Montana Department of Public Health and Human Services Public Health and Safety Division Family and Community Health Services Bureau



Progress Report to the Children, Families, Health and Human Services Interim Committee Implementation of HB 28 Maternal Mortality Review

The Fetal, Infant, and Child Mortality Review (FICMR) Program began the process of implementing the requirements set forth in HB 28 to incorporate the review of maternal deaths into the established infant and child death review process (50-19-401 through 50-19-406 MCA). No funding was authorized for implementation of HB 28. HB 28 went into effect October 1, 2013.

The FICMMR (Fetal, Infant, Child, and Maternal Mortality Review) statue allows local counties to create their own FICMMR Review Teams or, in counties with smaller populations, they may collaborate with a neighboring county. As of June 1, 2014 Montana has 27 local FICMMR teams.

Montana averages about 12-15 maternal deaths per year. From October 1, 2013 through December 31, 2013, Montana had six maternal deaths. In 2014, one maternal death has been reported so far.

Progress:

- July to September 2013: DPHHS staff convened meetings to discuss an implementation workgroup that would assist in developing roles and processes for DPHHS, local review teams, and workgroup members.
- November 2013: DPHHS established a Montana Maternal Mortality Review (MMR)
 Workgroup consisting of 12 individuals that represent the Montana Chapter of the
 American Congress of Obstetricians and Gynecologists (ACOG), Lead FICMMR
 Coordinators from County Health Departments, the State Medical Officer, the State
 Epidemiologist, and program staff.
- **December 16, 2013:** Initial meeting of the MMR Workgroup. Discussions included review of 50-19-401 through 50-19-406 MCA, relevant program policies and procedures, and a maternal mortality case review form.
- January 13, 2014: The MMR Workgroup discussed the first draft of the maternal mortality case review reporting form and finalized policies and procedures.
- March 2014: The DPHHS FICMMR Coordinator provided a presentation about the progress of Maternal Mortality Review implementation to the county health departments and local county FICMMR coordinators.

 May 8, 2014: Second formal MMR Workgroup meeting conducted a mock review of six recent maternal deaths, finalized the MMR case review reporting form and discussed the MMR Workgroup's ongoing role and future meeting schedule. The workgroup will meet twice a year to review the local FICMMR Team's MMR case reviews and provide prevention recommendations that could be implemented at the state and local levels.

Implementation Plan with the FICMMR Local Teams:

- June 2014: Implement and train local FICMMR Teams on MMR process.
- June to December 2014: Local FICMMR Teams will review maternal mortality cases that occurred from October 1, 2013 to December 31, 2014. The MMR Case Report Form is due to the State FICMMR Coordinator by December 31, 2014. The MMR Workgroup will be available for technical assistance.
- Fall 2014: Schedule a formal meeting with MMR Workgroup to discuss the progress of the 2013 MMR reviews and include discussion regarding any changes with process, policy, or MMR Case Reporting form.

Future Outcomes:

- DPHHS will convene MMR Workgroup meeting every six months to review cases and discuss prevention recommendations at the state and local levels.
- The FICMMR program will develop a report about the data findings and prevention recommendations that will be presented to DPHHS, the MMR Workgroup, local FICMMR Coordinators, FICMMR team members, and stakeholders.
- DPHHS will continue to provide education and technical assistance to local FICMMR coordinators and team members as needed.

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