Kansas Maternal Mortality Review Committee

Guidance Document

June 2024

Kansas Maternal Mortality Review Committee

KANSAS MATERNAL & CHILD HEALTH

Contents

Acknowledgements
Tools and Resources for this project were adapted from the Review to Action Website: www.reveiwtoaction.org.

Introduction to Maternal Mortality Review Committees

Data to Action:

There are two national sources for trends and information on maternal deaths using vital statistics data.

1) The National Center for Health Statistics (NCHS), uses death certificate information to assign ICD-10 codes that are then used to identify maternal deaths and produce a maternal mortality rate (maternal deaths while pregnant or within 42 days postpartum per 100,000 live births.)

2) The pregnancy Mortality Surveillance System (PMSS) uses death certificates with a relationship to pregnancy identified by either a check box on the death certificate, or by a linked birth certificate registered in the year preceding death. Medical epidemiologists review this information to identify pregnancy related deaths and produce a pregnancy related mortality ratio (pregnancy-related deaths while pregnant or within a year postpartum per 100,000 live births.)

	CDC-National Center for Health Statistics (NCHS)	**CDC-Pregnancy Mortality Surveillance System (PMSS)**
Data Source	Death Certificates	Death Certificates linked to fetal death and birth certificates
Time Frame	During pregnancy-42 days post-partum	During pregnancy-365 days post-partum
Source of classification	ICD-10-codes	Medical epidemiologists (PMSS codes)
Terms	Maternal Death	Pregnancy-associated, (Associated and) pregnancy related, (associated but)not pregnancy related
Measure	Maternal mortality rate- # of maternal deaths per 100,000 live births	Pregnancy related mortality ratio- # of pregnancy-related deaths per 100,000 live births

A reliance on vital statistics alone to measure maternal mortality makes it challenging to determine whether changes observed are the result of improved identification of maternal deaths or changes in the risk. While surveillance using vital statistics can tell us about the trends and disparities, state maternal mortality review committees are best positioned to compressively assess maternal deaths and identify opportunities for prevention.

There are six (6) key decisions that maternal mortality review committees make for each death reviewed:

1) Was the death pregnancy related?
2) If pregnancy related, what was the cause of death?
3) ***Was the death preventable?***
4) ***What were the critical contributing factors to the death?***
5) ***What are the recommendations and actions that address those contributing factors?***
6) ***What is the anticipated impact of those actions if implemented?***

While all six questions are essential, the last four questions highlight the unique and critical role of the review committees: preventability, contributing factors, recommendations for improvement and measurement of impact.

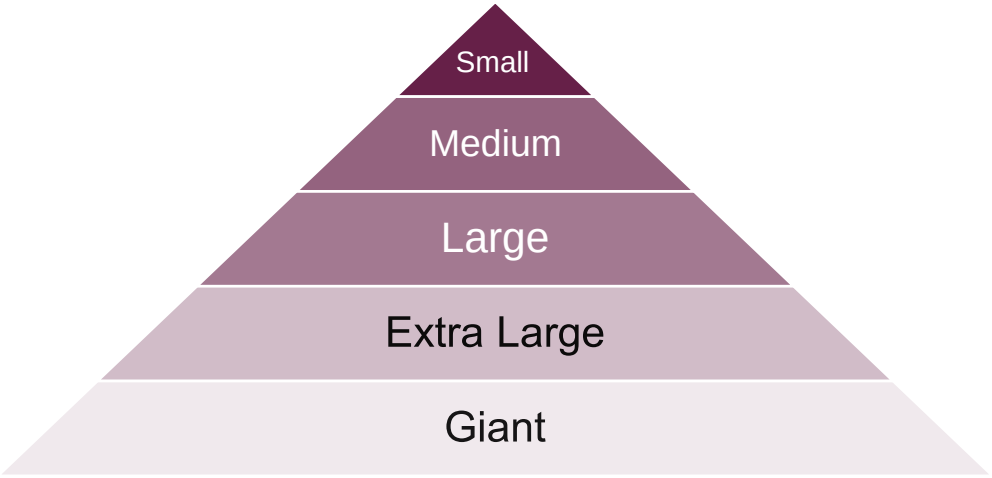
Levels of Prevention:

For each recommendation that the committee makes, the level of prevention should be determined. This decision helps support prioritization of recommendations by the committee for translation to action.

