Washington State

Department of Health

Maternal Mortality Review Procedures Manual

Policies, Rules, Forms, and Definitions

2016-2017

****

DOH 140-156 May 2017

Contents

[Mission, Goals, and Scope 3](#_Toc480363524)

[Statutory Authority 4](#_Toc480363525)

[Definitions 5](#_Toc480363526)

[Committee Structure 7](#_Toc480363527)

[Committee Member Responsibility 9](#_Toc480363528)

[Confidentiality 10](#_Toc480363529)

[*Institutional Review Board* 11](#_Toc480363530)

[Maternal Mortality Multi-Level Review Process 11](#_Toc480363531)

[Level 1 Review: Case identification 11](#_Toc480363532)

[Level 2 Review: Case Examination and Prioritization 16](#_Toc480363533)

[Level 3 Review: Case Investigation and Preventability Discussion 17](#_Toc480363534)

[Level 4: High Level Systems Changes Discussion and Recommendation 20](#_Toc480363535)

[RCW 70.54.450 22](#_Toc480363536)

[Rural/Urban Classification Coding 25](#_Toc480363537)

[Cause of Death Decision Guidelines Maternal Mortality Review 2016 26](#_Toc480363538)

[Title: 30](#_Toc480363539)

[Responsibilities for Confidential Information 30](#_Toc480363540)

[Number: 17.005 30](#_Toc480363541)

[Confidentiality Statement for Maternal Mortality Review Panel 33](#_Toc480363542)

[Maternal Mortality Review Panel Conflict of Interest Policy 35](#_Toc480363543)

[Maternal Mortality Review Panel Conflict of Interest Disclosure Form 37](#_Toc480363544)

[Maternal Mortality Review Panel Recusal Policy 39](#_Toc480363545)

[Re: Request for medical records for Washington State Maternal Mortality Review 42](#_Toc480363546)

[Maternal Mortality Review Case Decision and Discussion Form (CDC 2016) 43](#_Toc480363547)

**Maternal Mortality Review Panel Manual**

**Rules, Definitions, and Processes**

## **Mission, Goals, and Scope**

**Mission:**

1. Increase awareness of the issues surrounding pregnancy-related death and to promote change among individuals, communities, and health care systems in order to reduce the number of deaths.
2. Identify and review maternal deaths, identify risks contributing to these deaths, and recommend interventions that may reduce these deaths.
3. Develop an understanding of how maternal death disproportionately affects women based on socioeconomic variables.
4. Improve the overall wellbeing of women and children in the State of Washington.

**Vision:** The Washington Maternal Mortality Review Panel is a multidisciplinary committee who’s geographically, professionally, and culturally diverse members represent various specialties, facilities, and systems that interact with and impact maternal health. The panel conducts comprehensive reviews of maternal deaths in Washington State to help reduce the number of preventable deaths and improve maternal and child health and well-being. The committee consists of approximately 63 members who commit to serve the legislative term, to commence in January 2017 and to end in July 2020.

**Goals of the MMRP:**

1. In accordance with [RCW 70.54.450,](http://app.leg.wa.gov/RCW/default.aspx?cite=70.54.450) the maternal mortality review panel is established to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington to:
	1. Identify factors associated with maternal deaths
		1. Perform thorough record abstraction, in order to obtain details of events and issues leading up to the terminal event
		2. Perform a multidisciplinary review of cases to gain a holistic understanding of the issues
		3. Determine the annual number of maternal deaths related to pregnancy (pregnancy-related mortality)
		4. Identify trends and risk factors among pregnancy-related deaths in <state>.
		5. Recommend improvements to care at the individual, provider and system levels with the potential for reducing or preventing future events.
		6. Prioritize the findings and recommendations to guide the development of effective actions
		7. Recommend actionable strategies for prevention and intervention.
		8. Disseminate the findings and recommendations to a broad array of individuals and organizations
		9. Promote the translation of findings and recommendations into quality improvement actions at all levels
	2. Make recommendations for system changes to improve health care services for women in this state.
2. Further the commitment to health equity and improving the health and wellbeing of women in Washington state and:
	1. Develop a better understanding of how some populations are disproportionately affected by maternal deaths
	2. Develop a better understanding of the underlying medical and social factors which disproportionately affect women based on socioeconomic variables

**Scope of problem:** According to the Centers for Disease Control and Prevention (CDC), approximately 650 women die each year in the United States due to pregnancy and/or delivery complications. Many factors contribute to pregnancy-related health outcomes, which is why it is important for women to adopt healthy lifestyles and address any health issues prior to becoming pregnant. In order to combat the steadily increasing maternal mortality ratio, the CDC encourages ongoing systematic collection, analysis, and interpretation of data focused on improving public health practice. At the state-level, effective public health surveillance will allow for the implementation of successful prevention and intervention mechanisms that can ensure healthy pregnancies for both the mother and child in the future.

## **Statutory Authority**

Please refer to [RCW 70.54.450](http://app.leg.wa.gov/RCW/default.aspx?cite=70.54.450)

**Scope of review**: According to the legislation ([RCW 70.54.450](http://app.leg.wa.gov/RCW/default.aspx?cite=70.54.450)), the Washington State Department of Health Maternal Mortality Review Panel will review all **maternal deaths**. Every two years, the panel will submit a report of findings and recommendations to the legislation covering the previous two years maternal deaths.

1. For the first review (2016/2017), the MMRP will be reviewing deaths from 2014 and 2015. Time and resource constraints do not allow for the same level of review for all deaths identified. As such, the DOH MMR Team has made the following decisions:
	1. All maternal deaths will be reviewed by DOH MMR Team and several panel members
		1. The first review will focus on medical causes of death
	2. Pregnancy related and potentially pregnancy related cases will be reviewed “in-depth”
	3. Pregnancy associated – not related deaths will be reviewed at a high level
2. For subsequent reviews and when time and resources allow, the MMRP and the DOH team will work to review all maternal deaths “in depth” and expand the focus to include social determinants leading to death
3. More information about the details of each level of reviews is outlined in the Review Process section.

## **Definitions**

**Department of Health Maternal Mortality Review Team (DOH MMR Team):** DOH staff members working on the maternal mortality program; includes epidemiologists from the Center for Health Statistics and the Maternal and Child Health Epidemiology Unit; infant and maternal nurse consultants, MMR program coordinator, and ASC Section Manager.

**Maternal Mortality Review Panel Members (MMRP Members):** Professionals, stakeholders, clinical experts, and community members who applied to be on the Washington State MMRP, were recommended by DOH MMR Team staff, and were appointed by the Secretary of Health.

**Maternal Mortality Review:** A comprehensive, multidisciplinary, and multi-level review of maternal deaths in Washington State to identify factors associated with maternal death and to make recommendations for healthcare and systems changes to reduce maternal mortality.

**Maternal death:** A death that occurs to a woman during pregnancy or up to 365 days after the pregnancy ends.

**Pregnancy Related Death:** 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 (per CDC definition). Specific diagnoses, and timelines of death and diagnoses, are based on [cause of death decision](causes%20of%20death/Cause%20of%20Death%20Decision%20Guide%20Sept%202016.xlsx) rules.

**Pregnancy Associated Death, Not Related:** The death of a woman from any cause during pregnancy or within one year of the end of pregnancy *that is not pregnancy related* (see most recent [CDC Decision Form](Forms/Case%20Forms/Dec.%202016%20CDC%20MMRDS%20Committe%20Review%20and%20Decision%20Form.pdf)).This includes MVA, cancer, homicide, suicide, overdose, other accidents, some seizure.

**Pregnancy Associated Death, Unable to Determine if Pregnancy Related:** The death of a women that is definitely pregnancy associated, but whether the death is pregnancy related is not able to be determined.

**Possibly Pregnancy Related Death:** The death of a women that may be pregnancy related, but requires more investigation to make a final determination of categorization.

**Preventability:** A maternal death is considered preventable if the MMRP members determine that there was at least *some chance* of a death being averted by *one or more reasonable changes* to patient, community, provider, facility, and/or systems factors (see most recent [CDC Decision Form](Forms/Case%20Forms/Dec.%202016%20CDC%20MMRDS%20Committe%20Review%20and%20Decision%20Form.pdf)).

**Level 1 Review - Case Identification:** DOH MMR Team identifies all maternal deaths from birth and fetal death certificate records, death certificate records, and hospitalization records. A detailed process description can be found in the appendix of this document.

