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Mission, Goals, and Scope

**Purpose:** In response to rising rates of maternal mortality nationwide, and the rise of chronic disease and mental health disorders which affect maternal health outcomes, the purpose of the maternal mortality review in Washington is to develop a better understanding of the nature of maternal mortality in our state, and in accordance with the law, RCW 70.54.450, to review all maternal deaths in Washington state to identify factors surrounding the deaths and make recommendations for systems changes to prevent the deaths and improve healthcare services for women in the state.

**Mission:**
1. Reduce maternal mortality and inequities in maternal mortality in Washington.
2. Develop a better understanding of social determinants of health and their impact on maternal health outcomes.
3. Increase awareness of the factors contributing to maternal mortality to promote change among individuals, communities, and health care systems.
4. Improve the overall wellbeing of women and children in Washington.
5. Monitor progress and trends of maternal mortality, and identify emerging problems and recommend interventions.

**Vision:** While not all maternal deaths are preventable, it is our vision that we work to prevent maternal deaths in our state, and that all women and children have equitable access to quality and affordable healthcare services when they need them.

**Goal of maternal mortality review:**
1. Fulfill charge with the law [RCW 70.54.450](https://www.leg.wa.gov/laws), and conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington to:
   a. Determine whether a maternal death is related to pregnancy and identify the underlying cause of death
   b. Identify factors associated with pregnancy-related deaths
   c. Identify trends and risk factors among pregnancy-related deaths
   d. Make recommendations for changes to improve health care services for women in this state
2. Submit a report to the healthcare committees of the Washington State House of Representatives and the Senate every two years which:
   a. Describes the findings of the maternal mortality review
   b. Presents data and trends in aggregate
   c. Presents recommendations for healthcare and systems changes to improve women’s healthcare services in the state that reflect the data and the MMRP findings, and best practices in women’s healthcare

**Scope of problem:** According to the Centers for Disease Control and Prevention (Centers for Disease Control), maternal mortality has been on the rise in the United States since the 1980s and approximately 700 women die each year due to pregnancy and/or delivery complications. Many factors seem to have contributed to this rise in rates, including changes in pregnancy surveillance systems and the increase of chronic disease diagnoses among women throughout the country. Further, racial/ethnic, income-based, and geographic health inequities persist in
maternal healthcare delivery, and contribute to maternal mortality, nationwide. Maternal mortality rates have been steady in Washington State since the 1990s. Previous maternal mortality reviews were underfunded and did not utilize comprehensive records review. In order to combat the steadily increasing maternal mortality ratio, the Centers for Disease Control 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.

**Death inclusion criteria:** Deaths which occur in Washington State to women during pregnancy or within 365 days after the end of pregnancy who are Washington State residents.

**Scope of Work:** Within resources available, review all maternal/pregnancy associated-deaths to determine pregnancy relatedness; conduct data and clinical abstractions/chart review on all potentially pregnancy-related deaths to determine preventability, identify critical factors and opportunities for intervention, and make recommendations for prevention. Submit recommendations on the prevention of maternal deaths to state legislators.

**Statutory Authority**

Please refer to RCW 70.54.450

**Important Definitions**

*Department of Health Maternal Mortality Review Team (Department of Health MMR Team):* Department of Health staff members working on the maternal mortality program; includes epidemiologists from the Center for Health Statistics and the Maternal and Child Health Epidemiology Unit; Perinatal unit supervisor, 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 Department of Health 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. This term is used interchangeable with pregnancy-associated death (RCW 70.54.450)

**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 Centers for Disease Control definition). Specific diagnoses, and timelines of death and diagnoses, are based on cause of death decision 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 Maternal Mortality Review Panel Decision Form). This includes MVA, cancer, homicide, suicide, overdose, other accidents, some seizure.

Unable to determine if Pregnancy Related: A maternal death, but whether the death is pregnancy-related is not able to be determined.

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 Maternal Mortality Review Panel Decision Form).

Level 1 Review – Identification of Maternal Deaths: Department of Health MMR Team identifies all maternal deaths from birth and fetal death certificate records, death certificate records, and hospitalization records.

Level 2 Review – Categorization of Maternal Deaths, and Records Review and Abstraction: Department of Health 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 deaths for Level 3 Review, and complete or pre-fill the Maternal Mortality Review Panel Decision Form.

Level 3 Review – Pregnancy-Related Maternal Death Review 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 Centers for Disease Control Death Discussion Forms.

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

Level 4 Review - High-Level Recommendations Development and Discussion:
Department of Health staff, MMRP Members, and Community Stakeholders review and discuss findings and death-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 Department of Health MMR Team; this also includes obtaining approval from the Department of Health Executives, and submitting the report to the legislature.
Maternal Mortality Review Panel Decision Form: Form provided by the Centers for Disease Control which will be completed on each potentially pregnancy-related death, and will help guide discussion for preliminary and in-person death reviews. (See document at the end of this manual)

Core Summary Report: A data summary of maternal death information compiled from all available aggregate records, including medical records, vital statistics records, and autopsy records. This report is generated using the maternal mortality review data base software (MMRDS).