- **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 of progression of an ongoing contributing factor once it has occurred (i.e. management).

Levels of Impact:

For each recommendation a committee makes, the expected level of impact of implementation should be determined. The following can be used as a guide; the image was adapted from CDC Director Tom Frieden's Impact Pyramid below.



- **Small**: Education and Counseling
    - Community/provider-based health promotion and education activities
- **Medium**: Clinical intervention and coordination of care
    - Protocols
    - Prescriptions
- **Large**: Long Lasting Protective Intervention
    - Improve readiness, recognition, and response to obstetric emergencies
    - Increase access to long-acting reversible contraceptives (LARC)
- **Extra Large**: Change in Context
    - Improve public transportation
    - Reduce vehicle carbon emissions
    - Ensure available and accessible services
    - Promote Environments that support healthy living
- **Giant**: Address Social Determinants of Health
    - Poverty
    - Inequality

Kansas Maternal Mortality Review Committee (KMMRC)

The Kansas Department of Health & Environment (KDHE) Bureau of Family Health is responsible for administering the Title V Maternal & Child Health (MCH) Block Grant Program which involves monitoring, researching, and evaluating health status and conducting activities to identify and address community health problems through the use of the 10 essential health services (www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html).

Within the population of women of reproductive age, maternal mortality is an indicator that is monitored by KDHE pursuant to K.S.A. 65-177. Maternal mortality is considered a sentinel (patient safety) event that warrants close scrutiny. An increasing national and state trend in maternal mortality indicates the need to conduct maternal mortality review in order to gain insight into the medical and social factors leading to these events and to prevent future occurrences of maternal mortality.

Scope:

The scope of cases for Kansas review is all pregnancy-associated deaths or any deaths of women with indication of pregnancy up to 365 days, regardless of cause (i.e. motor vehicle accidents during pregnancy, motor vehicle accidents postpartum, suicide, and homicide). Deaths are identified from review of death certificates with a pregnancy check-box selection and linkage of vital records by searching death certificates of women of reproductive age and matching them to birth or fetal death certificates in the year prior.

Purpose:

The purpose of the review is to determine the factors contributing to maternal and pregnancy-associated mortality in Kansas and identify public health and clinical interventions to improve systems of care.

Vision:

The Maternal Mortality Review Committee's vision is to eliminate preventable maternal deaths in Kansas.

Mission:

The mission is to increase awareness of the issues surrounding pregnancy-related death and to promote change among individuals, communities, and healthcare systems in order to reduce the number of deaths.

Goals:

The goals of the Maternal Review Committee are to:

- **Perform through record abstraction** in order to obtain details of events and issues leading up to a mother's death.
- **Perform a multidisciplinary review of cases** to gain a holistic understanding of the issues.
- **Determine the annual number of maternal deaths related to pregnancy** (pregnancy related mortality).
- **Identify trends and risk factors** among pregnancy-related death in Kansas.
- **Recommend improvements to care** at the individual, provider, and system levels with the potential for reducing or preventing future events.
- **Prioritize findings and recommendations** to guide development of effective preventive measures
- **Recommend actionable strategies for prevention** and intervention.

- **Disseminate the findings and recommendations** to a broad array of individuals and organizations.
- **Promote the translation of findings and recommendations** into quality improvement actions at all levels.

Statutory Authority & Protections:

The maternal mortality review is conducted pursuant to K.S.A. 65-177 and 65-2422d. See Appendix A for full text of the public health laws that apply.

- **K.S.A. 65-177** provides authority for the KDHE to conduct studies to reduce morbidity or mortality; all data shall be treated as confidential. Interviewing patients or family members must be done pursuant to K.S.A. 65-2422d. Provides authority for non-identifying aggregate statistical and narrative reports/publications.
- **K.S.A. 65-2422d** authorizes the secretary to use birth, death and still birth certificates as identifiable data for purposes of maternal and child health surveillance and monitoring. The secretary or the secretary's designee may interview individuals for purposes of maternal and child health surveillance and monitoring only with an approval of the health and environmental institutional review board as provided in title 45, part 46 of the code of federal regulations**.**

Process:

Information is gathered from death certificates, birth certificates, medical records, autopsy reports, and other pertinent resources. Records are abstracted by a trained abstractor, who prepares de-identified case narratives for review by a committee of experts from diverse disciplines. Review the Logic Model (Appendix B) and Committee Decisions Form for more information.