**Level 2 Review – Case Examination and Prioritization:** DOH MMR Team and 5–6 MMRP Members review all maternal deaths of years identified to confirm pregnancy related or pregnancy associated-not related categorization, to determine cause of death or whether more information is required to determine this, to prioritize pregnancy related death cases for Level 3 Review, and complete or pre-fill the [CDC Decision Form](Forms/Case%20Forms/Dec.%202016%20CDC%20MMRDS%20Committe%20Review%20and%20Decision%20Form.pdf).

**Level 3 Review - Case Investigation and Preventability Discussion:** MMRP Members conduct an **in-depth** review of pregnancy related deaths which were prioritized during the Level 2 Review process, discuss the preventability of those deaths, provide recommendation(s) for prevention, and complete CDC Case Discussion Forms.

**“In-depth”** review of cases refers to the development of a **case report** and a **deidentified case file** for each pregnancy related or possibly pregnancy related case which are presented for review to the panel.

**Level 4 Review - High-Level Recommendations Development and Discussion:** DOH staff, MMRP Members, and Community Stakeholders review and discuss findings and case-specific recommendations from Level 3 Review, identify common risk factors for pregnancy related deaths, discuss further recommendations as appropriate, and discuss potential healthcare and policy system changes in order to address proposed recommendations.

**Report Development and Submission:** The drafting of the final report containing information about the development of the maternal mortality review process, findings from the maternal mortality review, data collected and analyzed on maternal deaths, and recommendations based on those findings by MMRP members and the DOH MMR Team; this also includes obtaining approval from the DOH Executives, and submitting the report to the legislature.

[**CDC Case Decision Form:**](Forms/Case%20Forms/Dec.%202016%20CDC%20MMRDS%20Committe%20Review%20and%20Decision%20Form.pdf) Form provided by the CDC which will be completed on each maternal death, and will help guide discussion for preliminary and in-person case reviews.

[**Cause of Death Decision Rules**](causes%20of%20death/Cause%20of%20Death%20Decision%20Guide%20Sept%202016.xlsx)**:** Decision tool used to determine whether a death is pregnancy related based on diagnosis and timeline of diagnosis/symptoms in relation to pregnancy.

**Case:** A maternal death which occurs to a Washington resident in the state of Washington.

**Case Summary:** A summary of all case information compiled from all available aggregate records, including medical records, vital statistics records, and autopsy records.

**Case Narrative**: Broad overview of each case written by DOH clinician and/or MMRP Member. Includes summary of mother’s death, fetal birth and death (if applicable), pertinent facility and transfer information, psychosocial history and information, and other information pertinent to the case and understanding events leading to death.

**Case Report:** Combination of case summary, the case narrative, and/or other pertinent documents to be used for maternal mortality review.

**Case Records:** Any record or piece of information associated with a case, including (but not limited to): medical records, autopsy or coroner records/reports, DSHS records, vital statistics records, interviews, and media/news articles.

**Case File:** A completely de-identified case record that has been placed into a file folder. To be used for MMRP Member review if more information than the case record is needed to determine cause of death, preventability of death, or recommendations in prevention and education.

**De-identification:** The process of redacting personally identifiable information from all maternal death/pregnancy related death/pregnancy associated death records. CHARS and HIPAA guidelines for identifiable information have been followed (see Deidentification Process)

**Committee Structure**

1. Member application: interested parties are asked to apply to be on the MMRP through the program’s website application
2. Once an application has been submitted, members are selected by the DOH MMR Team and select panel members using the following criteria:
	1. Clinical expertise in the field of women’s health, including (but not limited to), maternal fetal medicine, obstetrics, and midwifery
	2. Interest in women’s health and maternal mortality and morbidity
	3. Geographic and cultural/ethnic representation
	4. Ability to commit to one or more of the panel membership roles, which include
		1. Chart abstraction and review
		2. Case preparation and summary development
		3. Specialist case review/consult
		4. Panel proceedings assistance and/or facilitation
		5. Case presentation for in person meetings
		6. Preliminary case review in preparation for meetings
		7. Service on subcommittee for in-person meetings
	5. Commitment to health equity and the overall improvement of quality of life for women and children in Washington State

The MMRP is a multidisciplinary and diverse group of women’s health providers and prevention practitioners from across Washington State and includes Department of Health staff members and external stakeholders. Professional representation includes obstetrics and gynecology, forensic pathology, nurse-midwifery, maternal fetal medicine, anesthesiology, nursing, psychiatry, social work, mental/behavioral health and public health.

Committee members are nominated by Department of Health MMR Team staff, and are then appointed by the Secretary of Health. Recruitment of new MMRP members occurs as needed. Interested individuals complete an application that is reviewed by Department MMR staff members (Attachment #: MMRP Application). This application is revised as needed to reflect current vacancies within the committee. The Department engages the MMRP to identify and recruit interested individuals when necessary; however, the Department maintains the authority to appoint the membership. MMMRP members are asked to serve the term of the legislative period. If at any time a member no longer wishes to serve on the panel, they are asked to notify the MMR coordinator as soon as possible.

**Diversity**

In accordance with Department of Health values of diversity, the DOH MMR Team worked to ensure the composition of the MMRP was diverse in a variety of ways. The DOH MMR Team worked with internal diversity specialist to implement outreach to external community organizations to enhance professional, cultural/ethnic, and geographic diversity when needed. Panel members recruited and appointed represent:

1. A wide range of women’s health professions and various stages of those professions.
2. A variety of cultural and ethnic backgrounds
3. Most geographic regions of Washington State

**Tribal Representation**

The DOH MMR Team worked closely with the DOH Tribal Liaison to ensure tribal representation on the MMRP.

1. Tribal representatives were chosen by the tribes and the American Indian Health Commission
2. Individuals chosen by the tribes and the AIHC did not need to apply; their participation in the panel proceedings was guaranteed
3. Individuals chosen to participate were not required to participate for any length of time

# Committee Member Responsibility

All MMRP members serve in a volunteer capacity and do not receive compensation for their participation in the review process. The maternal mortality review panel is established to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington/ Member responsibilities include:

* Review data and cases as prepared and presented by DOH MMR Team staff
* Discuss, develop and make recommendations on death prevention
* Identify risk factors associated with maternal deaths
* Make recommendations for systems changes to improve healthcare services for women in the state
* Assist DOH MMR Team with the development and submission of a report outlining the panel proceedings and findings to the Secretary of Health and the Health Care Committees of the Senate and the House of Representatives
	+ The first report is due to the legislation by July 1, 2017; a report is due biennially thereafter
* Attend meetings as requested and when available
* Ask questions related to data and cases in order to make determinations
* Respond to questions made by other panel members and/or DOH MMR Team staff regarding cases and/or data
* Assist DOH MMR Team Staff to reach meeting and program goals and objectives
* Review RCW 70.54.450
* Review the DOH MMRP Program policies, procedures, definitions, and complete the appropriate forms.
	+ All MMRP members must abide by the Department of Health Confidentiality Policy and Agreement and RCW 70.54.450 when engaging in case review discussions. This rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and rules regarding the release of information without patient consent. All MMRP members will be reminded at the start of each meeting that they must adhere to these standards, and may not expose patient-identifying information about a case should they recognize it.
	+ All MMRP members must sign the Department MMRP Confidentiality Statement (Attachment #: MMRP Confidentiality Statement). This is done at the time of panel member appointment. Completed and signed forms are stored electronically. Committee members are reminded at the start of each meeting that all information discussed in the reviews must remain confidential and may not be used for reasons other than for the maternal mortality review
	+ All MMRP members must abide by the DOH MMRP Conflict of Interest Policy and must sign the Conflict of Interest Disclosure Form. This is done prior to the panel member’s first meeting attendance. Completed and signed forms are stored electronically. This policy requires panel members to disclose conflicts of interest or potential conflicts of interest to the DOH MMR Team. Disclosures are kept confidential and are not shared with other panel members (Attachment # Conflict of Interest Policy and Conflict of Interest Disclosure Form)
	+ All MMRP members must abide by the DOH MMRP Recusal Policy and must sign the Recusal Form. This is done prior to the panel member’s first meeting attendance. Completed and signed forms are stored electronically. This policy requires panel members to recuse themselves from panel proceedings if member participated directly or indirectly on a case which is being discussed or reviewed. (Attachment # Recusal Policy and Form)
* MMRP members who are not Department employees are not covered under the Department’s statutory authority to conduct maternal mortality review work. Thus, external members may not:
	+ Request records themselves
	+ Follow up on records requested but not received
	+ Review personal health information that is not de-identified
	+ Access the Maternal Mortality Review Data System
	+ Failure to comply with the defined responsibilities will result in termination from the MMRP. Members who are terminated from the MMRPP are ineligible for future participation.
* MMRP members may not call witness or take testimony from any individual involved in the investigation of a maternal death or enforce any public health standard or criminal law or otherwise participate in any legal proceeding relating to a maternal death

