Illinois Maternal Mortality Review Committee Review of Purpose and Process

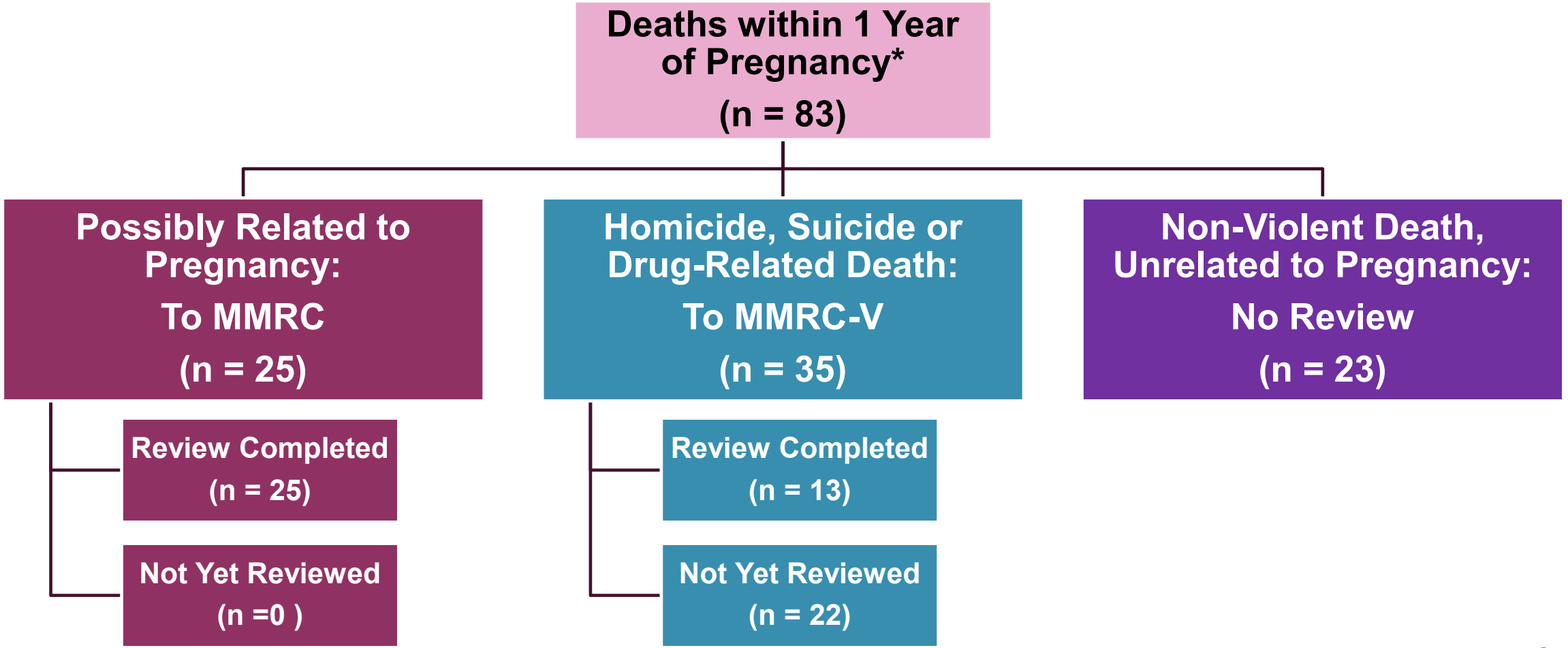
Illinois Department of Public Health

May 2021

Vision & Purpose of MMRC and MMRC-V in Illinois

- **Vision:** Eliminate preventable pregnancy-associated deaths in Illinois
- **Scope of Case Reviews:**
  - MMRC reviews medical deaths that are potentially related to pregnancy
  - MMRC-V reviews deaths due to homicide, suicide, or drug-related causes
- **Purpose:** Determine contributing factors to maternal mortality and identify potential interventions to prevent future maternal deaths