Meeting Structure:

The Maternal Mortality Review Committee (MMRC) reviews and makes decisions about each case based on the case narrative and abstracted data. The committee examines the cause of death and contributing factors, and determines:

1. Was the death pregnancy-related?
2. If pregnancy-related, what was the underlying cause of death?
3. **Was the death preventable?**
4. **If there were chances to alter the outcome, what were they?**
5. **What were the contributing factors to death?**
6. **What specific and feasible recommendation for actions should be taken to prevent future deaths?**

The Role of the Abstractor:

The abstractor represents the MMRC while out in the field and holds a great deal of responsibility to ensure the protection and confidentially of the information gathered. The abstractor typically reviews and abstracts information from death certificates, fetal death certificates, medical and hospitalization records, autopsies, and social service records. The abstractor will receive assigned cases from the program coordinator and will obtain the information within a defined period of time. The abstractor is responsible for writing the case narrative, and providing additional information on each case based on clinical documentation in the records. The abstractor will attend review committee meetings and report to the program coordinator.

Membership:

The Kansas Maternal Mortality Review Committee (KMMRC) is a multidisciplinary committee whose geographically diverse members represent various specialties, facilities, and systems that interact with and impact maternal health. Membership represents obstetrics and gynecology, forensic pathology, nurse-midwifery, maternal fetal medicine, anesthesiology, nursing, psychiatry, mental/behavioral health, public health, advocacy, Indian/Tribal health, and more. Committee members are appointed by the Department. Recruitment of new KMMRC members may occur annually as needed unless a specific type of expertise is required during the year for a case review (Example: domestic violence). Interested individuals must complete a membership application (Appendix F) that will be reviewed by Department KMMRC staff members. The application will be revised annually as needed to reflect current vacancies within the committee. The Department will engage the KMMRC to identify and recruit interested individuals; however, the Department will maintain the authority to appoint the membership. The KMMRC membership will not exceed 40 members, excluding Department staff. KMMRC members do not have a term limit for their volunteer stewardship.

Membership Responsibilities:

All KMMRC members will serve in a volunteer capacity and will not receive compensation for participation in the review process. Reimbursement for travel, lodging and other actual expenses may be available pursuant to the Department's policy (Appendix C). Request for reimbursement must be submitted on the Department's reimbursement form (Appendix C1), including actual receipts.

KMMRC 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

Failure to comply with the defined responsibilities will result in termination from the KMMRC. Members who are terminated from the KMMRC are ineligible for future participation.

Kansas Maternal Mortality Review Committee Policies and Procedures

Maintaining Confidentiality:

Maternal Mortality Review Committee (MMRC) members will be 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 information regarding facilities, providers and families is considered confidential and is not shared.

All individual case materials presented to review committee members contain de-identified information.

All review committee members must complete a Code of Ethics and Professional Conduct Form (Appendix D) that will remain on file. The Pledge of Confidentiality Statement (Appendix E) must be signed annually.

All MMRC members must abide by the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule 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 MMRC members will be reminded at the start of each meeting that they must adhere to confidentiality/privacy and HIPAA standards, and may not expose patient-identifying information about a case should they recognize it. A MMRC member may, at any time, request additional information from the Department regarding HIPAA.

The Department will ensure strict compliance with our state statutes, which requires that the Department protect the confidentiality of maternal mortality information, as well as the HIPAA Privacy Rules. To ensure the protection of committee members, individuals, families and providers, the KMMRC will adhere to the following safeguards:

- All MMRC meetings will be held in private. The MMRC is not a policy-making body, and thus is not subject to the open meeting requirements of the Kansas Open Meetings Act (KOMA), KSA 75-4317 et seq.
- Members of the public or press will not be allowed at MMRC meetings. If members of the public or press show up uninvited at a meeting they will be notified that the MMRC 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 MMRC meetings.
- Case-associated information will only be available for discussion at the MMRC meetings.
- Agenda and meeting notes may be distributed outside of the meeting time and will not contain case-associated information.
- MMRC members must meet in person to review information.
- MMRC members must submit all meeting materials and papers with case-associated notes back to Department staff at the end of the MMRC meetings.
- All case summaries reviewed will include de-identified data/information.
- A MMRC 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/Committee staff. Additional information beyond HIPAA requirements may be redacted if it could lead to the identification of a case.