## **Confidentiality**

The Department will ensure strict compliance with our state statutes, which requires that the Department protect the confidentiality of maternal mortality information as outlined in RCW 70.54.450 and in the [Department of Health Confidentiality Policy](Policies%20and%20Procedures/MMRP%20Confidentiality%20Agreement.doc). Please refer to this policy (Appendix #). To ensure the protection of committee members, individuals, families and providers, the MMRP will adhere to the following safeguards:

1. All MMRP meetings will be held in private. The MMRP is not a policy-making body, and thus is not subject to the open meeting requirements.
2. Members of the public or press will not be allowed at MMRP meetings. If members of the public or press show up uninvited at a meeting they will be notified that the MMRP meetings are not open to the public and will be asked to leave. Members of the public or press will be offered the opportunity to engage with Department staff about the work at a separate time outside of the MMRP meetings.
3. Case-associated information will only be available for review and discussion at the MMRP meetings.
4. Agenda and meeting notes may be distributed outside of the meeting time and will not contain case-associated information.
5. MMRP members must submit all meeting materials and papers with case-associated notes back to Department staff at the end of the MMRP meetings.
6. All case summaries and medical records reviewed will be redacted as outlined in RCW 70.54.450 and in the MMRP program rules.
7. A MMRP member may request to review a de-identified record for additional information pertinent to the case review. The record(s) will be de-identified by Department staff. Additional information beyond RCW 70.54.450 requirements may be redacted if it could lead to the identification of a case.
8. While committee members may have concerns or disagreements regarding a case, the review of maternal deaths is not an opportunity for the MMRP to criticize provider or agency decisions. As the appointing agency of the MMRP, the Department reserves the right to ensure discussions remain focused on the meeting’s intended purpose. All information discussed by committee members in the reviews will remain confidential and may not be used for reasons other than that which are intended.

## *Institutional Review Board*

According to the Washington State Institutional Review Board Procedures Manual (July 21, 2016, pp. 30), data collection for the administration of a program is not considered “research” and as such, is not subject to review by the Institutional Review Board. All data collected for this program is done solely to fulfill the requirements of the law and the maternal mortality review program.

# **Maternal Mortality Multi-Level Review Process**

## **Level 1 Review: Case identification**

Women's deaths are linked with birth and fetal death data to identify women who died within 365 days of giving birth. Additional deaths were identified by using (i) ICD-10 codes for maternal mortality, (ii) the pregnancy check box on the death certificate, and (iii) by using matching software. Washington State does not collect records of fetal deaths that occur within the first 20 weeks of gestation (RCW 70.58.150), and does not have identifiable records on abortions. No maternal mortality cases were linked to information on abortions. Fetal death certificates are filed for fetal deaths that occur at 20 weeks gestation or greater. Birth certificates are filed with the state for all live born fetuses regardless of gestational age. If a fetus dies within minutes of birth, a death certificate is also filed with the state.

Identification of maternal mortality cases are outlined in the following steps and in Figure 1.

**STEP 1:** All information from birth and fetal death certificate records for 2013, 2014 and 2015, and female death certificates were extracted from the data server. Birth, fetal death, and female death information were standardized to prepare for linkage process.

**STEP 2:** Information from birth or fetal death were matched to female death certificates based on names of decedent and spouse, birth date, death date, address, marital status, and race, using standard query language. Matches were scored, evaluated, and manually reviewed for validation. Verified matched records were checked for duplication

**STEP 3**: Additional maternal mortality cases beyond the linkage and matching process were identified through the checked pregnancy check box or ICD-10 maternal mortality 'O' code present in the underlying or other causes of death codes on the death certificate.

**STEP 4:** A file that includes infant birth or fetal death, and maternal death information for maternal deaths identified through Steps 2 and 3 is created.

**STEP 5:** Additional maternal mortality cases are identified through probabilistic linkage of deaths and birth or fetal death files using LinkPlus software. These cases are added to the file created in Step 4.

**STEP 6:** The final file created in Step 5 is then probabilistically linked with the 2010–2014 CHARS hospital revisit file and the 2010–2014 CHARS annual files (for deaths that occurred in 2014), and 2011-2015 CHARS Revisit file and the 2011–2015 CHARS annual files (for deaths that occurred in 2015). This step is done to obtain all hospital discharge record data captured by CHARS for these women in the last 5 years of their life.



**Case exclusions**

1. Certificates linked with pregnancies occurring greater than 365 days prior to death or others not appropriate (men, women over 60, etc.) are excluded.

**Cases for review**

1. The goal of the MMRP is to review all maternal deaths in Washington State to help inform on cause of death data collection and intervention and prevention strategies and recommendations. All maternal deaths during years identified will be reviewed.

**Case Information and Medical Records Requests**

1. All maternal deaths: information collected includes data from the birth and death certificates.
2. For pregnancy related and possibly pregnancy related deaths: additional information is gathered from pertinent records.
	1. Records requests and receipts are managed by the MMR Coordinator
	2. All records are stored in a locked file cabinet or on a restricted DOH Y drive
	3. Identifiable records are only accessed and viewed by DOH staff
		1. All records must be deidentified before they may be viewed by MMR panel members
	4. Records needed are identified through the birth and death certificates and the hospitalization data
	5. Records are requested from the birthing facility, the death facility, the coroner or medical examiner, the prenatal and/or primary care physician, and any other hospital facility that the deceased sought care from during her pregnancy and up to 365 days after termination of birth.

**Case abstraction**

1. Birth and death certificate data along with hospitalization data is collected from Vital Statistics and entered into the Maternal Mortality Review Data System (MMRDS) on all maternal deaths
2. For pregnancy related and possibly pregnancy related deaths, pertinent data from obtained records is abstracted by DOH MMRP team members in coordination with the MMR nurse consultant and panel members (when available)
	1. Pertinent data is entered into MMRDS as outlined by the program (Attachment # MMRDS Forms)
	2. Important case-specific information is outlined in a case narrative (Attachment # Case narrative)
		1. For complex cases, physician panelists are asked to review cases and identify pertinent data and information to be abstracted and included in the case narrative
		2. Specialist panel members are asked to review cases based on cause of death or specific diagnoses and identify pertinent data and information to be abstracted and included in the case narrative

**Chart Redaction/Deidentification Procedure**

1. Paper records
	1. Receive record, make a copy (one sided); original to be stored in appropriate location
	2. Using a black sharpie, black out all identifiable information; copy redacted document
	3. Shred original redacted copy; return copied redacted version to be stored in appropriate location
2. Electronic records
	1. Receive CD/email; copy onto Y drive; original to be stored in appropriate location
	2. Using *Redact it* software program, black out all identifiable information; save copy of redacted document in Y drive and include “redacted” in file name
3. Record storage and management
	1. All paper records and discs are to be stored in file cabinet, which is to remain locked at all times
	2. Medical records should never leave Tumwater PPE building
	3. If working on records at personal desk, they should be locked up when not in use; all records should be returned to cabinet at the end of the day

**Deidentification Guidelines**

In accordance with RCW 70.54.450, prior to the review of any case-related document or records, the following items will be redacted from data, medical records, autopsy reports, birth and death certificates, and/or any other information or documents related to a case:

1. In accordance with CHARS:
2. First names, middle names or initials, maiden names, legal names
3. Social Security Numbers
4. Patient Control Numbers or Medical Record Numbers
5. Full zip codes (i.e., 5-digit + 4-digit)
	* Replaced with RUCA code for rural/urban description
6. Hospital or provider identifiers
7. 5-digit zip codes
8. County, state, and country of residence
9. Initials in addition to middle initials of names
10. Facility names in addition to hospitals and providers (e.g., clinics, laboratories, birth facilities, X-ray facilities)
11. Facility logos
12. Street addresses
13. Phone numbers
14. Cities and towns
15. Case numbers, visit numbers, account numbers, order numbers, insurance numbers
16. Signatures and signed initials
17. In order to comply with HIPAA:
18. Names of the individual or of relatives, employers, or household members of the individual
19. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes
20. Telephone numbers
21. Fax numbers
22. Email addresses
23. Social security numbers
24. Medical record numbers
25. Health plan beneficiary numbers
26. Account numbers
27. Certificate/license numbers
28. Vehicle identifiers and serial numbers, including license plate numbers
29. Device identifiers and serial numbers
30. Web Universal Resource Locators (URLs)
31. Internet Protocol (IP) addresses
32. Biometric identifiers, including finger and voice prints
33. Full-face photographs and any comparable images
34. Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section [Paragraph (c) is presented below in the section “Re-identification”]; and
	* (ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.
35. Exceptions:
	1. For the purposes of trending, analysis, and understanding timelines of pregnancy and death, dates (other than birthdates) will not be redacted. This includes hospital admission, discharge dates; prenatal care dates; emergency department visit dates; death dates of women and infant/fetus;

