Draft Maternal Mortality Review Committee (MMRC) Decision Brief

January 5, 2020

Issue Definition: Provide a high-level statement on the issue that is trying to be solved

The Montana Department of Public Health and Human Services (DPHHS) must decide whether to create a Montana-based Maternal Mortality Review Committee (MMRC) or join a regional MMRC with Utah and Wyoming.

Executive Summary: Input relevant information, history, regulation, context.

The Health Resources and Services Administration (HRSA) Maternal Health Innovation (MHI) program that funded the Montana Obstetrics and Maternal Support (MOMS) program requires coordination with a MMRC. The federal program also requires coordination with a Perinatal Quality Collaborative (PQC), informed by the work of the MMRC and collaborating with MOMS. Currently, Montana does not have a MMRC.

MMRCs are multidisciplinary committees that perform comprehensive reviews of deaths of women during a pregnancy or within a year of the end of a pregnancy. They include representatives from public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental and behavioral health, patient advocacy groups and community-based organizations. The Centers for Disease Control (CDC) works with MMRCs to improve review processes that inform recommendations for preventing deaths.

Maternal death reviews in Montana are currently done at the county level by the Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) teams, authorized by Montana statute (MCA 50-19-401 to 406): the Fetal, Infant, Child, and Maternal Mortality Prevention Act. These county teams conduct death reviews with limited resources, with limited expert consultation and challenges accessing and effectively organizing data to determine whether the death was related to pregnancy; if it could have been prevented; factors that contributed to the death; and recommendations to prevent future deaths. In order to achieve MOMS objectives to elevate maternal health as a priority issue in Montana and to collect and analyze maternal health data, aligning multiple datasets, a more comprehensive state-level death review is necessary.

MOMS program staff, including the Title V Maternal and Child Health Block Grant Director, MOMS Program Specialist and MOMS Medical Director have been researching and consulting with other states and national experts on the details of both options. Some MOMS staff observed a UT-WY MMRC meeting to learn their process. MOMS staff has also consulted with the Utah and Wyoming Departments of Health and experts at the Centers for Disease Control (CDC). The CDC recommends that if a state opts to develop their own state MMRC, that a nurse abstractor be hired. The nurse abstractor plays a pivotal role identifying maternal death cases and accessing any number of records, i.e. decedent's medical records; motor vehicle reports;

etc., pertaining to the maternal death. The records are used to ascertain the preventability of the maternal death.

Wyoming has partnered with Utah on the CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant, whereby, Wyoming participates on Utah's MMRC. Wyoming hired their own nurse abstractor, a Certified Nurse Midwife, to do their own case identifications and abstractions. Wyoming staff review their cases and then the Utah MMRC reviews them twice a year.

It is important to note that Wyoming has approximately five to ten maternal deaths that occur among about 9,000 births per year. Montana averages 10 deaths per year among about 12,000 births per year. Also, Wyoming does not have any maternal-fetal medicine specialists or level three birthing facilities; whereas Montana has nine maternal-fetal medicine specialists and six level three birthing facilities. Therefore, Montana is positioned to consider creating a Montana MMRC.

Identification of Alternatives: Provide the options the decision maker could consider as a possible solution

Option 1 – Join the regional UT-WY MMRC.

Option 2 – Create a Montana MMRC.

Comparison of Alternatives: Provide the benefits and risks of each of the options described above, detailing if there are potential political, fiscal or other implications as well.

Option 1– Join the regional UT-WY MMRC.

Risks

- Less of an opportunity to forge relationships among maternal healthcare providers in Montana around maternal death prevention.
- More difficult to ensure a timely feedback loop of death data review into prevention recommendations to inform clinical care – Montana providers would be less engaged.
- Without ownership of a Montana MMRC, the entity could have less of a driving force in elevating maternal health significance for MOMS, PQC and other maternal health initiatives.