MMRDS – Maternal Mortality Review Data System: database used to house maternal mortality review data

Medical Case Narrative: Broad overview of each death written by Department of Health perinatal 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 death and understanding events leading to death.

Death File: Combination of death summary, the death narrative, and/or other pertinent documents to be used for maternal mortality review.

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

Deidentification: 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

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 and more.

Committee members are appointed by the Secretary of Health. Recruitment of new members occurs as needed. Members are asked to serve the term of the legislative period; however, if at any time a member no longer wishes to serve on the panel, they are asked to notify the coordinator as soon as possible.
1. Members were selected by the Department of Health based on the following criteria:
   a. Clinical expertise in the field of women's health, including (but not limited to), maternal fetal medicine, obstetrics, and midwifery
   b. Interest in women's health and maternal mortality and morbidity
   c. Geographic and cultural/ethnic representation
   d. Ability to commit to one or more of the panel membership roles, which include:
      i. Chart abstraction and review
      ii. Death preparation and summary development
      iii. Specialist death review/consult
      iv. Panel proceedings assistance and/or facilitation
      v. Death presentation for in person meetings
      vi. Preliminary death review in preparation for meetings
      vii. Service on subcommittee for in-person meetings
   e. Commitment to health equity and the overall improvement of quality of life for women and children in Washington State

**Diversity**
In accordance with Department of Health values of diversity, work has been done to ensure the composition of the MMRP was diverse in a variety of ways. 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 Department of Health worked to ensure tribal representation on the MMRP.
   1. Tribal representatives were chosen by the tribes and the American Indian Health Commission (AIHC)
   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 panel is established to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington. Depending on role assignment, member responsibilities may include:
   - Review deidentified data and death information as prepared and presented by Department of Health 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
   - Attend training, review, discussion, and update meetings as requested and when available
• Ask questions related to data and deaths in order to make determinations
• Respond to questions made by other panel members and/or Department of Health MMR Team staff regarding deaths and/or data
• Review RCW 70.54.450
• Review and sign the program policies and procedures on an annual basis. Electronic signatures and storage are acceptable.
• Panel members who are not Department of Health employees are not covered under the Department’s statutory authority to conduct maternal mortality review work. Thus, external members may not:
  o Request records themselves
  o Follow up on records requested but not received
  o Review personal health information that is not de-identified
  o Access the Maternal Mortality Review Data System (MMRDS/MMRIA)
  o Failure to comply with the defined responsibilities will result in termination from the MMRP. Members who are terminated from the MMRP 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. 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. Death-associated information will only be available for review and discussion at the MMRP meetings and will be deidentified.
4. Agenda and meeting notes may be distributed outside of the meeting time and will not contain death-associated information.
5. MMRP members must submit all meeting materials and papers with death-associated notes back to Department of Health staff at the end of all meetings.
6. All information reviewed by the MMRP 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 death review. The record(s) will be de-identified by Department of Health staff. Additional information beyond RCW 70.54.450 requirements may be redacted if it could lead to the identification of a death.
8. While committee members may have concerns or disagreements regarding a death, 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, Department of Health 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.

**Washington State Maternal Mortality Review: Multi-level Review Process**

**Level 1 Review: Identification of Maternal Deaths**

The Level 1 Review process is a coordinated effort between several units at the Department of Health that results in a list of potential maternal deaths for the time period outlined. The process begins at the Center for Health Statistics, where women's deaths are linked with birth and fetal death data to identify women who died within 365 days of giving birth. Additional deaths are 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 deaths are 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.

Once a preliminary list of potential maternal deaths is identified through the linkage processes described above, epidemiological, clinical and program staff review the list of deaths and key data elements and work to remove false maternal deaths and deaths which do not meet death inclusion criteria. Data is then entered into the maternal mortality review data base system (MMRDS). Records needed to meet the objectives of the review process are requested.

**Center for Health Statistics Linkage Process**

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 deaths 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 deaths are identified through probabilistic linkage of deaths and birth or fetal death files using LinkPlus software. These deaths 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.

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

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

Level 2 Review: Categorization of Maternal Deaths, and Records Review and Abstraction
The purpose of the Level 2 Review is to categorize the maternal deaths as either potentially pregnancy-related or pregnancy-associated, not related, and thus identify the scope of work for the in-depth reviews for preventability and then prepare information and data in order to meet the objectives of the review process. First, a subcommittee of the MMRP comes together to review the entire list of maternal deaths for the time period identified, and then based on the cause of death for each maternal death (and using the Maternal Mortality Review Panel Decision Form), the subcommittee works to decide which deaths are potentially pregnancy related. Next, work is done by Department of Health staff to prepare a pregnancy-related
death file for each potentially pregnancy-related death to be used for the Level 3 Review process. The death file includes a medical case narrative and a core summary report on each potentially pregnancy-related death. Records needed to create these documents and meet the review objections are identified and requested for each potentially pregnancy related death. Records are abstracted for the in-depth reviews moving forward.