**Records retention**

1. All paper and electronic medical records will be maintained by the MMRP team for three years from the time of receipt at which point, the records will be destroyed (see this RCW)

## **Level 2 Review: Case Examination and Prioritization**

Level 2 Review is conducted by DOH MMR Staff and 5-6 MMR Panel Members

*The purpose of this review is to:*

1. High-level overview of all data on maternal deaths for the years identified
2. Confirm categorization of maternal deaths as pregnancy associated, not related or pregnancy related.
	1. Identify gaps in information to determine this categorization to be addressed at a later date
3. Determine cause of death (COD), and/or what information is needed to make this determination
4. Selection of 10 pregnancy related cases to be prioritized for Level 3 Review
5. Partial or total completion of CDC Committee Decision form up to cause of death and preventability (when possible) for pregnancy related cases

*Activities to take place at this review include:*

1. A presentation of high-level data on all maternal deaths for the years identified (begin with 2014 and 2015) to the present panel members by DOH MMR team epidemiologist.
2. Overview of deidentified pregnancy associated, not related cases by DOH MMR team epidemiologist. Variables to be presented will be completely deidentified and include:
	1. Age, race/ethnicity, education level, marital status, RUCA code of residence on death certificate, insurance type, prenatal care entry, BMI, gravida/para, birth outcome, delivery route, gestation length, time of death in relation to termination of pregnancy
3. Overview of pregnancy related and possibly pregnancy related cases based on available information for panel members to consider by DOH MMR team nurse consultant. Information presented to panel members will be completely deidentified and will include:
	1. Age, race/ethnicity, education level, marital status, RUCA code of residence on death certificate, insurance type, prenatal care entry, BMI, gravida/para, birth outcome, delivery route, gestation length, time of death in relation to termination of pregnancy
	2. Prenatal care information (when available)
	3. Deidentified case narrative developed by MMRP coordinator and nurse clinician
	4. Deidentified autopsy reports/coroner reports (when available)
4. Panel members and DOH MMR team to determine cause of death, and/or whether more information/investigation is needed to determine this
5. Panel members to develop *preliminary thoughts* on preventability using CDC definition of the term
	1. Identify cases which were not preventable
6. Panel members to select ten cases for Level 3 Review
	1. This maximum caseload for in-depth review is 10. This is based on time and resource constraints.
	2. *Some suggestions for selection include, but are not limited to:*
		1. Review all cases based on year of death; i.e. from 2014 or 2015
		2. Review cases based on uniqueness, specific learning/education potential
		3. Review cases based on complexity or severity
		4. Review cases based on specific diagnosis
		5. Review cases based on underlying cause of death (i.e. medical vs. social)
		6. Location of death (home vs. medical facility)
7. Panel members and DOH MMR team to develop preliminary recommendations for prevention of death for those cases that will not be reviewed at the In-Person Review
8. MMR DOH team will work to complete CDC Case Discussion form for each pregnancy related case

## **Level 3 Review: Case Investigation and Preventability Discussion**

This review is conducted by DOH MMR Staff and 18-20 MMR Panel Members.

*The purpose of this review is to:*

1. Review available data on maternal deaths for the years identified
	1. Aggregate data
	2. Pregnancy Associated
	3. Pregnancy Related
2. Review of prioritized (Level 2) pregnancy related cases using case report, which includes a completed case narrative, data from core-summary report, and a deidentified medical records. For each prioritized pregnancy-related case, the panel:
	1. Confirms cause of death determined by panel at Level 2 Review
	2. Determines whether a death was preventable and the degree to which it was preventable
	3. Discuss gaps in care or services related to the death and it’s preventability
	4. Identify and discuss risk factors associated with death and preventability
	5. Develop case-specific recommendations on prevention and intervention
	6. Complete CDC Case Discussion Form for each case discussed
3. Overview of pregnancy related cases which were not prioritized using the pregnancy related core-summary spreadsheet and a summary of Level 2 findings

*Activities at this review include:*

1. A presentation of high-level data and preliminary analysis on all maternal deaths for the years identified (begin with 2014 and 2015) to present panel members by DOH MMR team epidemiologist.
2. Overview of deidentified pregnancy associated, not related cases by DOH MMR team epidemiologist. Variables presented are deidentified and include:
	1. Age, race/ethnicity, education level, marital status, RUCA code of residence on death certificate, insurance type, prenatal care entry, BMI, gravida/para, birth outcome, delivery route, gestation length, time of death in relation to termination of pregnancy
3. Presentation and review of pregnancy related cases. Information presented to panel members is completely deidentified and will include:
	1. Summary of pregnancy related cases that were not prioritized; includes a narrative of the case, Level 2 determination of cause of death and why case was not selected for Level 3 Review
	2. Review and Discussion of Prioritized Pregnancy Related Cases (Level 2 Review Findings). Information to cover includes:
		1. Age, race/ethnicity, education level, marital status, RUCA code of residence on death certificate, insurance type, prenatal care entry, BMI, gravida/para, birth outcome, delivery route, gestation length, time of death in relation to termination of pregnancy
		2. Deidentified prenatal care information, birth/death facility records, post-natal care information, coroner/autopsy reports, police records, and other records as necessary, pertinent and available.
		3. Deidentified core-summary data (MMRDS)
		4. Deidentified case narrative developed by nurse clinician developed with available records
		5. Deidentified autopsy reports/coroner reports (when available)
	3. Panel members determine whether a pregnancy related death was preventable and if so, make recommendations on prevention using CDC definition of prevention and guide
	4. Identify cases which were not preventable
4. MMR DOH team will work to complete CDC Case Discussion form for each pregnancy related case

Level 3 Review Case Preparation

Case Preparation is led by DOH MMR Team staff members with assistance from panel members as needed, and includes requesting, reviewing and abstracting case records, populating data into MMRDS, analyzing data, developing case summaries and writing case narratives in order to create a case report, reviewing case reports for completeness, consulting with specialists on a case-by-cases basis as needed.

1. Prepared case reports for those cases selected for priority at Level 2 Review
	1. Identify gaps or areas where more information is needed and follow up as appropriate
	2. Request and review medical records (DOH staff) as needed
	3. Abstract medical information into MMRDS (DOH Staff) as needed
	4. Develop a case report, to include core-summary spreadsheetand case narratives, for Level 3 Review
		1. Core summaries are generated by MMRDS and contain pertinent data abstracted from requested and collected records (can be in notebook or spreadsheet format)
		2. Case narrative is developed by DOH Staff nurse consultant; these are edited, updated, or changed as panel members and/or DOH MMR staff deem necessary
		3. Panel members (nursing or physician) consulted for expertise and/or may be asked to review a medical record and/or assist with writing case narratives
2. Deidentification of all case records and a completed case file to be used for review by panel

*Activities at this review include:*

1. A presentation of high-level data and preliminary analysis on all maternal deaths for the years identified (begin with 2014 and 2015) to present panel members by DOH MMR team epidemiologist.
2. Overview of deidentified pregnancy associated, not related cases by DOH MMR team epidemiologist. Variables presented are deidentified and include:
	1. Age, race/ethnicity, education level, marital status, RUCA code of residence on death certificate, insurance type, prenatal care entry, BMI, gravida/para, birth outcome, delivery route, gestation length, time of death in relation to termination of pregnancy
3. Presentation and review of pregnancy related cases. Information presented to panel members is completely deidentified and will include:
	1. Summary of pregnancy related cases that were not prioritized; includes a narrative of the case, Level 2 determination of cause of death and why case was not selected for Level 3 Review
	2. Review and Discussion of Prioritized Pregnancy Related Cases (Level 2 Review Findings). Information to cover includes:
		1. Age, race/ethnicity, education level, marital status, RUCA code of residence on death certificate, insurance type, prenatal care entry, BMI, gravida/para, birth outcome, delivery route, gestation length, time of death in relation to termination of pregnancy
		2. Deidentified prenatal care information, birth/death facility records, post-natal care information, coroner/autopsy reports, police records, and other records as necessary, pertinent and available.
		3. Deidentified core-summary data (MMRDS)
		4. Deidentified case narrative developed by nurse clinician developed with available records
		5. Deidentified autopsy reports/coroner reports (when available)
	3. Panel members determine whether a pregnancy related death was preventable and if so, make recommendations on prevention using CDC definition of prevention and guide
	4. Identify cases which were not preventable
4. MMR DOH team will work to complete CDC Case Discussion form for each pregnancy related case

## **Level 4: High Level Systems Changes Discussion and Recommendation**

This review is conducted by DOH MMR Team and the entire MMRP.