Conflict of Interest:

MMRC members may inadvertently recognize a case regardless of the Department's compliance with HIPAA standards and the Kansas Vital Records Act. If this should happen, the member is not required to disclose that they recognize the case, but may not discuss the Committee's discussion of the case outside of the MMRC meeting or with non-MMRC members. The member may choose to provide additional information that is pertinent to the case review. The member must contact the Abstractor to provide information pursuant to law and protocol versus reveal in a Committee meeting, so the information can be reviewed and provided back to the Committee if necessary.

Agency Conflict Resolution:

The MMRC is not a peer review committee, and, thus, does not seek to examine the performance of individual practitioners, hospitals or other agencies. The MMRC is a professional process aimed at improving systems of care for pregnant and postpartum women. While committee members may have concerns or disagreements regarding a case, the review of maternal deaths is not an opportunity for the MMRC to criticize provider or agency decisions. As the appointing agency of the MMRC, 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.

Appendix A

K.S.A. 65-177. Study of diseases and deaths from maternal, perinatal and anesthetic causes; "data" defined; medical records; confidentiality, use; liability, immunity; admissibility as evidence; reports, contents. (a) (1) "Data," as used in K.S.A. 65-177 through 65-179, and amendments thereto, includes all facts, information, records of interviews, written reports, statements, notes or memoranda secured in connection with an authorized medical research study.

(2) "Maternal death" means the death of any woman from any cause while pregnant or within one calendar year of the end of any pregnancy, regardless of the duration of the pregnancy or the site of the end of the pregnancy.

(b) (1) The secretary of health and environment shall have access to all law enforcement investigative information regarding a maternal death in Kansas, any autopsy records and coroner's investigative records relating to the death, any medical records of the mother and any records of the Kansas department for children and families or any other state social service agency that has provided services to the mother.

(2) (A) The secretary may apply to the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any maternal death being investigated by the secretary. Any books, records or papers received by the secretary pursuant to the subpoena shall be confidential and privileged information and not subject to disclosure.

(c) The secretary of health and environment shall:

(1) Identify maternal death cases;

(2) review medical records and other relevant data;

(3) contact family members and other affected or involved persons to collect additional relevant data;

(4) consult with relevant experts to evaluate the records and data collected;

(5) make determinations regarding the preventability of maternal deaths;

(6) develop recommendations and actionable strategies to prevent maternal deaths; and

(7) disseminate findings and recommendations to the legislature, healthcare providers, healthcare facilities and the general public.

(d) (1) Healthcare providers licensed pursuant to chapters 65 and 74 of the Kansas Statutes Annotated, and amendments thereto, medical care facilities licensed pursuant to article 4 of chapter 65 of the Kansas Statues Annotated, and amendments thereto, maternity centers licensed pursuant to article 5 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto, and pharmacies licensed pursuant to article 16 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto, shall provide reasonable access to all relevant medical records associated with a maternal death case under review by the secretary.

(2) A healthcare provider, medical care facility, maternity center or pharmacy providing access to medical records pursuant to this section shall not be held liable for civil damages or be subject to criminal or disciplinary administrative action for good faith efforts to provide such records.

(e) (1) Information, records, reports, statements, notes, memoranda or other data collected pursuant to this section shall be privileged and confidential and shall not be admissible as evidence in any action of any kind in any court or before another tribunal, board, agency or person. Such information, records, reports, statements, notes, memoranda or other data shall not be exhibited nor their contents disclosed in any way, in whole or in part, by any officer or representative of the department of health and environment or any other person, except as may be necessary for the purpose of furthering the investigation of the case to which they relate. No person participating in such investigation shall disclose, in any manner, the information so obtained.

(f) (1) All proceedings and activities of the secretary or representatives of the secretary under this section, opinions of the secretary or representatives of the secretary formed as a result of such proceedings and activities and records obtained, created or maintained pursuant to this section, including records of interviews, written reports and statements procured by the secretary or any other person, agency or organization acting jointly or under contract with the department of health and environment in connection with the requirements of

this section, shall be confidential and not subject to the provisions of the open records act or the open meetings act or subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding. Nothing in this section shall be construed to limit or otherwise restrict the right to discover or use in any civil or criminal proceeding any document or record that is available and entirely independent of proceedings and activities of the secretary or representatives of the secretary under this section.