**Level 2 Review process**

1. **Level 2 Review Meeting: Categorization of all maternal deaths; identify deaths to abstract for review**
   a. 5-7 panel members meet with Department of Health Staff to review Core Summary Report and determine death categorization of each maternal death, and identify deaths for abstraction and preventability review by MMRP (based on whether a death is categorized as pregnancy related or possibly pregnancy related)

2. **Preparation of Pregnancy-Related Death File for Level 3 Review Meeting**
   a. All Pregnancy-Related and possibly Pregnancy Related Death records are abstracted
      i. Records requested on all potentially pregnancy-related deaths as necessary
         1. Request death investigation/autopsy reports when available
         2. Request prenatal, birth/death records as available (begin with facilities identified through vital records and hospitalization files; identify other facilities/providers through records, themselves)
         3. Request other records (social services, WIC, police reports, healthcare authority, etc) as needed for review process
      ii. Maternal Nurse Consultant reviews all records and abstracts information into Medical Case Narrative
      iii. Data entry into MMRIA is conducted and a Core Summary Report is generated from MMRIA for all maternal deaths
      iv. Records are deidentified

**Records Management and Abstraction**

1. All maternal deaths: information collected includes data from the birth and death records and hospitalization revisit files.
2. For all potentially pregnancy-related deaths: additional information is gathered from pertinent records.
   a. Records needed are identified through the birth and death certificates and hospitalization data provided by CHS
   b. 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.
   c. Records requests and receipts are managed by the MMR Coordinator
   d. All records are stored in a locked file cabinet or on a restricted and confidential drive onsite at the Department of Health
e. Identifiable records are only accessed and viewed by Department of Health staff
   i. All records are deidentified before they may be viewed by any MMRP member

Department of Health staff work to abstract pertinent information from all records collected for
the purpose of creating a core summary report and a medical death narrative for MMRP to use
to review deaths.

1. Abstraction into maternal mortality data base system (MMRDS) – Core Summary Report:
   a. Birth and death certificate data along with hospitalization data is collected from
      Vital Statistics and entered into the maternal mortality database on all maternal
deaths. These are deidentified prior to panel member review.
   b. For pregnancy-related and possibly pregnancy related deaths, pertinent data
      from certain records is abstracted depending on resources available;
      Department of Health staff prioritize autopsy and coroner reports for
      abstraction, as well as birth and death records, followed by prenatal records.
      These are deidentified prior to panel member review.

2. Abstraction for Medical Case Narrative
   a. For all pregnancy-related or possibly pregnancy-related deaths, the maternal
      nurse consultant abstracts all available records to create a medical death
      narrative. These are deidentified prior to panel member review.

3. Specialist panel members are asked to review deaths based on cause of death or
   specific diagnoses and identify pertinent data and information to be abstracted and
   included in the death narrative. Panel members only have access to deidentified
   records and narratives.

Records retention
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)

Deidentification Guidelines
In accordance with RCW 70.54.450, prior to the review of any death-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 death:

1. In accordance with Comprehensive Hospital Abstract Report System (CHARS):
   a. First names, middle names or initials, maiden names, legal names
   b. Social Security Numbers
   c. Patient Control Numbers or Medical Record Numbers
   d. Full zip codes (i.e., 5-digit + 4-digit)
      o Replaced with RUCA code for rural/urban description
   e. Hospital or provider identifiers
   f. 5-digit zip codes
   g. County, state, and country of residence
   h. Initials in addition to middle initials of names
   i. Facility names in addition to hospitals and providers (e.g., clinics, laboratories, birth
      facilities, X-ray facilities)
   j. Facility logos
   k. Street addresses
   l. Phone numbers
m. Cities and towns
n. Death numbers, visit numbers, account numbers, order numbers, insurance numbers
o. Signatures and signed initials

2. To comply with Health Insurance Portability and Accountability Act (HIPAA):
   a. Names of the individual or of relatives, employers, or household members of the individual
   b. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes
   c. Telephone numbers
d. Fax numbers
e. Email addresses
f. Social security numbers
g. Medical record numbers
h. Health plan beneficiary numbers
   i. Account numbers
   j. Certificate/license numbers
   k. Vehicle identifiers and serial numbers, including license plate numbers
   l. Device identifiers and serial numbers
   m. Web Universal Resource Locators (URLs)
   n. Internet Protocol (IP) addresses
   o. Biometric identifiers, including finger and voice prints
   p. Full-face photographs and any comparable images
   q. 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 "Red-identification"]; and
   o (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.

