MATERNAL MORTALITY REVIEW PROCESS

By Lori Rowe
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History and Progress

• HB 28 introduced to 2013 MT Legislature
  • Amend FICMR Act
    • Perform in-depth analysis of maternal deaths within 1 year of delivery.
    • Teams to include OB, FP, or PA who's duties include obstetrical care
  • Passed January 31, 2013
  • Law effective October 1, 2013

• Developed MMR Workgroup
  • 12 Members (County Health, ACOG Reps, DPHHS Staff)
  • Develop reporting form and policies
  • Continue to meet 2x’s year
    • Review MMR cases
    • Make prevention recommendations
How Many Maternal Deaths does Montana Encounter Annually?

- Average about 12-15 deaths per year
  - Small/Medium counties
  - Large counties may encounter more deaths
- 2003-2009 Maternal Deaths
  - 41% attributed to indirect or direct obstetric causes
  - 59% are not attributed to a medical condition thought to be pregnancy related
  - 23% Motor Vehicle Crashes
How is Maternal Mortality going to coincide with the Child Death Reviews?

• Use current child death review team
  • Include OB, Family Practice MD, or PA with obstetric duties when reviewing maternal death.
    • Recommend becoming a core member for child reviews.
  • Incorporate MMR case when scheduling child death review meeting

• Monthly Death List
  • Separate child and maternal list
  • Encouraged to find maternal deaths
  • May not see any change
    • Vital stats is about 90 days out

• One year to complete reviews and submit cases
  • Deaths from Oct 1, 2013 through December 31, 2013 will be due by December 31, 2014.
  • Six cases identified for 2013
  • One case so far for 2014
Montana Maternal Mortality Review Process

- MMR questionnaires will be prepopulated
  - Maternal Death Certificate
  - Birth Certificate (when available)
    - Child may be born out of MT

- Report form will be sent in a secure email or by postal service, along with the maternal death certificate.
  - Infants birth or death certificate will be included when available.

- Medical deaths will be reviewed by county of residence.
  - May have to request records outside of county
  - Collaboration efforts

- Intentional or unintentional deaths will be reviewed by the county where death occurred.
Montana Maternal Mortality Review Process Continued

- Teen Pregnancy Death use the MMR form.
- Unique cases, State Coordinator will decide which county will complete review.
- MMR completed cases need to be returned to the State FICMMR Coordinator.
  - Keep copy of case review in a secure locked cabinet or electronic file.
  - Data entry will be done at the department.
    - MMR case reviews may not be entered into the CDR.
    - Missing information letters
- MMR Case Review Reporting form posted on FICMMR Website.
Local Coordinators need to continue to look for deaths.
- Ascertainment: State/Community
- Skip Logic Applied
- Section B and C Teen Related Death
- Case reporting form can be completed electronically
- Returned electronically thru E-Pass or mail.
- Must be legible
- E-Pass [https://transfer.mt.gov](https://transfer.mt.gov)
QUESTIONS?

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