(2) The secretary or representatives of the secretary shall not be questioned in any civil or criminal proceeding regarding the information presented in or opinions formed as a result of an investigation. Nothing in this section shall be construed to prevent the secretary or representatives of the secretary from testifying to information obtained independently of this section or that is public information.

(g) Reports of aggregate non-individually identifiable data shall be compiled on a routine basis for distribution in an effort to further study the causes and problems associated with maternal deaths. Reports shall be distributed to healthcare providers and medical care facilities and other persons necessary to reduce the maternal death rate.

(h) The secretary of health and environment shall receive data secured in connection with medical research studies conducted for the purpose of reducing morbidity or mortality from maternal, perinatal and anesthetic causes. Such studies may be conducted by the secretary of health and environment and staff or with other qualified persons, agencies or organizations. If such studies are conducted with any funding not provided by the state of Kansas, then the source of such funding shall be clearly identified in such study. Where authorization to conduct such a study is granted by the secretary of health and environment, all data voluntarily made available to the secretary of health and environment in connection with such study shall be treated as confidential and shall be used solely for purposes of medical research. Research files and opinions expressed upon the evidence found in such research shall not be admissible as evidence in any action in any court or before any other tribunal, except that statistics or tables resulting from such data shall be admissible and may be received as evidence. This section shall not affect the right of any patient or such patient's guardians, representatives or heirs to require hospitals, physicians, sanatoriums, rest homes, nursing homes or other persons or agencies to furnish such patient's hospital record to such patient's representatives upon written authorization, or the admissibility in evidence thereof.

(i) No employee of the secretary of health and environment shall interview any patient named in any such report, nor any relative of any such patient, unless otherwise provided in K.S.A. 65-2422d, and amendments thereto. Nothing in this section shall prohibit the publication by the secretary of health and environment or a duly authorized cooperating person, agency or organization, of final reports or statistical compilations derived from morbidity or mortality studies, which reports or compilations do not identify individuals, associations, corporations or institutions which were the subjects of such studies, or reveal sources of information.

History: L. 1961, ch. 289, § 1; L. 1974, ch. 352, § 46; L. 2010, ch. 143, § 1; L. 2018, ch. 66, § 2; L.2023, ch. 25, § 5; July 1.

K.S.A. 65-2422d. Disclosure of records; disclosure of child birth information; monthly reports of deceased residents to county election officers; section not applicable to certain records created prior to July 1, 1911; social security number, availability; fact of death information; use of information for maternal and child health surveillance and monitoring. (a) The records and files of the division of health pertaining to vital statistics shall be open to inspection, subject to the provisions of the uniform vital statistics act and rules and regulations of the secretary. It shall be unlawful for any officer or employee of the state to disclose data contained in vital statistical records, except as authorized by the uniform vital statistics act and the secretary, and it shall be unlawful for anyone who possesses, stores or in any way handles vital statistics records under contract with the state to disclose any data contained in the records, except as authorized by law.

(b) No information concerning the birth of a child shall be disclosed in a manner that enables determination that the child was born out of wedlock, except upon order of a court in a case where the information is necessary for the determination of personal or property rights and then only for that purpose, or except that employees of the office of child support enforcement of the federal department of health and human services shall be provided information when the information is necessary to ensure compliance with federal reporting and audit requirements pursuant to title IV-D of the federal social security act or except that the secretary of social and rehabilitation services or the secretary's designee performing child support enforcement functions pursuant to

title IV-D of the federal social security act shall be provided information and copies of birth certificates when the information is necessary to establish parentage in legal actions or to ensure compliance with federal reporting and audit requirements pursuant to title IV-D of the federal social security act. Nothing in this subsection shall be construed as exempting such employees of the federal department of health and human services or the secretary of social and rehabilitation services or the secretary's designee from the fees prescribed by K.S.A. 65-2418, and amendments thereto.

(c) Except as provided in subsection (b), and amendments thereto, the state registrar shall not permit inspection of the records or issue a certified copy or abstract of a certificate or part thereof unless the state registrar is satisfied the applicant therefor has a direct interest in the matter recorded and the information contained in the record is necessary for the determination of personal or property rights. The state registrar's decision shall be subject, however, to review by the secretary or by a court in accordance with the Kansas judicial review act, subject to the limitations of this section.