3. Exceptions:
a. 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;

Chart Redaction/Deidentification Procedure

Paper records
1. Department of Health makes every effort to discourage the use of paper records for this review process due to cost and efficiency.
2. If a paper record is received, staff make a copy (one sided); the original is stored
3. Using a black sharpie, black out all identifiable information as outlined above; copy redacted document
4. Shred original redacted copy; return copied redacted version to be stored in appropriate location

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
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

Level 3 Review: Pregnancy-Related Maternal Death Review and Preventability Discussion

The goal of the Level 3 Review is to review each potentially pregnancy-related death using information and data gathered from records abstraction, and then determine pregnancy relatedness, the immediate and underlying cause of death, any critical factors surrounding death, whether a death is preventable, and any recommendations for prevention/intervention. This work is done at an in-person meeting of a subcommittee of the MMRP; the process is guided by the Centers for Disease Control/Maternal Mortality Review Panel Decision Form and Facilitation Guide.

Summary of Level 3 Review Process

1. Level 3 Review Meeting – 20-25 Maternal Mortality Review Panel members meet to review deaths
   a. Meeting Objectives
      1. Panel is presented with deidentified information on each potentially pregnancy-related death
      2. Nurse consultant begins by presenting a death using the Core Summary Report and the Medical Case Narrative; Panel members have opportunity to review information, ask questions
      3. Coordinator facilitates meeting using Centers for Disease Control/Maternal Mortality Review Panel Decision Form to assist the panel to:
         a. Determine whether a deaths is pregnancy related, pregnancy associated-not related, or unable to determine
         b. Identify immediate and underlying causes of each death
         c. Identify critical factors surrounding each death
         d. Determine preventability
         e. Develop recommendations on prevention/intervention
      4. Department of Health perinatal nurse consultant manages records files, answers death-specific questions
      5. Department of Health epidemiologists complete forms, answers data-related or vital records questions, and take notes of review meeting

2. Data analysis and interpretation
   a. All information from the review process is entered into the maternal mortality review database and analyzed
   b. Trends, critical factors, and key issues are identified in the data and from the findings of the review
c. Department of Health staff work to review data descriptions and analyses and identify critical factors, gaps, emerging issues, and recommendations; all are analyzed and summarized
d. A summary of findings will be presented to the panel at Level 4 Review meeting

Level 4: High Level Systems Changes Discussion and Recommendation
The purpose of the Level 4 Review is to connect the MMRP with Department of Health leadership and maternal health stakeholders to review the findings of the maternal mortality review and then work to make healthcare and systems-level recommendations to prevent maternal deaths and improve women’s health services in the state

1. MMRP and Department of Health guests (stakeholders) are invited to develop healthcare and systems level recommendations based on the findings of the MMRP review of maternal deaths, data analyses, and the critical factors and key issues identified
2. Department of Health Leadership is briefed and consulted of the findings and emerging issues and works with staff to prioritize and articulate legislative recommendations
3. This meeting takes place once every two years, and findings and decisions are included in the biannual report submitted to legislators.
Policies, Procedures, and Forms

RCW 70.54.450
RCWs > Title 70 > Chapter 70.54 > Section 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 death solely for the purposes of trending and analysis over time. All individually identifiable information must be removed before any death 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 Area Coding
To maintain confidentiality of each maternal death, and to also allow MMRP members to understand locale of each death, Rural Urban Classification Coding (RUCA) is used in place of actual names/locations of maternal death residences or locations. The RUCA coding system is based on maternal residential zip codes. 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
Washington State Department of Health
Maternal Mortality Review Panel

Confidentiality Policy

<table>
<thead>
<tr>
<th>Title:</th>
<th>Responsibilities for Confidential Information</th>
<th>Number: 17.005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure:</td>
<td>See associated procedure</td>
<td></td>
</tr>
<tr>
<td>References:</td>
<td>RCW 42.56, RCW 42.48, RCW 42.52, RCW 70.02, Department of Health Policies 17.003 and 17.006, Department of Health Information Technology Security Standards and Governor’s Executive Order 00-003</td>
<td></td>
</tr>
<tr>
<td>Applies to:</td>
<td>All Department of Health employees, volunteers, students/interns, and federal assignees</td>
<td></td>
</tr>
<tr>
<td>Contact:</td>
<td>Privacy Officer</td>
<td></td>
</tr>
<tr>
<td>Effective Date:</td>
<td>June 1, 2011</td>
<td></td>
</tr>
<tr>
<td>Review Date:</td>
<td>June 1, 2014</td>
<td></td>
</tr>
<tr>
<td>Supersedes:</td>
<td>Department of Health Policy 17.005 dated March 15, 2010</td>
<td></td>
</tr>
<tr>
<td>Approved:</td>
<td>Signed by Mary C. Selecky</td>
<td></td>
</tr>
</tbody>
</table>

Policy Statement:

The Department of Health (Department of Health) 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 Department of Health 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 Department of Health 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 Department of Health Information Technology Data Security Standards to:

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

Department of Health 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 Department of Health Information Technology Data Security Standards.