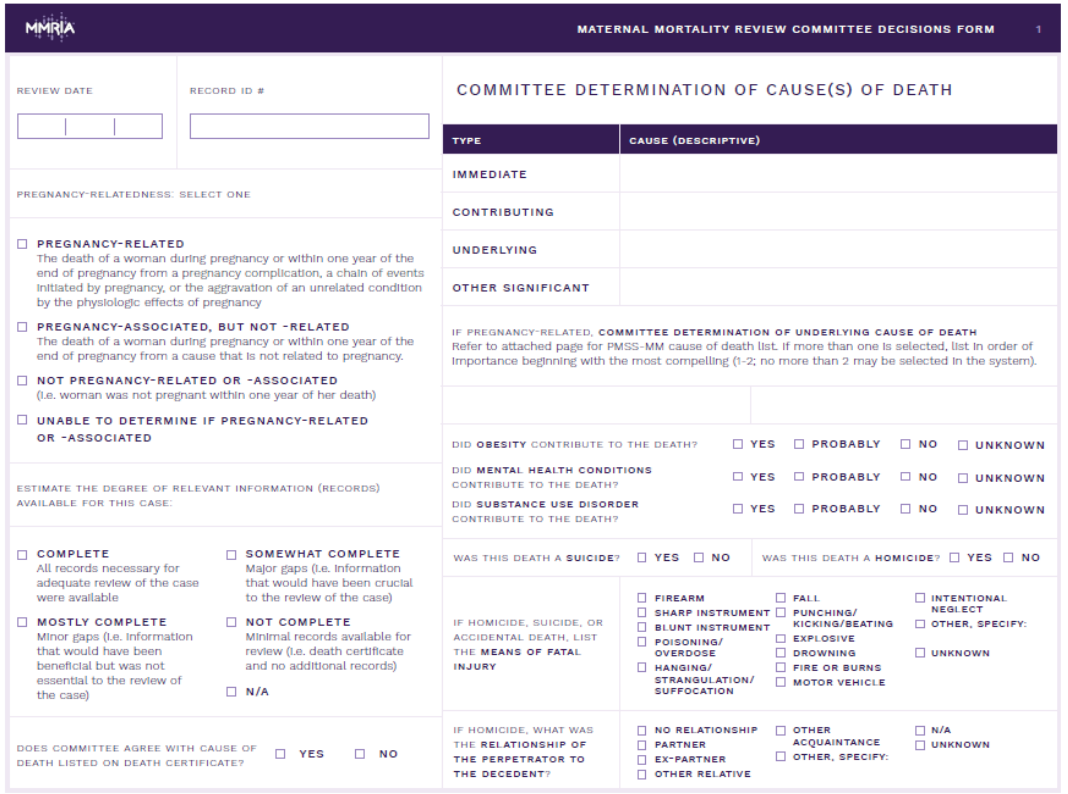
2018 Illinois Case Review Progress *(as of 5/11/2021)*



* *Illinois residents only*

MMRIA Committee Decision Form

1. What was the **cause of death**?
2. Was the death **pregnancy-related**?
3. Was the death **preventable**?
4. What **factors contributed** to the death?
5. What are **recommendations** to prevent future deaths?



MMRIA — MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM 1

REVIEW DATE

RECORD ID #

PREGNANCY-RELATEDNESS: SELECT ONE

- ☐ PREGNANCY-RELATED — The death of a woman during pregnancy 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
- ☐ PREGNANCY-ASSOCIATED, BUT NOT -RELATED — The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy.
- ☐ NOT PREGNANCY-RELATED OR -ASSOCIATED (i.e. woman was not pregnant within one year of her death)
- ☐ UNABLE TO DETERMINE IF PREGNANCY-RELATED OR -ASSOCIATED

ESTIMATE THE DEGREE OF RELEVANT INFORMATION (RECORDS) AVAILABLE FOR THIS CASE:

- ☐ COMPLETE — All records necessary for adequate review of the case were available
- ☐ SOMEWHAT COMPLETE — Major gaps (i.e. information that would have been crucial to the review of the case)
- ☐ MOSTLY COMPLETE — Minor gaps (i.e. information that would have been beneficial but was not essential to the review of the case)
- ☐ NOT COMPLETE — Minimal records available for review (i.e. death certificate and no additional records)
- ☐ N/A

DOES COMMITTEE AGREE WITH CAUSE OF DEATH LISTED ON DEATH CERTIFICATE? ☐ YES ☐ NO

COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH

TYPE	CAUSE (DESCRIPTIVE)
IMMEDIATE	
CONTRIBUTING	
UNDERLYING	
OTHER SIGNIFICANT	

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH
Refer to attached page for PMSS-MM cause of death list. If more than one is selected, list in order of importance beginning with the most compelling (1-2; no more than 2 may be selected in the system).