(d) The secretary shall permit the use of data contained in vital statistical records for research purposes only, but no identifying use of them shall be made. The secretary shall permit the use of birth, death and still birth certificates as identifiable data for purposes of maternal and child health surveillance and monitoring. The secretary or the secretary's designee may interview individuals for purposes of maternal and child health surveillance and monitoring only with an approval of the health and environmental institutional review board as provided in title 45, part 46 of the code of federal regulations. The secretary shall inform such individuals that the participation in such surveillance and monitoring is voluntary and may only be conducted with the written consent of the person who is the subject of the information or with the informed consent of a parent or legal guardian if the person is under 18 years of age. Informed consent is not required if the person who is the subject of the information is deceased.

(e) Subject to the provisions of this section the secretary may direct the state registrar to release birth, death and stillbirth certificate data to federal, state or municipal agencies.

(f) On or before the 20th day of each month, the state registrar shall furnish to the county election officer of each county and the clerk of the district court in each county, without charge, a list of deceased residents of the county who were at least 18 years of age and for whom death certificates have been filed in the office of the state registrar during the preceding calendar month. The list shall include the name, age or date of birth, address and date of death of each of the deceased persons and shall be used solely by the election officer for the purpose of correcting records of their offices and by the clerk of the district court in each county for the purpose of correcting juror information for such county. Information provided under this subsection to the clerk of the district court shall be considered confidential and shall not be disclosed to the public. The provisions of subsection (b) of K.S.A. 45-229, and amendments thereto, shall not apply to the provisions of this subsection.

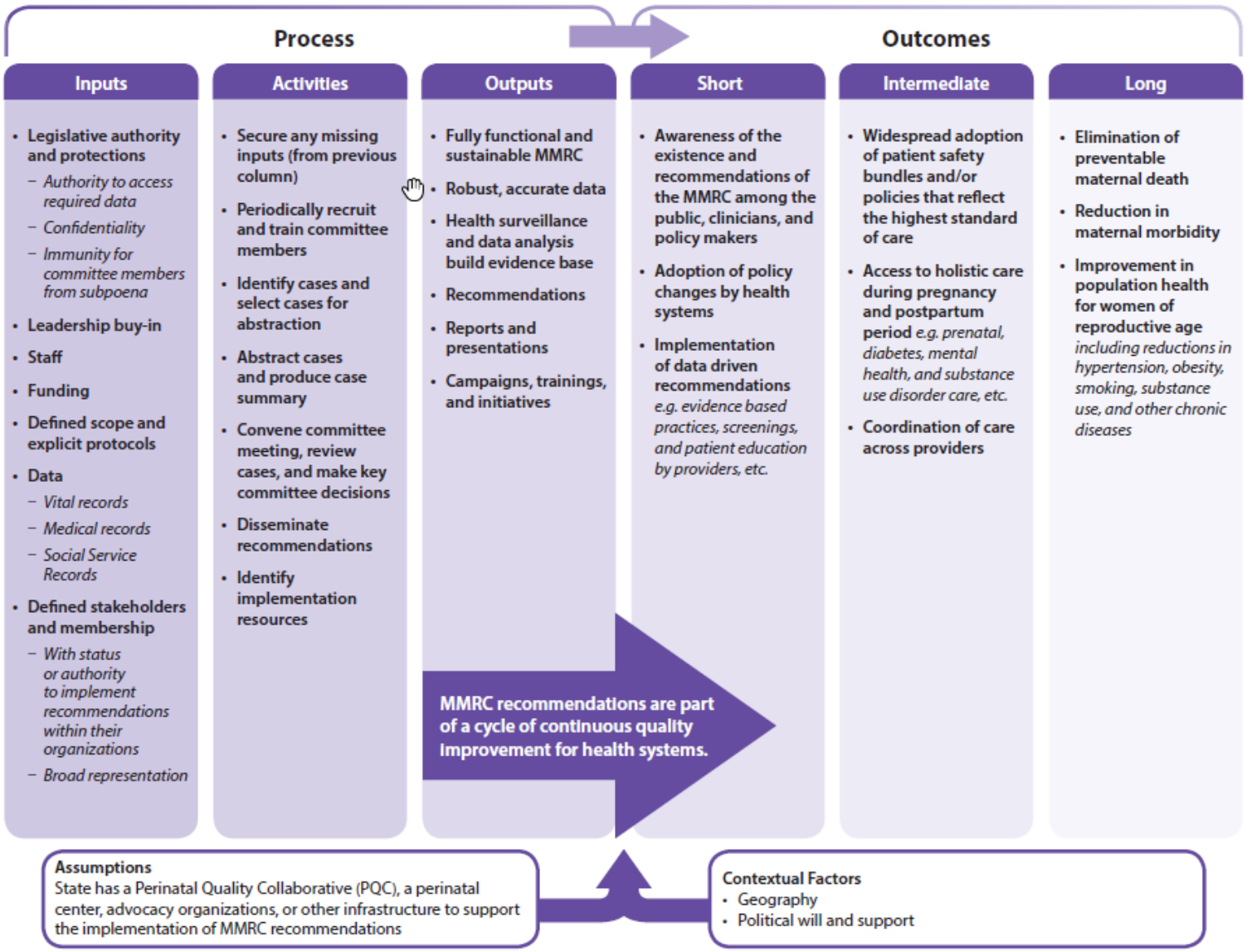
(g) No person shall prepare or issue any certificate which purports to be an original, certified copy or abstract or copy of a certificate of birth, death or fetal death, except as authorized in this act or rules and regulations adopted under this act.