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 Department of Health 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.

Washington State Department of Health
Maternal Mortality Review Panel
Confidentiality Statement

GENERAL RULE
As a general rule, all records in the Department of Health (Department of Health) 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 (Department of Health), 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 Department of Health.

I recognize and respect the confidential nature of certain information I may have access to during the course of my employment with Department of Health. 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 Department of Health 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 Department of Health.
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.
Policy Statement:
The Conflict of Interest Policy provides guidance for existing or potential conflicts of interest among Maternal Mortality Panel Member.

The Maternal Mortality Review Panel (MMRP) is a voluntary review committee hosted by the Washington State Department of Health (Department of Health), in the Division of Prevention and Community Health, in the Office of Family and Community Health Improvement.

Policy:
The Washington State Department of Health (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 confidentiality of patients, health care professionals and facilities, and 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. 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. Department of Health 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, Department of Health and its collaborators, MMRP Panel members will adhere to the following procedures:

1. Each Panel member shall submit to Department of Health 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 a conflict of interest arise during the review process, or the appearance of a conflict of interest, for MMRP member, the affected member will 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 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

This document was developed using examples obtained from the California State Pregnancy Associated Mortality Review Program (2016).
Washington State Department of Health
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 an MMRP member has a financial, professional or personal interest that could directly affect findings or recommendations developed by the MMRP program.

**MMRP Conflict of Interest Disclosure – Please answer Yes or No to the following:**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you, your family members or those with whom you have common financial interest, have financial investments or property interest that could be directly affected by the MMRP death reviews, findings or recommendations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 death reviews, findings or recommendations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 death reviews, findings or recommendations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Could your current research, funding or support, including equipment, facilities, industry partnerships, research assistants and other research personnel be directly affected by the MMRP death reviews, findings or recommendations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Department of Health 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 Department of Health MMRP Coordinator.

Signature __________________________ Date __________

This document was developed using examples obtained from the California State Pregnancy Associated Mortality Review Program (2016).
Washington State Department of Health
Maternal Mortality Review Panel:
Recusal Policy and Form

Policy Statement:
The Recusal Policy directs Maternal Mortality Panel Members to recuse themselves from Maternal Mortality Panel proceedings if a conflict of interest arises. The purpose of the MMRP Recusal Policy is to protect the confidentiality of the identified MMRP member and to keep death review discussions consistent with the neutrality and anonymity of other reviews.

Background:
The Maternal Mortality Review Panel (MMRP) is a voluntary review committee hosted by the Washington State Department of Health (Department of Health), in the Division of Prevention and Community Health, in the Office of Family and Community Health Improvement. The MMRP seeks to determine the causes of maternal mortality in Washington to identify policy and healthcare systems changes to reduce maternal mortality, improve maternal healthcare services, and address 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 confidentiality of the patients, health care professionals and facilities, and 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. There is the possibility that a member may have been involved in the care of a death under review by MMRP, or that the member may have participated in institutional review of the death, expert testimony for legal proceedings. To address such situations, guidance is provided below for when recusal of MMRP members may be appropriate.

Procedure:
REQUIRED RECUSAL and Required Non-participation in MMRP Deliberations
In deaths where a MMRP member is identified as having been actively involved in the care, either as the primary provider or consultant, of a death under review, the member will be recused from the death 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 death in question is reviewed.
- The panel member will be aware of when the death 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 death in question will be provided by the Department of Health MMR Team
- The identity of the panel member will be protected and known to Department of Health MMR Team staff on an as-needed basis.
SELF-RECUAL
In deaths where a MMRP member was peripherally involved in the care or has independent knowledge of a death under review, the member has the option 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 death include, but are not limited to: having provided a consult on the death, 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 death include, but are not limited to: having served or anticipate being on an institutional mortality review board for the death 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 death was or will be discussed.

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

- If a member realizes they have peripheral or independent knowledge of a death, they should contact project staff as soon as possible.
- If a member realizes in the course of the death review and or discussion that they have peripheral or independent knowledge of the death, the panel member has the option to leave the proceedings, or may choose to remain in the room and listen to the deliberations, but should refrain from participating in the discussion.

I agree to be recused from MMRP death review discussion for deaths 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 deaths when applicable and self-recuse from further death review.

Signature

Date

This document was developed using examples obtained from the California State Pregnancy Associated Mortality Review Program (2016).
**Maternal Mortality Review Committee Decisions Form**

**COMMITTEE DETERMINATION OF PREVENTABILITY**
A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, community, provider, facility, and/or systems factors.

**CRITICAL FACTORS WORKSHEET**
What were the critical factors that contributed to this death? Multiple class categories may be assigned to each critical factor.