DID OBESITY CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

DID MENTAL HEALTH CONDITIONS CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

DID SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

WAS THIS DEATH A SUICIDE? ☐ YES ☐ NO

WAS THIS DEATH A HOMICIDE? ☐ YES ☐ NO

IF HOMICIDE, SUICIDE, OR ACCIDENTAL DEATH, LIST THE MEANS OF FATAL INJURY

- ☐ FIREARM
- ☐ SHARP INSTRUMENT
- ☐ BLUNT INSTRUMENT
- ☐ POISONING/ OVERDOSE
- ☐ HANGING/ STRANGULATION/ SUFFOCATION
- ☐ FALL
- ☐ PUNCHING/ KICKING/BEATING
- ☐ EXPLOSIVE
- ☐ DROWNING
- ☐ FIRE OR BURNS
- ☐ MOTOR VEHICLE
- ☐ INTENTIONAL NEGLECT
- ☐ OTHER, SPECIFY:
- ☐ UNKNOWN

IF HOMICIDE, WHAT WAS THE RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT?

- ☐ NO RELATIONSHIP
- ☐ PARTNER
- ☐ EX-PARTNER
- ☐ OTHER RELATIVE
- ☐ OTHER ACQUAINTANCE
- ☐ OTHER, SPECIFY:
- ☐ N/A
- ☐ UNKNOWN

1. What was the cause of death?

- **Underlying Cause of Death** is the most important cause to determine
  - The disease or injury which initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury

CAUSE OF DEATH (See instructions and examples)

32. **PART I.** Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition ---------> resulting in death)	a.	Multisystem Organ Failure
		Due to (or as a consequence of):
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**	b.	Disseminated Intravascular Coagulopathy
		Due to (or as a consequence of):
	c.	Postpartum Hemorrhage/ Status Post Cesarean Section
		Due to (or as a consequence of):
	d.	

2. Was the death pregnancy-related?

- The death of a woman during pregnancy or within one year of the end of a pregnancy from:*
  1. **A pregnancy complication**
  2. **A chain of events initiated by pregnancy**
  3. **The aggravation of an unrelated condition by the physiologic effects of pregnancy**

- **Shortcut: *If she had not been pregnant, would she have died?***

Change in Review Process

- If the death is **not** pregnancy related, the committee will **not** move on to recommendations
  - Focus on pregnancy-related deaths
  - Standardizes process with MMRC
  - Best use of meeting time

3. Was the death potentially preventable?

- A death is considered “preventable” if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors
- If the death is NOT preventable, then there are no contributing factors or recommendations are identified

4. What factors contributed to the death?

- Identify factors at various levels
  - Patient / family
  - Provider
  - Facility
  - System
  - Community
- The CDC committee decision form defines factor themes
- We record the theme and the details of how that theme was evident in the case
- *Example:*
  - Facility Factor: Delay.
  - Details: There was no OB available in the hospital to see her right away, had to wait 90 minutes for provider to arrive.

5. What are recommendations that could have averted her death (and future deaths from similar factors)?

- Each recommendation should be tied to a specific contributing factor
  - *PROCESS*: Identify one contributing factor and then discuss recommendations to address it
- Recommendations do not need to be directed to the same level or actor as the contributing factor

- Recommendations should target a variety of actors, including:
  - Providers
  - Facilities
  - Payers
  - State Agencies & Programs
  - Community-Based Organizations
  - Women & Their Families and Friends

Prioritization of Recommendations

How feasible is the recommendation to implement?

How many people will be impacted?

What is the prevention level?

What is the expected impact level?

Prioritization of Recommendations

- Recently, there have been 20-30 recommendations per case
  - Loss of importance in which recommendation would have made the most change
  - Lack of specificity in what would have best prevented the death

- No limit to recommendations, but:
  - What recommendation would have most likely prevented this death?
  - What recommendations are **most** applicable in the case?
  - Look at past recommendations and identify those that make the biggest influence
  - Many recommendations may apply to a lot of cases, but which best address causes for certain cases