*The purpose of this review is to:*

1. Review available data on maternal deaths for the years identified using core summary spreadsheet
	1. Pregnancy Associated – not related cases
	2. Pregnancy Related cases
2. Review findings and next steps from Level 1, 2, and 3 Reviews
3. Discuss elements of prevention, strategies for intervention, and risk factors associated with maternal deaths
4. Identify and discuss socioeconomic determinants of health
5. Develop healthcare and systems level recommendations for prevention and intervention to submit to legislation

*Activities at this review include:*

1. Overview of deidentified maternal deaths by DOH MMR team members. Variables presented are deidentified and include:
	1. Age, race/ethnicity, education level, marital status, RUCA code of residence on death certificate, insurance type, prenatal care entry, BMI, gravida/para, birth outcome, delivery route, gestation length, time of death in relation to termination of pregnancy
	2. Level 1, 2, and 3 findings and next steps
2. Presentation and findings and recommendations from Level 3 Review.
3. Discussion of risk factors associated with deaths and development of recommendations on prevention
	1. Break out into groups
		1. For each group, facilitator and note taker
		2. The follow questions can be used to guide group facilitation
			1. For PA case groups – discuss preventability potential based on information available and panel member expertise
			2. For PR case groups – discuss Level 2 and 3 panel member determination of prevention and review recommendations
			3. Ask if there are additional recommendations (within the context of that group)
			4. Discuss new prevention recommendations - *Recommendations should be specific and feasible:* ***Who******is responsible to act?******When?*** *Phrase recommendations in actionable terms. (Think of SMART – Specific, measureable, achievable, relevant, and timeline)*
				1. What is the recommendation(s)?
				2. Who is responsible to act?
				3. When does the activity need to occur?
				4. What is the activity associated with the recommendations?
				5. What level is the recommendation?

Primary – prevent incidence of mortality

Secondary – Prevent progression of morbidity

Tertiary – prevent complications of pregnancy

* + - * 1. What is the impact?

Small – education/counseling

Medium – clinical intervention and coordination of care

Large – long-lasting protective intervention

Extra large – change in context

Giant – Address social determinants of health

**Policies, Procedures, and Forms**

RCW 70.54.450

RCWs > Title 70 > Chapter 70.54 > Section 70.54.450

RCW 70.54.450

http://app.leg.wa.gov/RCW/default.aspx?cite=70.54.450

Maternal mortality review panel—Membership—Duties—Confidentiality, testimonial privilege, and liability—Identification of maternal deaths—Reports. (Expires June 30, 2020.)

(1) For the purposes of this section, "maternal mortality" or "maternal death" means a death of a woman while pregnant or within one year of delivering or following the end of a pregnancy, whether or not the woman's death is related to or aggravated by the pregnancy.

(2) A maternal mortality review panel is established to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington to identify factors associated with the deaths and make recommendations for system changes to improve health care services for women in this state. The members of the panel must be appointed by the secretary of the department of health, must serve without compensation, and may include:

(a) An obstetrician;

(b) A physician specializing in maternal fetal medicine;

(c) A neonatologist;

(d) A midwife with licensure in the state of Washington;

(e) A representative from the department of health who works in the field of maternal and child health;

(f) A department of health epidemiologist with experience analyzing perinatal data;

(g) A pathologist; and

(h) A representative of the community mental health centers.

(3) The maternal mortality review panel must conduct comprehensive, multidisciplinary reviews of maternal mortality in Washington. The panel may not call witnesses or take testimony from any individual involved in the investigation of a maternal death or enforce any public health standard or criminal law or otherwise participate in any legal proceeding relating to a maternal death.

(4)(a) Information, documents, proceedings, records, and opinions created, collected, or maintained by the maternity mortality review panel or the department of health in support of the maternal mortality review panel are confidential and are not subject to public inspection or copying under chapter 42.56 RCW and are not subject to discovery or introduction into evidence in any civil or criminal action.

(b) Any person who was in attendance at a meeting of the maternal mortality review panel or who participated in the creation, collection, or maintenance of the panel's information, documents, proceedings, records, or opinions may not be permitted or required to testify in any civil or criminal action as to the content of such proceedings, or the panel's information, documents, records, or opinions. This subsection does not prevent a member of the panel from testifying in a civil or criminal action concerning facts which form the basis for the panel's proceedings of which the panel member had personal knowledge acquired independently of the panel or which is public information.

(c) Any person who, in substantial good faith, participates as a member of the maternal mortality review panel or provides information to further the purposes of the maternal mortality review panel may not be subject to an action for civil damages or other relief as a result of the activity or its consequences.

(d) All meetings, proceedings, and deliberations of the maternal mortality review panel may, at the discretion of the maternal mortality review panel, be confidential and may be conducted in executive session.

(e) The maternal mortality review panel and the secretary of the department of health may retain identifiable information regarding facilities where maternal deaths, or from which the patient was transferred, occur and geographic information on each case solely for the purposes of trending and analysis over time. All individually identifiable information must be removed before any case review by the panel.

(5) The department of health shall review department available data to identify maternal deaths. To aid in determining whether a maternal death was related to or aggravated by the pregnancy, and whether it was preventable, the department of health has the authority to:

(a) Request and receive data for specific maternal deaths including, but not limited to, all medical records, autopsy reports, medical examiner reports, coroner reports, and social service records; and

(b) Request and receive data as described in (a) of this subsection from health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, professions and facilities licensed by the department of health, local health jurisdictions, the health care authority and its licensees and providers, and the department of social and health services and its licensees and providers.

(6) Upon request by the department of health, health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, professions and facilities licensed by the department of health, local health jurisdictions, the health care authority and its licensees and providers, and the department of social and health services and its licensees and providers must provide all medical records, autopsy reports, medical examiner reports, coroner reports, social services records, information and records related to sexually transmitted diseases, and other data requested for specific maternal deaths as provided for in subsection (5) of this section to the department.

(7) By July 1, 2017, and biennially thereafter, the maternal mortality review panel must submit a report to the secretary of the department of health and the health care committees of the senate and house of representatives. The report must protect the confidentiality of all decedents and other participants involved in any incident. The report must be distributed to relevant stakeholder groups for performance improvement. Interim results may be shared at the Washington state hospital association coordinated quality improvement program. The report must include the following:

(a) A description of the maternal deaths reviewed by the panel during the preceding twenty-four months, including statistics and causes of maternal deaths presented in the aggregate, but the report must not disclose any identifying information of patients, decedents, providers, and organizations involved; and

(b) Evidence-based system changes and possible legislation to improve maternal outcomes and reduce preventable maternal deaths in Washington.

[ 2016 c 238 § 1.]

NOTES:

Expiration date—2016 c 238: "This act expires June 30, 2020." [ 2016 c 238

## Rural/Urban Classification Coding

Trajectory of recorded zip code changes among maternal deaths among 2014–2015 Washington State residents

* Zip codes of maternal residence were obtained from babies’ birth or fetal death certificates, death certificates, and maternal hospitalizations from the last 5 years of the women’s lives.
* A Rural-Urban classification scheme, RUCA 3.10 Scheme 1) was implemented on all zip codes, as per the Washington State Department of Health Guidelines for Using Rural-Urban Classification Systems for Community Health Assessment, to further describe the women’s residences in terms of distance away from necessary resources and services.
	+ The coding scheme chosen was selected to take into account the concept of potential access to resources and services in its broadest sense. It emphasizes populations, population density, and daily commuting pattern.
		- Urban Core: Contiguous built-up areas of 50,000 persons or more. These areas correspond to US Census Bureau’s Urbanized Areas
		- Sub-Urban: Areas, often in metropolitan counties, with high commuting flows to Urban Cores and areas where 30–49% of the population commutes to Urban Cores for work
		- Large Rural Town: Towns with populations between 10,000–49,999 and surrounding rural areas with 10% or more primary commuting flows to these towns, and towns with secondary commuting flows of 10% or more to Urban Cores
		- Small Town / Isolated Rural Town: Towns with populations below 10,000 and surrounding commuter areas with more than a 1 hour driving distance to the closest city
* Of 73 maternal deaths, 20 are pregnancy-related (14 in 2004 and 6 in 2015).
* Of 20 pregnancy-related deaths, only 1 woman had a classification change between her prenatal care place of residence, residence listed in the baby’s birth certificate, and her death certificate. Specifically, her place of residence codes to a Small Town/Isolated Rural Town in the baby’s birth certificate whereas in all other documents it codes to a Large Rural Town.
* Of 20 pregnancy-related deaths, 13 (65%) women lived in Urban Cores, 3 (15%) in Sub-Urban areas, 2 (10%) in Large Rural Towns, and 2 (10%) in Small Town/Isolated Rural Towns, at the time of their death.
* Of 20 pregnancy-related deaths, hospitalization data were obtained from 17 hospital discharge records. Of these 17 women, 4 women had changing zip codes of residence reported in their hospitalization records.