<table>
<thead>
<tr>
<th>CRITICAL FACTOR</th>
<th>CLASS CATEGORY AND DESCRIPTION OF ISSUE</th>
<th>RECOMMENDATIONS OF THE COMMITTEE</th>
<th>LEVEL OF PREVENTION (SELECT FROM MENU BELOW)</th>
<th>LEVEL OF IMPACT (SELECT FROM MENU BELOW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT/ FAMILY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMMUNITY</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>PROVIDER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FACILITY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SYSTEM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CLASS CATEGORY KEY (Definitions on Page 4)**
- Delay
- Adherence
- Knowledge
- Cultural / religious
- Environmental
- Violence
- Mental Health
- Substance Abuse
- Chronic disease
- Childhood abuse / trauma
- Access / financial
- Unstable housing
- Social Support / Isolation
- Equipment / technology
- Policies / procedures
- Communication
- Continuity of care / care coordination
- Clinical skill / quality of care
- Outreach
- Enforcement
- Referral
- Assessment
- Legal
- Other

**PREVENTION**
- PRIMARY
  - Prevents the contributing factor before it ever occurs
- SECONDARY
  - Reduces the impact of the contributing factor once it has occurred (i.e., treatment)
- TERTIARY
  - Reduces the impact or progression of an ongoing contributing factor once it has occurred (i.e., management of complications)

**EXPECTED IMPACT LEVEL**
- SMALL
  - Education/Counseling (Community- and/or provider-based health promotion and education activities)
- MEDIUM
  - Clinical intervention and coordination of care across continuum of well-woman visits through obstetrics (protocol, prescriptions)
- LARGE
  - Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies / LARC)
- GIANT
  - Change in context (promote environments that support healthy living / ensure available and accessible services)

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).
## IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH* PMSS-MM

If more than one is selected, please list them in order of importance beginning with the most compelling (1-2, no more than 2 may be selected in the system).

*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.