Identifying Case Examples

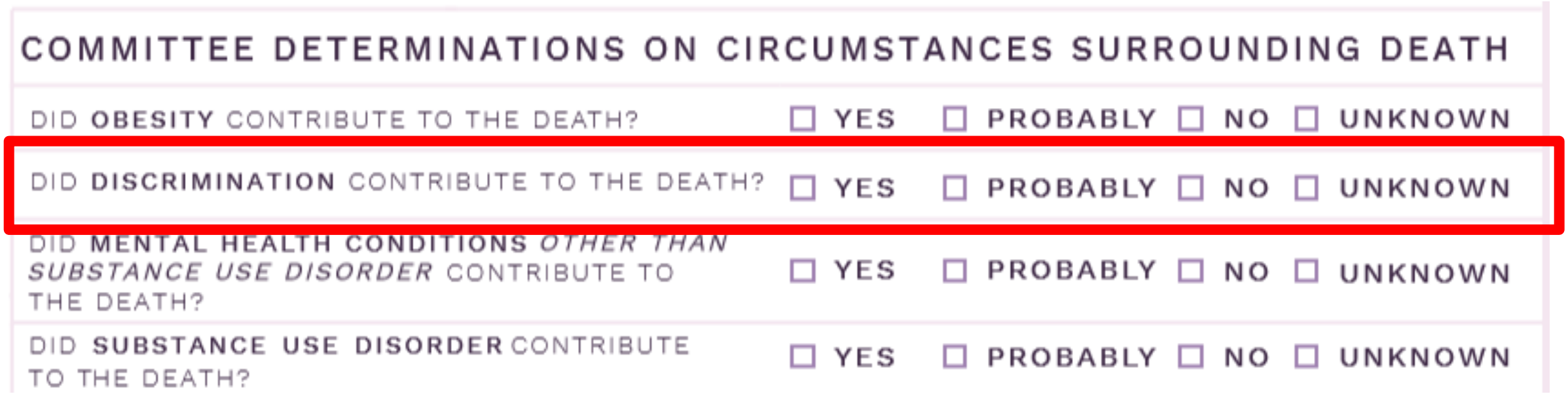
- Please identify cases that are good examples for:
  - illustrating the broad factors that contribute to maternal mortality
  - clinical teaching purposes

- We will consider using these case examples when we develop state reports, presentations, or training materials

Considerations for Case Reviews

- Use “unable to determine” sparingly
  - Especially for the determination about relation to pregnancy
  - Seek consensus, but if there is not 100% agreement, consider majority vote
- If it is not documented, assume it did NOT happen
- Acknowledge uncertainty, but don’t let it hinder decision-making

Reminder: Addition of Discrimination & Racism



COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH

DID **OBESITY** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **DISCRIMINATION** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **MENTAL HEALTH CONDITIONS** *OTHER THAN SUBSTANCE USE DISORDER* CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **SUBSTANCE USE DISORDER** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN

- This question will now be part of standard review process for every case
- We will take notes about type/form of discrimination (if identified)

Reminder: Addition of Discrimination & Racism

- 3 new categories have been added to list of potential contributing factors
  - Discrimination
  - Interpersonal Racism
  - Structural Racism
- These contributing factors can be identified at any of the various levels we usually discuss (*e.g., patient, provider, facility, system, community*)

“Discrimination” is Intentionally Broad

- Race/Ethnicity
- Culture/Religion
- Citizenship
- Primary Language
- Age
- Marital Status
- Weight Status
- Pregnancy/Abortion History
- Mental Health Condition
- Substance Use Disorder
- Income
- Education
- Gender
- Sexuality
- Disability
- Housing status
- Occupation
- *and more…*

Potential Situations Indicating Discrimination or Racism*

- Negative interactions between patient and provider/facility
- Documentation of “non-compliance”
- Leaving against medical advice
- Lack of cultural humility
- Excessive gatekeeping (*inability to reach provider*)
- Treatment decisions inconsistent with best practice
- Indicated labs are not ordered or are delayed
- Repeated visits to ED for care in short time frame
- Lack of access to care across the life course

* *List developed by Texas MMRC; Presented during CDC ERASE-MM webinar on April 27, 2020*

Our Path Forward in Identifying Potential Discrimination

- Discrimination and racism will almost never be recorded in a medical chart
- We will need to “read between the lines” in patient-provider interactions and social context
- This discussion may feel very uncomfortable at first
  - Please allow those with more experience in identifying and calling out discrimination to lead conversation
- Reminder -- the goal is not to label a provider as “racist” or “biased”, but to link to the broader MMRC purpose:
  - Document factors impacting maternal health and mortality
  - Identify prevention opportunities
  - Create actionable recommendations