(h) Records of births, deaths or marriages which are not in the custody of the secretary of health and environment and which were created before July 1, 1911, pursuant to chapter 129 of the 1885 Session Laws of Kansas, and any copies of such records, shall be open to inspection by any person and the provisions of this section shall not apply to such records.

(i) Social security numbers furnished pursuant to K.S.A. 65-2409a, and amendments thereto, shall only be used as permitted by title IV-D of the federal social security act, and amendments thereto, or as permitted by section 7(a) of the federal privacy act of 1974, and amendments thereto. The secretary shall make social security numbers furnished pursuant to K.S.A. 65-2409a, and amendments thereto, available to the department of social and rehabilitation services for purposes permitted under title IV-D of the federal social security act.

(j) Fact of death information may be disseminated to state and federal agencies administering benefit programs. Such information shall be used for file clearance purposes only.

Maternal Mortality Review Committee Logic Model



REVIEW DATE

Month/Day/Year

RECORD ID #

PREGNANCY-RELATEDNESS: SELECT ONE

☐ PREGNANCY-RELATED
A death 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

☐ PREGNANCY-ASSOCIATED, BUT NOT-RELATED
A death during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy

☐ PREGNANCY-ASSOCIATED BUT UNABLE TO DETERMINE PREGNANCY-RELATEDNESS

ESTIMATE THE DEGREE OF RELEVANT INFORMATION (RECORDS) AVAILABLE FOR THIS CASE:
These fields are for internal jurisdiction use in order to evaluate opportunities to gain better access to information for reviews.

☐ COMPLETE
All records necessary for adequate review of the case were available

☐ SOMEWHAT COMPLETE
Major gaps (i.e., information that would have been crucial to the review of the case)

☐ MOSTLY COMPLETE
Minor gaps (i.e., information that would have been beneficial but was not essential to the review of the case)

☐ NOT COMPLETE
Minimal records available for review (i.e., death certificate and no additional records)

DOES THE COMMITTEE AGREE WITH THE UNDERLYING[1] CAUSE OF DEATH LISTED ON DEATH CERTIFICATE?
The underlying cause of death determination as documented by a multidisciplinary MMRC may be different from the underlying cause of death used by pathologists in the course of death certification documented in the Vital Statistics system.

☐ YES ☐ NO

COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING[1] CAUSE OF DEATH
Refer to Appendix A for PMSS-MM cause of death list.

If a death is pregnancy-associated, not related then an underlying cause of death entry is not necessary. Use optional box below.