<table>
<thead>
<tr>
<th>Number</th>
<th>Condition Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Hemorrhage (excludes aneurysms or CVA)</td>
</tr>
<tr>
<td>10.1</td>
<td>Hemorrhage - rupture/laceration/ intra-abdominal bleeding</td>
</tr>
<tr>
<td>10.2</td>
<td>Placental abruption</td>
</tr>
<tr>
<td>10.3</td>
<td>Placenta previa</td>
</tr>
<tr>
<td>10.4</td>
<td>Ruptured ectopic pregnancy</td>
</tr>
<tr>
<td>10.5</td>
<td>Hemorrhage – uterine atony/ post-partum hemorrhage</td>
</tr>
<tr>
<td>10.6</td>
<td>Placenta accreta/increta/previa</td>
</tr>
<tr>
<td>10.7</td>
<td>Hemorrhage due to retained placenta</td>
</tr>
<tr>
<td>10.8</td>
<td>Hemorrhage due to primary DIC</td>
</tr>
<tr>
<td>10.9</td>
<td>Other hemorrhage/NOS</td>
</tr>
<tr>
<td>20</td>
<td>Infection</td>
</tr>
<tr>
<td>20.1</td>
<td>Post-partum genital tract (e.g. of the uterus/ pelvis/perineum/necrotizing fasciitis)</td>
</tr>
<tr>
<td>20.2</td>
<td>Sepsis/septic shock</td>
</tr>
<tr>
<td>20.4</td>
<td>Chorioamnionitis/ante partum infection</td>
</tr>
<tr>
<td>20.5</td>
<td>Non-pelvic infections (e.g. pneumonia, TR, meningitis, HIV)</td>
</tr>
<tr>
<td>20.6</td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td>20.9</td>
<td>Other infections/NOS</td>
</tr>
<tr>
<td>30</td>
<td>Embolism - thrombotic (non-cerebral)</td>
</tr>
<tr>
<td>30.9</td>
<td>Other embolism/NOS</td>
</tr>
<tr>
<td>31</td>
<td>Embolism - amniotic fluid</td>
</tr>
<tr>
<td>40</td>
<td>Pre-eclampsia</td>
</tr>
<tr>
<td>60</td>
<td>Chronic hypertension with superimposed preeclampsia</td>
</tr>
<tr>
<td>70</td>
<td>Anesthesia complications</td>
</tr>
<tr>
<td>80</td>
<td>Cardiomyopathy</td>
</tr>
<tr>
<td>80.1</td>
<td>Cardiomyopathy/post-partum cardiomyopathy</td>
</tr>
<tr>
<td>80.2</td>
<td>Hypertrophic cardiomyopathy</td>
</tr>
<tr>
<td>80.3</td>
<td>Other cardiomyopathy/NOS</td>
</tr>
<tr>
<td>82</td>
<td>Hematologic</td>
</tr>
<tr>
<td>82.1</td>
<td>Sickle cell anemia</td>
</tr>
<tr>
<td>82.9</td>
<td>Other hematologic conditions including thromboembolias/TTP/HUS/NOS</td>
</tr>
<tr>
<td>83</td>
<td>Collagen vascular/autoimmune diseases</td>
</tr>
<tr>
<td>83.1</td>
<td>Systemic lupus erythematosus (SLE)</td>
</tr>
<tr>
<td>83.9</td>
<td>Other collagen vascular diseases/NOS</td>
</tr>
<tr>
<td>85</td>
<td>Conditions unique to pregnancy (e.g. gestational diabetes, hyperemesis, liver disease of pregnancy)</td>
</tr>
<tr>
<td>86</td>
<td>Injury</td>
</tr>
<tr>
<td>87</td>
<td>Intentional (homicide)</td>
</tr>
<tr>
<td>88.2</td>
<td>Unintentional</td>
</tr>
<tr>
<td>88.9</td>
<td>Unknown/NOS</td>
</tr>
<tr>
<td>89</td>
<td>Cancer</td>
</tr>
<tr>
<td>89.1</td>
<td>Gestational trophoblastic disease (GTN)</td>
</tr>
<tr>
<td>89.3</td>
<td>Malignant melanoma</td>
</tr>
<tr>
<td>89.9</td>
<td>Other malignancies/NOS</td>
</tr>
<tr>
<td>90</td>
<td>Cardiovascular conditions</td>
</tr>
<tr>
<td>90.1</td>
<td>Coronary artery disease/myocardial infarction (MI)/atherosclerotic cardiovascular disease</td>
</tr>
<tr>
<td>90.2</td>
<td>Pulmonary hypertension</td>
</tr>
<tr>
<td>90.3</td>
<td>Valvular heart disease</td>
</tr>
<tr>
<td>90.4</td>
<td>Vascular aneurysm/dissection</td>
</tr>
<tr>
<td>90.5</td>
<td>Hypertensive cardiovascular disease</td>
</tr>
<tr>
<td>90.6</td>
<td>Marfan's syndrome</td>
</tr>
<tr>
<td>90.7</td>
<td>Conduction defects/arrhythmias</td>
</tr>
<tr>
<td>90.8</td>
<td>Vascular malformations outside head and coronary arteries</td>
</tr>
<tr>
<td>90.9</td>
<td>Other cardiovascular disease, including CHF, cardiomegaly, cardiac hypertrophy, cardiac fibrosis, nonacute myocarditis/NOS</td>
</tr>
<tr>
<td>91</td>
<td>Pulmonary conditions (excludes ARDS,Adult respiratory distress syndrome)</td>
</tr>
<tr>
<td>91.1</td>
<td>Chronic lung disease</td>
</tr>
<tr>
<td>91.2</td>
<td>Gastroesophageal fibrosis</td>
</tr>
<tr>
<td>91.3</td>
<td>Asthma</td>
</tr>
<tr>
<td>91.9</td>
<td>Other pulmonary disease/NOS</td>
</tr>
<tr>
<td>92</td>
<td>Neurologic/neuromuscular conditions (excluding CVAs)</td>
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</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Condition Description</th>
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<tr>
<td>92.0</td>
<td>Other neurologic diseases/NOS</td>
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<tr>
<td>93</td>
<td>Renal disease</td>
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<tr>
<td>93.1</td>
<td>Chronic renal failure/end-stage renal disease (ESRD)</td>
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<td>93.3</td>
<td>Other renal disease/NOS</td>
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<td>95</td>
<td>cerebrovascular accident (hemorrhage/thrombosis/aneurysm/ malformation) not secondary to hypertensive disease</td>
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<td>96</td>
<td>Metabolic/endocrine</td>
</tr>
<tr>
<td>96.1</td>
<td>Obesity</td>
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<tr>
<td>96.2</td>
<td>Diabetes mellitus</td>
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<tr>
<td>96.3</td>
<td>Other metabolic/endocrine disorders</td>
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<tr>
<td>97</td>
<td>Gastrointestinal disorders</td>
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<td>97.1</td>
<td>Crohn’s disease/ulcerative colitis</td>
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<td>97.2</td>
<td>Liver disease/failure/transplant</td>
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<td>Other gastrointestinal diseases/NOS</td>
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<td>Mental health conditions</td>
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<tr>
<td>100.1</td>
<td>Depression</td>
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<td>100.9</td>
<td>Other psychiatric conditions/NOS</td>
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<td>Unknown E00</td>
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CLASS DESCRIPTIONS

DELAY OR FAILURE TO SEEK CARE
The woman was delayed in seeking or did not access care, treatment or follow-up care/actions (e.g., missed appointment and did not reschedule).

ADHERENCE WITH MEDICAL RECOMMENDATIONS
The woman did not accept medical advice (e.g., refused treatment for religious or other reasons or left the hospital against medical advice).