|  |
| --- |
| **Cause of Death Decision Guidelines Maternal Mortality Review 2016** |
|   |
|   |   |   |   |
| **Maternal Mortality Codes** |   |   |
|   |  |  |   |
| **INFOSRC = Pregnancy Information Source** |  |   |
| 1 = Birth Certificate |  |   |
| 2 = Fetal Death Certificate |  |   |
| 3 = CHARS hospital discharge data |  |   |
| 4 = Birth Certificate and CHARS |  |   |
| 5 = Fetal Death Certificate and CHARS |  |   |
| 6 = Death Certificate ICD code only |  |   |
| 7 = Match Fetal Death Certificate, Birth Certificate and CHARS |   |
| 8 = Match Fetal Death, Birth Certificate, NO CHARS |   |
|   |  |  |   |
| **Outcome=Outcome of Index Pregnancy (preg)** |   |
| 0=Undelivered |  |  |   |
| 1=therapeutic abortion |  |   |
| 2=live birth |  |  |   |
| 3=stillbirth (> 20 weeks) |  |   |
| 4=ectopic |  |  |   |
| 5=Gest. Trophoblastic Neoplasia |  |   |
| 6=Other (incl. Missed abortion) (not included) |  |   |
| 8=spontaneous abortion (not included) |  |   |
| 9=Unk |  |  |   |
| ***In November, 2001 the Washington State Maternal Mortality Subcommittee of the Perinatal Advisory Committee made the following decisions about death classification to guide the future classification of deaths to women within one year of pregnancy. [Updated September 2016]***  |
| The Subcommittee also determined that in order to be considered a maternal death, the death must clearly be directly related to pregnancy or exacerbated by pregnancy with a known cause. By definition all indefinite/vague causes of death will be grouped as not-pregnancy related. |
| **Pregnancy-related deaths**  |   |   |
| ***Cause of death group*** | ***1*** | ***2*** | ***3*** |
|   | Hemorrhage | Uterine laceration/rupture |   |
|   |   | Abruptio placentae |   |
|   |   | Placenta previa |   |
|   |   | Placenta acreta/percreta or increta |   |
|   |   | Ruptured ectopic |   |
|   |   | Other site |   |
|   |   | Unknown |   |
|   | Embolism (NOT CEREBRAL) | Thrombotic (includes pulmonary embolism, NOS) | Deep vein thrombosis (if death occurs < 42 days post pregnancy) |
|   |  | Amniotic fluid, autopsy yes |   |
|   |  | Amniotic fluid, autopsy no |   |
|   |  | Cardiac embolism |   |
|   |  | Air |   |
|   |  | Other (includes septic embolism) |   |
|   |   | Unknown/NOS pulmonary embolism |   |
|   | Hypertension | pre-eclampsia associated with/-- | 1=Cerebrovascular hemorrhage |
|   |   | eclampsia associated with/-- | 2=Cerebral edema |
|   |   | other/NOS hypertension in pregnancy | 3=Cerebral embolism |
|   |   | pre-existing hypertension with superimposed pre-eclampsia or eclampsia | 4=Metabolic complications (renal failure) |
|   |   |   | 5=Metabolic complications (hepatic failure) |
|   |   |   | 6=HELLP syndrome |
|   |   |   | 7=DIC-Disseminated Intravascular Coagulopathy |
|   |   |   | 8=Other (includes encephalopathy) (Note - CDC now includes CVA nos, Cerebral infarct, thrombosis) |
|   |   |   | 9=Unknown/NOS |
|   | Infection | 1=Chorioamnionitis/antepartal infection |   |
|   |  | 2=Postpartum pelvic infection |   |
|   |  | 3=Generalized septicemia/septic shock/septic Ab |   |
|   |  | 4=Peritonitis |   |
|   |  | 5=Other pelvic tract infection |   |
|   |  | 6=Nonpelvic infection (eg, pneumonia) |   |
|   |  | 7=Urinary tract infection (ex pyelonephritis, cystitis, UTI) |   |
|   |  | 8=other |   |
|   |   | 9=Unknown |   |
|   | Cancer | Choriocarcinoma | \*\*Added after Level 2 Review Meeting 12-21-16 |
|   | Cardiac | 1=cardiomyopathy |   |
|   |   | 2=cardiomegaly |   |
|   |   | 3=cardiac defect (eg, Eisenmenger syndrome) |
|   |   | 4=cardiac defect (maternal congenital cardiac defects) |
|   |   | 5=cardiac defect (acquired valvular disease, including SBE/ABE and rheumatic disease) |
|   |   | 4=acute myocardial infarction |   |
|   |   | 5=coronary artery dissection |   |
|   |   | 6=atherosclerosis |   |
|   |   | 8=other |   |
|   | Anesthesia |   |   |
|   | Gatrointestinal | Acute fatty liver of pregnancy |   |
|   |   |   |   |
|   | Other | 1=cerebral hemorrhage |   |
|   |  | 2=ruptured other aneurysm |   |
|   |  | 3=thrombotic thrombocytopenic purpura (TTP) |
|   |  | 4 = neurologic/neurovascular (incl. Cerebral aneurysm?), CVA |
|   |  | 5=pulmonary |   |
|   |  | 8=Other |   |
|   |   | 9=Don't know |   |
| **Not pregnancy-related deaths** |   |   |
| ***Cause of death group*** | ***1*** | ***2*** | ***3*** |
|   |   | Mechanism | Intent |
|   | Injury | Motor vehicle accident | Unintended |
|   |   | Fall | Suicide |
|   |   | Firearm | Homicide |
|   |   | Overdose |   |
|   |   | Cut/pierce |   |
|   |   | Strangulation/suffocation |   |
|   |   | Other |   |
|   |   | Unknown |   |
|   | Infection/sepsis (if death occurs ≥ 42 days post pregnancy) |   |   |
|   | Cancer | Exception: choriocarcinoma |   |
|   | Cardiovascular (Case specific) |   |
|   | Respiratory (Case specific) |   |   |
|   | Epilepsy (if death occurs ≥ 42 days post pregnancy) |   |   |
|   | Deep vein thrombosis (if death occurs ≥ 42 days post pregnancy) |   |   |
|   | Intracerebral hemorrhage (if death occurs ≥ 30 days post pregnancy) |   |   |
|   |  *Diseases of the circulatory system* | 1=Myocardial infarction, ischaemic heart dx |
|   |   | 2=Cerebral hemorrhage or infarction  |   |
|   |   | 3=Pulmonary heart dx, dx of pulmonary circ |
|   |   | 4=Other forms of heart dx, (incl Cardiomyopathy) |
|   |   | 8=Other |   |
| ***\*\*\*Maybe pregnancy-related cases - need to be carefully reviewed with additional clinical information wherever possible.*** |
| Specifically, the following underlying causes of death need to be carefully reviewed: |   |
|   | Cardiovascular deaths (if death occurs < 90 days post pregnancy) |   |
|   | Myocardial infarction (if death occurs < 42 days post pregnancy) |   |
|   | Epilepsy (if death occurs < 42 days post pregnancy) |   |
|   | Infection (if death occurs < 42 days post pregnancy) |   |
|   |   |   |   |

**Department of Health**

**Policy**

|  |  |  |
| --- | --- | --- |
| Title: | Responsibilities for Confidential Information | Number: 17.005 |
| Procedure: | [See associated procedure](https://doh.sp.wa.gov/sites/OS/pr/hr/Shared%20Documents/OS17005pro.doc) |
| References: | RCW 42.56, RCW 42.48, RCW 42.52, RCW 70.02, DOH Policies 17.003 and 17.006, DOH Information Technology Security Standards and Governor’s Executive Order 00-003 |
| Applies to: | All DOH employees, volunteers, students/interns, and federal assignees |
| Contact: | Privacy Officer |
| Effective Date: |  June 1, 2011 | Review Date:  | June 1, 2014 |
| Supersedes: | DOH Policy 17.005 dated March 15, 2010  |
| Approved: | Signed by Mary C. Selecky | Secretary, Department of Health |

**Policy Statement:**

The Department of Health (DOH) recognizes that to do its work people must trust the agency to protect their confidential information. The Department of Health maintains the minimum confidential information necessary to do its work, makes confidential information available to the fewest number of people necessary, and protects confidential information from unlawful disclosure. This policy and associated procedure outline the department’s expectation that DOH staff protect, in good faith, all confidential information, complying with state and federal law regarding disclosure.

