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### **Maternal Mortality Review Launches in Kansas**

Review committee begins work to address maternal and pregnancy-associated deaths

**TOPEKA** – Pregnancy is often a positive experience filled with joy and anticipation. For some families, this exciting time turns tragic. Miscarriage and still births are one form of tragedy, but also there is an increasing trend of maternal and pregnancy-associated deaths in our state. In 2017, there were 17 pregnancy-associated maternal deaths reported in Kansas. Today, KDHE Secretary Jeff Andersen is pleased to announce that to address this issue, KDHE has launched the Maternal Mortality Review (MMR), which includes a review committee.

“We have been focused on implementing comprehensive review of maternal and pregnancy-associated mortality for some time and look forward to working closely with partners, women and families to learn more about how to prevent these events,” said Rachel Sisson, MS, Bureau of Family Health Director, KDHE. “We want to thank all of our partners for supporting development along the way, especially the American College of Obstetricians and Gynecologists (ACOG) Kansas leadership who was instrumental in furthering legislation needed to strengthen the process and position Kansas for this important work.”

Other project partners include the March of Dimes and other experts who represent various disciplines from across the state.

Approximately half of states in the U.S. have a comprehensive maternal mortality review process, the gold standard for maternal and pregnancy-associated death surveillance. As part of the process, a review committee gathers extensive information about each individual case of maternal death and synthesizes information to determine if the death was preventable and what specific and feasible actions, if implemented or altered, might have changed the course of events. Committee membership

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includes a vast array of professionals and partners engaging with and serving women during pregnancy and the year postpartum. Collectively, they will examine patient/family, community, provider, facility and system factors that led to a woman's death. More information about the maternal mortality review process is available online at [www.reviewtoaction.org](http://www.reviewtoaction.org), a portal provided by national partners with many valuable resources for states.

The MMR Committee convened for the first time on June 12. KDHE Bureau of Family Health and a team from the Centers for Disease Control & Prevention (CDC) provided information to the committee on the importance of conducting maternal and pregnancy-associated death reviews to prevent future cases and oriented them to their new role as a member. The committee completed a mock case review. The first full meeting to review 2016 Kansas death cases will be held in November 2018.

**About the Kansas Department of Health & Environment, Bureau of Family Health**

The KDHE Bureau of Family Health is responsible for administering the Title V Maternal & Child Health (MCH) Block Grant Program which involves monitoring, researching and evaluating health status and conducting activities to identify and address community health problems. Within the population of women of reproductive age, maternal mortality is an indicator monitored by the department, pursuant to K.S.A. 65-177. The Title V MCH program plays a key role in the provision of maternal and child health services in Kansas and targets activities to improve the health of all women and infants. Find more information at <http://kansasmch.org> or [www.kdheks.gov/bfh](http://www.kdheks.gov/bfh).

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