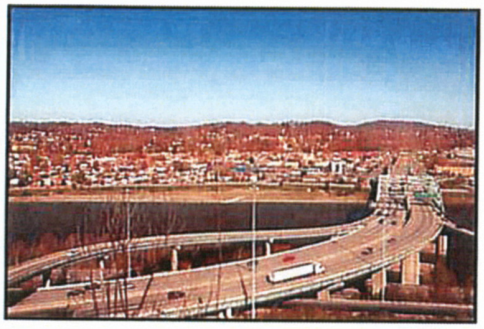
West Virginia Maternal Mortality Review




December 2009

WEST VIRGINIA Department of Health Human Resources

West Virginia Maternal Mortality Review Team
350 Capitol Street, Room 427
Charleston, WV 25301

Joe Manchin III, Governor
Patsy Hardy, Cabinet Secretary

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Membership

The Maternal Mortality Review Team (MMRT) is multidisciplinary with representatives from medical specialties and public health. Members of the Review Team receive no monetary reimbursement, not even travel. The Case Review Team first met in July 2009 and was provided a manual containing the Code, Legislative Rules, confidentiality agreements and other pertinent documents. Following is the list of current MMRT members:

Michael Adelman, DO, JD
VP Academic Affairs/Dean
West Virginia School of Osteopathic Medicine

Luis A. Bracero, MD, FACOG
(Designee for: Fernando Indacochea, MD)
West Virginia Chapter
American Academy of Pediatrics

James Brick, MD, Interim Dean
Robert C. Byrd Health Sciences Center

Jeff Bowles, Director
Child Fatality Review Team
Office of the Chief Medical Examiner

Stephen Bush, MD, Director
Department of Obstetrics and Gynecology
CAMC Women and Children's Hospital

David G. Chaffin, Jr., MD
Associate Professor and Director
Maternal Hypertension Center
Department of Obstetrics and Gynecology
Joan C. Edwards School of Medicine

Chris Curtis, MPH, Acting Commissioner
Bureau for Public Health

Renee Domanico, MD
(Designee for: Joe Werthammer, MD)
University Pediatrics
Marshall University Medical Center

Brenda Dawley, MD
West Virginia Chapter
American College of Obstetrics and Gynecology

James A. Kaplan, MD, Chief Medical Examiner
Office of the Chief Medical Examiner

Stefan Maxwell, MD, Director
Neonatal Intensive Care Unit
CAMC Women and Children's Hospital

Charles McKown, Jr., MD, Dean
Joan C. Edwards School of Medicine

Pat Moss, Chair, MMRT
Director, Office of Maternal, Child and Family Health

Pam Neal, RN, MSN-NA, CFNP, President
West Virginia Nurses Association

Angelita Nixon, CNM
West Virginia Chapter of the American College of Nurse Midwives

Giovanni Piedimonte, MD, Chair
Department of Pediatrics
WVU Robert C. Byrd Health Sciences Center

Mark Polak, MD, Chief
Neonatology Section, West Virginia University

Linda Savory, MD
West Virginia Academy of Family Physicians

Victoria Shuman, DO, President
West Virginia Society of Osteopathic Medicine

Mary Beth Stewart, RN, BSN
Clinical Manager of Obstetric Department
St. Mary's Medical Center

Michael L. Stitely, MD
WVU Department of OB/Gyn
(Also Representing WV State Medical Association)

Gary Thompson, State Registrar
Alternate: Brandy Byrnside, Deputy State Registrar
Vital Registration

Gerry Thompson, RNC
Nurse Manager, Labor and Delivery
Cabell Huntington Hospital

STAFF:
Annette Roberts, RN
Office of Maternal, Child and Family Health

Legislation

The West Virginia Legislature passed Senate Bill 234 on March 6, 2008. The bill established the expectation for a formalized review of maternal deaths by a team of experts, as listed in §48-25A. Maternal deaths subject to review are those who died during pregnancy; at time of birth; or within one year of the birth of the child from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes.

Purpose

West Virginia's Maternal Mortality Review Team reviews all pregnancy-related maternal deaths in West Virginia and develops recommendations to reduce those deaths. The review is conducted to understand the causes of maternal death. The results of these reviews will be used to make recommendations in practice and public policy to improve systems of care for women.

Statistics

Each year in the United States 1,000 women die of pregnancy-related complications, making such deaths relatively uncommon. In West Virginia, the number of maternal deaths attributable to medical conditions is small, as reflected below with death reviews completed for 2007 and 2008 occurrences.

Year	Maternal Deaths	Births
2004	1	20,911
2005	5	20,834
2006	5	20,931
2007	5	22,017
2008	6	20,914

Maternal deaths occurring in 2004, 2005, and 2006 are not subject to review under the legislation. These numbers do, however, establish a historical portrayal of maternal death occurrences in West Virginia.

Case Review

Team members identify factors that contributed to the death and discuss strategies for interventions and prevention. Contributing factors include the availability and accessibility of services, transportation issues, patient non-compliance or delay in seeking care, mental illness, substance use and abuse, and partner violence. The MMRT also explores the availability and effectiveness of treatment, referral and follow-up, adequacy of patient education, and continuity of care. As of December 31, 2009, the MMRT has conducted three meetings.

Case Abstraction Process

Abstraction forms capture information from medical and social history, prenatal, labor and delivery, postpartum, and terminal event records (ER for example). Cases are selected at the State level, and the Project Coordinator, who is a registered nurse, obtains information from data sources. All authority to access information for the review is based on West Virginia Code §47-25A. Once information is gathered, all identifiers are removed; names of health practitioners, facilities, and patients are not included. These de-identified records are shared with reviewers along with a summary of findings. All case specific information is kept strictly confidential. All Review Team members sign confidentiality statements.

Reporting

The process for obtaining information, confidentiality protections, and specific information about patient education levels, access to and initiation of care, etc. has been established. Due to the small number of maternal deaths in a single year, the MMRT will report full detail of findings and recommendations for policy and practice changes after review of all maternal deaths that occurred in 2007, 2008, 2009, and 2010. This multiple year study will increase the number of pregnancy-related deaths available for analysis. The aggregation of data provides a means of identifying the causes of death and enhances the MMRT's ability to recommend interventions in practice and/or policy. The recommendations from the MMRT will be included in the report submitted December 31, 2011.