All records of the Department of Health are public records. Information in those records is disclosable except confidential information protected under RCW 42.56 and other applicable laws. This policy, associated procedure and references guide how DOH staff treats confidential information.

For represented employees the collective bargaining agreement (CBA) supersedes specific provisions of agency policies with which it conflicts.

**Definitions**:

Confidential information is a “writing” (see definition below) containing information that is exempt from public disclosure under either state or federal law. The term “writing” includes data. Information exempt from disclosure under law includes, but is not limited to, information protected under the state general public record disclosure law (RCW 42.56) and the health care information act (RCW 70.02). If information is exempt from public disclosure it is confidential and entitled to protection.

Confidentiality breach – unauthorized access, use or disclosure of confidential information.

Writing - means handwriting, typewriting, printing, photostatting, photographing, and every other means of recording any form of communication or representation, including, but not limited to, letters, words, pictures, sounds, or symbols, or combination thereof, and all papers, maps, magnetic or paper tapes, photographic films and prints, motion picture, film and video recordings, magnetic or punched cards, discs, drums, diskettes, sound recordings, and other documents including existing data compilations from which information may be obtained or translated. [RCW 42.56.010 (3)]

**Framework:**

Supervisors, Managers, and Appointing Authorities will use this policy and its associated procedures, the referenced Chapters in RCW and WAC, and the [DOH Information Technology Data Security Standards](http://dohweb/dirm/Security/securitystandards.htm) to:

1. determine which information is confidential and
2. manage confidential data/information regardless of subject matter, source, or format.

DOH staff, volunteers and federal assignees will access, use and disclose confidential information only as specifically authorized by state or federal law.

Appointing Authorities or their designees will authorize access and use of confidential information consistent with state and federal law and the [DOH Information Technology Data Security Standards](http://dohweb/dirm/Security/securitystandards.htm).

Employees will access only the confidential information they have been authorized to use. They will access, use and disclose the minimum amount of confidential information necessary to do their work. They will not otherwise access, use or disclose confidential information.

Upon initial employment each employee will read this policy and sign the Confidentiality Statement. Annually each employee will read the policy, and update and sign the Confidentiality Statement.

Employees will notify the agency Privacy Officer, and their supervisor or office director, of a potential or actual confidentiality breach.

Appointing Authorities and their designees will cooperate with the agency Privacy Officer in investigating the potential or actual breach and take appropriate disciplinary action for violations. Violations may result in administrative, civil and/or criminal penalties. Appointing Authorities, in consultation with the Privacy Officer, are responsible for determining when the department should provide information on violations to the appropriate civil or criminal legal authorities.

**Review and Approval:**

The DOH Privacy Officer and Information Technology Security Officer are responsible for amending this policy and its associated procedure(s), consulting with the Labor Relations Manager in the Office of Human Resources. The Secretary, Department of Health, has full authority to review and approve this policy and associated procedure(s). The Secretary also has the authority to delegate this responsibility.

## **Confidentiality Statement for Maternal Mortality Review Panel**

GENERAL RULE

As a general rule, all records in the Department of Health (DOH) are disclosable to the public. In very specific and narrow circumstances, identified in law, the department may withhold some or all of a record from the public.

RESPONSIBILITIES REGARDING CONFIDENTIAL INFORMATION

As an employee, appointee, volunteer, or federal assignee of the Washington State Department of Health (DOH), I understand that I may handle or have access to confidential information. I understand that I am responsible for maintaining the confidentiality of certain information collected, maintained, stored, or analyzed within DOH.

I recognize and respect the confidential nature of certain information I may have access to during the course of my employment with DOH. I will not at any time, or in any manner, either directly or indirectly, disclose confidential information to anyone outside the scope of my position, unless authorized by law. If I am authorized to disclose confidential information I will follow applicable rules/regulations and policies.

I have received and read the DOH confidentiality policy (17.005) and acknowledge that I understand the policy and the responsibilities delegated to me in it. The Department and I have identified the following types of confidential information I will likely access during my work this year: Pursuant to RCW 70.54.450, all information, documents, proceedings, records, and opinions created, collected, or maintained by the Maternal Mortality Review Panel (MMRP) or the Department in support of the MMRP are strictly confidential. All meetings, proceedings, and deliberations of the panel may be confidential and conducted in executive session.

I understand that I may receive guidance from my supervisor or other Department staff on the practices for handling this and other confidential information.

PENALTIES FOR DISCLOSING CONFIDENTIAL INFORMATION

I understand that if I disclose confidential information to any one in violation of federal and state law, administrative rule and this policy, through any means, it is grounds for disciplinary action against me, which may include termination of employment with DOH.

I understand that my unauthorized acquisition, access, use or disclosure of confidential information may be considered an ethics violation and subject to civil damages or other penalties.

I understand that specific sources of confidential information which include but are not limited to HIV/STD conditions, mental health, and drug and alcohol treatment, are subject to specific state and federal law and administrative rules/regulations. I understand that if I disclose such confidential information in violation of those laws and administrative rules/regulations, I may be subject to civil damages and criminal penalties, including fines and/or imprisonment.

Appointee signature:       Date:

Please print name:

I understand that I must provide information to my employee on the specific information that is confidential in within the scope of my employee’s job responsibilities, and my program, and the practices for handling this information.

Department signature:       Date:

Please print name:

## **Maternal Mortality Review Panel Conflict of Interest Policy**

**Policy Statement:**

The Conflict of Interest Policy provides guidance for existing or potential conflicts of interest among Maternal Mortality Panel Member.

**Background:**

The Maternal Mortality Review Panel (MMRP) is a project of the Washington State Department of Health (DOH) Office of Health Communities (OHC) and Maternal and Child Health, in collaboration with the Centers for Health Statistics (CHR). The MMRP seeks to determine the causes of maternal mortality in Washington to identify policy and healthcare systems changes to reduce maternal mortality and associated demographic and socioeconomic disparities.

**Policy:**

The Washington State Department of Health (DOH) takes numerous precautions to ensure the confidentiality and security of the data obtained through its review of maternal deaths in Washington. Great lengths are taken to ensure the de-identification of the patients, health care professionals and facilities, as well as requirements for the secure maintenance of electronic and hard copy data.

The MMRP is a multidisciplinary, volunteer panel comprised of expert clinicians from around the state. Panel members are experienced health professionals who possess the needed technical expertise in their respective fields. Therefore, owing to their status as leaders in maternity care, it is reasonable to anticipate that conflicts of interest may arise for individuals on the MMRP. Guidance is provided below for such situations.

**Procedure:**

A conflict of interest exists when a Panel member has a financial, professional or personal interest that could directly affect findings or recommendations developed by the MMRP project. DOH and its collaborators seek to avoid being in the position in which others could reasonably question, discredit, or dismiss the findings and recommendations from MMRP on the basis of conflicts of interest. To ensure the integrity of the MMRP project, DOH and its collaborators, MMRP Panel members will adhere to the following procedures:

1. Each Panel member shall submit to DOH MMRP Coordinator a signed “Confidential Conflict of Interest Disclosure” statement disclosing any financial, professional, or personal conflicts of interest relevant to the activities of MMRP.
2. Should an issue arise within the proceedings of the MMRP case review that constitutes a conflict of interest, or the appearance of a conflict of interest, for a Panel member, the affected Panel member shall disclose the possible conflict of interest and not participate in the development of findings or recommendations related to the existing or potential conflict of interest.
3. If a MMRP Panel member is unclear or has doubt as to whether a specific issue constitutes a conflict of interest, the Panel member should err on the side of caution to ensure that the potential conflict does not affect the credibility of the findings or recommendations developed by MMRP.