Benefits

- The experience of Utah, as they have been doing MMR since 1995 with one staff person abstracting 80-100 charts per year and running meetings to review their maternal deaths.
- Utah's expanded resources of the ERASE grant that has enabled them to hire an MMR coordinator to support their abstractor, as well as an epidemiologist. The increased capacity has allowed them to focus more on getting prevention recommendations out to the clinical community.

- Consultation on Montana maternal death reviews by specialists not available in Montana, such as an obstetrician-gynecologist with board certification in maternal-fetal medicine and addiction medicine, as well as work in psychiatry.

Option 2 - Create a Montana MMRC.

Risks

- Timing is an issue because work with an MMRC should have begun in year one of the MOMS program that ended September 29, 2020. Establishing the governance, infrastructure, training and resources for our own MMRC could take longer than joining a regional MMRC. It could also delay the goal of enrolling in the Alliance for Innovation in Maternal Health (AIM) in the spring 2021 cohort, which requires an established MMRC.
- Sustainability is a concern because staffing and support will be funded by MOMS now, but another revenue stream for the MMRC will need to be determined before the end of the MOMS five-year grant period, ending September 29, 2024.

Benefits

- A Montana-based MMRC would have greater synergy with the MOMS Leadership Council and PQC than a regional MMRC would with these state-based entities.
- Montana providers and community members at the table for death reviews keeps the data feedback loop into clinical care prevention recommendations more efficient and effective.

Additional Notes:

- Either option would require MT DPHHS to hire or contract with a nurse abstractor. Based on consultation with Wyoming staff and resources on www.reviewtoaction.org the estimated annual cost of a nurse abstractor is $14,600. This estimate is based on 15 deaths per year, training in the CDC's Maternal Mortality Review Information Application (MMRIA), the CDC's abstraction and case review time cost estimator and a $50 an hour salary.
- The option 2 – Montana MMRC's additional staff support for the committee would be provided by existing MOMS and FICMMR staff.

Recommendation: Provide and describe the option that the submitter of this decision request would recommend as the best solution to the issue.

Based on the background and analysis above and the feedback from stakeholders below, MOMS program staff recommends option two, create a Montana-based MMRC.

Feedback from MOMS Maternal Health Leadership Council:

This brief was presented at a council meeting and followed with questions, discussion and a recommendation vote.

- **Dr. Tersh McCracken (council chair, MOMS medical director, Billings Clinic)** – A partnership with Utah is not what was perceived and would still require nearly as much effort as if we did it on our own. MMRC is vital to the work we do on maternal health as a state, it is how we take our temperature, learn from our mistakes and find our gaps in care. We are trying to get a large Region 8 platform for MMRCs to compare data. For example, New Mexico may come up with around 200 recommendations based on 20 deaths in a year. ACOG could possibly provide support/funding for the ongoing sustainability of a MT MMRC and push the state to do so as well. Fully support a Montana MMRC.
- **Brie Maclaurin (Executive Director, Healthy Mothers, Healthy Babies**) – With a small number of deaths we could learn more from other states in the regional model but if it is state specific, we could apply the prevention factors more easily.
  - Dr. McCracken responded that the two are not mutually exclusive – we could conduct the case abstraction and review at the state level and then still collaborate regionally with other states through ACOG and other platforms like the CDC.
- **Brie Maclaurin** – Do many patients get transferred to Utah for care?
  - **Vicki Birkeland (Women and Children's Service Director at St. Vincent's)** – those that do are transferred for severe fetal complications rather than maternal and even those are very few.
  - Dr. McCracken agreed.
- **Vicki Birkeland** – We could start it on our own and if we struggle, then go back to Utah. If the timeline is an issue, which option would get us there more quickly?
  - Dr. McCracken – equivocal or we could get there more quickly on our own. We aren't going to get this perfect on our first try. The advantage of doing it on our own is getting more Montana professionals engaged in the MMR process and have a more heightened awareness of MMR in the state.
- **Olivia Riutta (Outreach and Engagement Manager at Montana Primary Care Association)** – I like Dr. McCracken's point about getting more Montana professionals involved if we build it in Montana, specifically for involving IHS. Indian Country needs to be represented due to the disproportionate amount of deaths.
- **Karen Cantrell (American Indian Health Director/DPHHS)** recommended reaching out to Bryce Redgrave (IHS Director) because he is very willing to work with us and it would be important to get him involved on the MMRC.
  - Rocky Mountain Tribal Epidemiology Center works with IHS on data and there needs to be a separate discussion with them on this.
- **Dr. Tersh McCracken** – a good MMRC needs to be multi-disciplinary and representative.
- **Vicki Birkeland made a motion for Montana to create its own MMRC; multiple people seconded the motion and it passed unanimously.**

