality improvement process.

Stacie Geller noted that hospitals need to assure the retention of knowledge over time. The really important issue is "are we improving over time." Stacie is interested in the RRT team being up to date and proper assessment of hemorrhage severity,

The MMRC states that the following is included in addition to the two year competency requirement:

1. Movement to look at **all** patients who have transfusion of 4 units or more.
2. Every hospital has to go through team training at a certain frequency, including yearly drills and reviews

Michael Sokol, Kevin Madsen, Paula Melone, Pat Prentice, Shirley Scott and Stacie Geller will review the requirements and resources to update the program.

Dr. Sokol thanked Charlene Wells for all her work on behalf o the MMRC and the Perinatal Program and wished her the best of luck home to her and her family.

Motion to adjourn the meeting was presented by Stacie Geller and seconded by Deborah Boyle. The meeting adjourned at 1308.