**I understand and agree to adhere to the conflict of interest policies of MMRP.**

­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

## **Maternal Mortality Review Panel Conflict of Interest Disclosure Form**

As specified in the Maternal Mortality Review Panel (MMRP) **Conflict of Interest Policy**, a conflict of interest exists when a Panel member has a financial, professional or personal interest that could directly affect findings or recommendations developed by the MMRP project.

Please answer to the best of your knowledge the following questions concerning your potential financial, professional and personal conflicts of interest relevant to your functions as a MMRP member.

**MMRP Conflict of Interest Disclosure**

***Financial Interests***

Financial interests include stocks, bonds, and other financial instruments and investments including partnerships exceeding $10,000, but excluding diversified mutual funds. Property interests include real estate and other property interests, as well as intellectual property, patents and copyrights.

1. Do you, your close family members or those with whom you have a substantial common financial interest, have financial investments or property interest that could be directly affected by the MMRP case reviews, findings or recommendations?
2. Could the financial or property interests of your employer, business partners or clients (or the financial interests of your spouse’s employer, business partners or clients) be directly affected by the MMRP case reviews, findings or recommendations?

\_\_\_\_ If the answer to both of the above questions under *Financial Interests* is **NO**, please initial.

\_\_\_\_ If the answer to either of the above questions under *Financial Interests* is **YES**, please initial.

***Professional Interests***

1. Could the employment or self-employment of you or your spouse, including any consulting relationships of you or your spouse be directly affected by the MMRP case reviews, findings or recommendations?
2. Could your current research, funding or support, including equipment, facilities, industry partnerships, research assistants and other research personnel be directly affected by the MMRP case reviews, findings or recommendations?
3. Do you have any existing professional obligations that effectively require you to publicly defend a previously established position on an issue that is relevant to the functions of MMRP?

\_\_\_ If the answer to all of the above questions under *Professional Interests* is **NO,** please initial.

\_\_\_ If the answer to any of the above questions under *Professional Interests* is **YES**, please initial.

***Personal Interests***

1. To the best of your knowledge, could your service to MMRP enable you to obtain access to a competitor’s or potential competitor’s confidential proprietary information?

\_\_\_\_\_ If the answer to the above question under *Personal Interests* is **NO,** please initial.

\_\_\_\_\_ If the answer to the above question under *Personal Interests* is **YES**, please initial.

Please describe the situations in which you answered YES to any question above in the space provided below:

Any changes in status to the above information during your tenure of service should be promptly reported in writing to DOH MMRP Coordinator.

**I have answered truthfully and agree to disclose any changes in potential conflicts of interest to MMRP. I also agree to promptly report any change in status to the above information to DOH MMRP Coordinator.**

Signature

## **Maternal Mortality Review Panel Recusal Policy**

**Policy Statement:**

The Recusal Policy directs Maternal Mortality Panel Members to recuse themselves from Maternal Mortality Panel proceedings if a conflict of interest arises.

**Background:**

The Maternal Mortality Review Panel (MMRP) is a project of the Washington State Department of Health (DOH) Office of Health Communities and Maternal and Child Health, in collaboration with the Centers for Health Statistics (CHR). The MMRP seeks to determine the causes of maternal mortality in Washington to identify policy and healthcare systems changes to reduce maternal mortality and associated demographic and socioeconomic disparities.

**Policy:**

The Washington State Department of Health takes numerous precautions to ensure the confidentiality and security of the data obtained through its review of maternal deaths in Washington. Great lengths are taken to ensure the de-identification of the patients, health care professionals and facilities, as well as requirements for the secure maintenance of electronic and hard copy data.

The Maternal Mortality Review Panel (MMRP) is a multidisciplinary, volunteer panel comprised of expert health professionals from around the state. Given that most members have many years of experience and actively practice medicine, there is the possibility that a member may have been involved in the care of a case under review by MMRP. The member may also have participated in institutional review of the case, expert testimony for legal proceedings.

To address such situations, guidance is provided below for when recusal of MMRP members may be appropriate. The purpose of the MMRP Recusal Policy is to protect the confidentiality of the identified Panel member and to keep case review discussions consistent with the neutrality and anonymity of other reviews. The goal of MMRP is to identify public health interventions and quality improvement to improve maternity care in Washington, not to identify fault or punitive action.

**Procedure:**

**REQUIRED RECUSAL and Required Non-participation in MMRP Deliberations**

In cases where a MMRP member is identified as having been actively involved in the care, either as the primary provider or consultant, of a case under review, the Panel member will be recused from the case review discussion. The process of recusal will be as follows:

* The panel member will be contacted prior to the meeting and informed that it will be necessary for them to be absent from the room when the case in question is reviewed.
* The panel member will be aware of when the case in question will be reviewed. Directions on how to remove him or herself from the room without identifying him or herself as involved in a the case in question will be provided by the DOH MMR Team
* The MMRP Coordinator will be informed ahead of time to ensure that the case is not assigned to the Panel member and that case review does not begin until the Panel member is absent from the room.
* There will be no discussion of the case before the panel member or by the panel member.
* The identity of the panel member will be protected and known to DOH MMRP Team staff on an as-needed basis.

**SELF-RECUSAL**

In cases where a Panel member was peripherally involved in the care or has independent knowledge of a case under review, the Panel member has the obligation to recuse themselves from the discussion. The intent is to avoid unintentional bias or the accidental admission of additional facts not found in the medical record.

Examples of having been peripherally involved in the care of a case include, but are not limited to: having provided a consult on the case, having had supervisory responsibility for the primary health care professional, being a partner in private practice with or a colleague in the same facility as the primary health care professional.

Examples of having independent knowledge of a case include, but are not limited to: having served or anticipate being on an institutional mortality review board for the case in question, having provided or anticipate being asked to provide expert testimony for legal proceedings or other investigations, or having served or anticipate being asked to serve on malpractice, medical risk, and other insurance-related panels where this case was or will be discussed.

In the event of a Panel member having peripheral or independent knowledge about a case under review in MMRP, the process of self-recusal will be as follows:

* If a Panel member realizes they have peripheral or independent knowledge of a case, they should contact project staff as soon as possible.
* If a Panel member realizes in the course of the case review and or discussion that they have peripheral or independent knowledge of the case, they should recuse themselves from the proceedings as soon as they believe this to be the situation. The Panel member has the option to leave the proceedings, or may choose to remain in the room and listen to the Panel deliberations, but should refrain from participating in the discussion.

**I agree to be recused from MMRP case review discussion for cases where I was directly involved in the care of the decedent as a primary provider or consultant. I also acknowledge that I will declare independent knowledge of cases when applicable and self-recuse from further case review.**

**Signature Date**



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Prevention and Community Health

Office of Healthy Communities

Post Office Box 47855

Olympia, Washington 98504-7855

Date:

To:

## Re: Request for medical records for Washington State Maternal Mortality Review

Attn: Medical Records

The Washington State Department of Health (DOH) is creating the Maternal Mortality Review Panel under RCW 70.54.450, which was passed by the legislature in March 2016. This law calls for “comprehensive, multidisciplinary reviews of maternal deaths in Washington to identify factors associated with those deaths and make recommendations for system changes to improve health care services for women in this state.”

In accordance with the new [bill](https://app.leg.wa.gov/billinfo/summary.aspx?year=2015&bill=6534), the Maternal Mortality Review Panel will be reviewing cases of deaths of women who died within a year of pregnancy or child birth. To conduct the review, the bill gives the Department of Health the authority to obtain records and data from a variety of sources, including health care providers and facilities, local health departments, coroner and medical examiners offices, and other medical and professional facilities licensed by the state of Washington. Information, documents, and records obtained by the Department of Health for the purposes of this review are protected by law and will remain confidential and are not subject to public inspection, copying, or introduction into evidence in any civil or criminal court proceedings.

|  |  |
| --- | --- |
| **Please send all available records on the following patients:** | **Send all records via mail to:****Maternal Mortality Review****Department of Health****Attn: Alexis Bates****PO Box 47880****310 Israel Rd SE****Tumwater, WA 98501** |
| Name | Date of Birth |
|  |  |
|  |  |
|  |  |
|  |  |

For questions or more information please contact Alexis Bates, Perinatal Health Coordinator at the Office of Health Communities by email at alexis.bates@doh.wa.gov or by phone at (360)-236-3510. Information can also be found at our website [www.doh.wa.gov/maternalmortality](http://www.doh.wa.gov/maternalmortality)

Thank you for your assistance with this important health measure,

Alexis Bates, MA

Perinatal Health Coordinator

Washington State Department of Health

## Maternal Mortality Review Case Decision and Discussion Form (CDC 2016)