Feedback from county FICMMR teams:

After sharing this brief with the 51-local county FICMMR leaders at their quarterly December 9, 2020 training, they were asked for their feedback on the phone and via a follow-up email. Our responses may have been limited because many counties have never had a maternal death and their increased work related to the COVID-19. The following is a summary of their comments that were received:

- **Marianne Saylor of Powell County** - I suppose it really doesn't matter which direction we go with the Review Committee. I worry about the loss of control and also Montanans value our autonomy. On the other hand, their experience could be valuable-if we joined could we pull out later?
- **Anne Jackson of Ravalli County** - I reviewed the draft you sent out regarding the MMCR and at this point I would recommend we go in with the regional effort.
- **Esther Wynne of Big Horn County Public Health** – Big Horn County will be very happy to have a statewide committee to review maternal mortalities.
- **Sue Hansen of Beaverhead County Public Health** - I feel Option II would be the most beneficial for our state as our experts and locals are knowledgeable about our communities and would provide more specifics and local “know” about cases. Sustainability is always a risk to take when forming a new program so that is a concern.
- **Frances Hayes of Roosevelt County Health Department** - My thought process was related to when recommendations are made to prevent these deaths, it would be important for the process to include recommendations that are meaningful to the populations they are intended for. With that being said, Native Americans are going to respond to each recommendation differently dependent on the cultural teachings present on the reservation in which they live. I am not sure if I am saying this right. I am Native American and as an example an owl is an omen of death in my culture. In a different culture it may (and does) represent something else entirely. So if there was a recommendation for an advertisement in which an owl was used as a symbol or “spokesperson” that would not be meaningful or appropriate for me. Which is why my chosen option would be 1. It is not so much related to the review process as is it the recommendations that come from the process.
- **Kathy Helmuth of Richland County** and a member of the initial Maternal Mortality Review Committee - I am in favor of Option 2, a MT MMRC team. I am concerned about the sustainability for either option, as both are grant dependent. Thank you for the opportunity to give our opinions. It appears to me that the MMRC is required, so it has to be done in some way as quickly as possible. That being said, between the two options that were presented, my preference is Option 2 to create a Montana MMRC. Candidly, this is mainly because I was raised an independent Montanan and I worry about losing our voice or diluting our data if we join with the UT-WY MMRC. I do not see Utah as a state that shares our demographics and challenges. As for the risk related to timing to establish an MMRC, are there not templates we can borrow or steal to speed up the

establishment of our state's own MMRC? I'm all about not reinventing the wheel. Can we utilize any of the work done in the past few years by the state mortality review committee we had going? Another question I had is regards to weighing the pros and cons. Under option 1, it is mentioned that because of the ERASE grant that Utah has, that would help increase output and hopefully impact. There's no mention of sustainability in that option. In option 2, one of the risks is related to the MOMS grant time period and sustainability is a concern. Let's compare apples to apples. How long is the ERASE grant? Is sustainability not a concern there as well? IF not, why not? I'm trying to understand and evaluate both options. Those are my notes I had made on the draft we were provided. Thank you for your time and consideration.