KNOWLEDGE - LACK OF KNOWLEDGE REGARDING IMPORTANCE OF EVENT OR OF TREATMENT OR FOLLOW-UP
The woman did not receive adequate education, or lacked knowledge or understanding regarding the significance of a health event (e.g., shortness of breath as a trigger to seek immediate care) or understanding about the need for treatment/follow-up after evaluation for a health event (e.g., needed to keep appointment for psychiatric referral after an Ed visit for exacerbation of depression).

CULTURAL, RELIGIOUS, OR LANGUAGE FACTORS
Demonstration that any of these factors was either a barrier to care due to lack of understanding or led to refusal of therapy due to beliefs (or belief systems)

ENVIRONMENTAL FACTORS
Factors related to weather or terrain (e.g., the advent of a sudden storm leads to a motor vehicle accident)

VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)
Physical or emotional abuse other than that perpetrated by intimate partner (e.g., family member or stranger) IPV Physical or emotional abuse perpetrated by the woman's current or former Intimate partner

MENTAL HEALTH
The woman carried a diagnosis of a psychiatric disorder. This includes postpartum depression

SUBSTANCE USE - ALCOHOL, ILLICIT DRUGS, PRESCRIPTION ABUSE
Women's substance abuse directly compromised women's health status (e.g., acute methamphetamine intoxication exacerbated postpartum depression, or woman was more vulnerable to infections or medical conditions) Instances of differential treatment by healthcare professionals or facilities (e.g., clinician bias/judgment affected treatment or how teams responded to woman's substance abuse should be appropriately noted in one of the clinical factors in the description of the issue.

SUBSTANCE USE - TObACCO
Women's use of tobacco directly compromised the woman's health status (e.g., long-term smoking led to underlying chronic lung disease).

CHRONIC DISEASE
Occurrence of one or more significant pre-existing medical condition(s) (e.g., obesity, cardiovascular disease or diabetes)

CHILDHOOD SEXUAL ABUSE / TRAUMA
Women experienced rape, molestation, or other sexual exploitation during childhood plus perception, inducement or coercion of a child to engage in sexually explicit conduct. Or woman experienced physical or emotional abuse or violence other than that related to sexual abuse during childhood.

UNINSURED/LACK OF ACCESS OR FINANCIAL RESOURCES
Lack or loss of health insurance or other financial status that impacted woman's ability to care for herself (e.g., did not have insurance because unable to work or afford postpartum visits after insurance expired) Barriers to accessing care (e.g., insurance, provider shortage, transportation, system issues) as opposed to woman's noncompliance related to lack of care. Examples include lack of insurance, non-eligibility, a provider shortage in woman's geographical area, or lack of public transportation

UNSTABLE HOUSING
Women lived "on the street" or in a homeless shelter OR lived in transitional or temporary circumstances with family or friends.

SocIAL SUPPORT/ISOLATION - LACK OF FAMILY/FRIEND SUPPORT SYSTEM
Social support from family, partner, or friends was lacking, inadequate and/or dysfunctional (e.g., domestic violence, no one to rely on to ensure appointments were kept).

INADEQUATE OR UNAVAILABLE EQUIPMENT/ TECHNOLOGY
Equipment was missing, unavailable or not functional, (e.g., absence of blood drawing connector).

LACK OF STANDARDIZED POLICIES/PROCEDURES
The facility lacked basic policies or infrastructure germane to the woman's needs, (e.g., response to high blood pressure or a lack of or outdated policy or protocol).

POOR COMMUNICATION / LACK OF CASE COORDINATION OR MANAGEMENT / LACK OF CONTINUITY OF CARE
Case was fragmented (i.e. uncoordinated or not comprehensive) among or between healthcare facilities or units, (e.g., records not available between inpatient to outpatient or among units within the hospital, such as Emergency Department and Labor and Delivery)

LACK OF CONTINUITY OF CARE
Care providers did not have access to woman's complete records or did not communicate woman's status sufficiently. Lack of continuity can be between prenatal, labor and delivery, and postpartum providers

CLINICAL SKILL/QUALITY OF CARE
Personnel were not appropriately skilled for the situation or did not exercise clinical judgment consistent with current standards of care, (e.g., error in the preparation or administration of medication or unavailability of translation services).

INADEQUATE COMMUNITY OUTREACH/RESOURCES
Lack of coordination among healthcare system and other outside agencies/organizations in the geographic/cultural area that work with maternal child health issues

INADEQUATE LAW ENFORCEMENT RESPONSE
Law enforcement response was not in a timely manner or was not appropriate or thorough in scope.

FAILURE TO REFER OR SEEK CONSULTATION
Specialists were not consulted or did not provide care; referrals to specialists were not made.

FAILURE TO SCREEN/INADEQUATE ASSESSMENT OF RISK
Factors placing the woman at risk for a poor clinical outcome were not recognized and the woman was not transferred/transported to a provider able to give a higher level of care.

LEGAL
Legal considerations that impacted outcome