TYPE	OPTIONAL: CAUSE (DESCRIPTIVE)
UNDERLYING[1,2]	
CONTRIBUTING[2,3]	
IMMEDIATE[2]	
OTHER SIGNIFICANT[2]	

COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH[4]

DID **OBESITY** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **DISCRIMINATION**[5] CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **MENTAL HEALTH CONDITIONS** OTHER THAN SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **SUBSTANCE USE DISORDER** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN

MANNER OF DEATH

WAS THIS DEATH A SUICIDE?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
WAS THIS DEATH A HOMICIDE?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN

IF ACCIDENTAL DEATH, HOMICIDE, OR SUICIDE, LIST THE MEANS OF FATAL INJURY

- ☐ FIREARM
- ☐ SHARP INSTRUMENT
- ☐ BLUNT INSTRUMENT
- ☐ POISONING/OVERDOSE
- ☐ HANGING/ STRANGULATION/ SUFFOCATION
- ☐ FALL
- ☐ PUNCHING/ KICKING/BEATING
- ☐ EXPLOSIVE
- ☐ DROWNING
- ☐ FIRE OR BURNS
- ☐ MOTOR VEHICLE
- ☐ INTENTIONAL NEGLECT
- ☐ OTHER, SPECIFY:
- ☐ UNKNOWN
- ☐ NOT APPLICABLE

IF HOMICIDE, WHAT WAS THE RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT?

- ☐ NO RELATIONSHIP
- ☐ PARTNER
- ☐ EX-PARTNER
- ☐ OTHER RELATIVE
- ☐ OTHER
- ☐ ACQUAINTANCE
- ☐ OTHER, SPECIFY:
- ☐ UNKNOWN
- ☐ NOT APPLICABLE

[1] Underlying cause refers to the disease or injury that initiated the chain of events leading to death or the circumstances of the accident or violence which produced the fatal injury.
[2] OPTIONAL field, CDC does not use this data.
[3] Add descriptions of contributors in the pathway between the immediate and underlying cause of death, as provided by the committee. Note that this is different from the contributing factors worksheet on page 2.
[4] If "Yes" or "Probably" is selected for preventable deaths, then an aligned contributing factor class and description would be expected in the grid on page 2.
[5] Encompasses Discrimination, Interpersonal Racism, and Structural Racism as described in Appendix B.

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, provider, facility, system and/or community factors.

WAS THIS DEATH PREVENTABLE? ☐ YES ☐ NO

CHANCE TO ALTER OUTCOME[6] ☐ GOOD CHANCE ☐ SOME CHANCE ☐ NO CHANCE ☐ UNABLE TO DETERMINE

CONTRIBUTING FACTORS AND RECOMMENDATIONS FOR ACTION (Entries may continue to grid on page 3)

CONTRIBUTING FACTORS WORKSHEET

What were the factors that contributed to this death? Multiple contributing factors may be present at each level: Choose one contributing factor per row until all contributing factors have been identified and described.

RECOMMENDATIONS OF THE COMMITTEE

If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events? Develop one recommendation per row until all contributing factors have been addressed.

DESCRIPTION OF ISSUE (enter a description for EACH contributing factor listed)	**CONTRIBUTING FACTOR** (enter one per row; repeat as needed if a contributor has more than one recommendation)	**LEVEL**	**COMMITTEE RECOMMENDATION** [Who?] should [do what?] [when?] Map recommendations to contributing factors; repeat as needed if a recommendation has more than one contributor.	**LEVEL**	**PREVENTION TYPE** (choose below)	**EXPECTED IMPACT** (choose below)

CONTRIBUTING FACTOR KEY (DESCRIPTIONS IN APPENDIX B)

- Access/financial
- Adherence
- Assessment
- Chronic disease
- Clinical skill/quality of care
- Communication
- Continuity of care/care coordination
- Cultural/religious
- Delay
- Discrimination
- Environmental
- Equipment/technology
- Interpersonal racism
- Knowledge
- Law Enforcement
- Legal
- Mental health conditions
- Outreach
- Policies/procedures
- Referral
- Social support/ isolation
- Structural racism
- Substance use disorder - alcohol, illicit/prescription drugs
- Tobacco use
- Trauma
- Unstable housing
- Violence
- Other

DEFINITION OF LEVELS

- PATIENT/FAMILY: An individual before, during or after a pregnancy, and their family, internal or external to the household, with influence on the individual
- PROVIDER: An individual with training and expertise who provides care, treatment, and/or advice
- FACILITY: A physical location where direct care is provided - ranges from small clinics and urgent care centers to hospitals with trauma centers
- SYSTEM: Interacting entities that support services before, during, or after a pregnancy - ranges from healthcare systems and payors to public services and programs
- COMMUNITY: A grouping based on a shared sense of place or identity - ranges from physical neighborhoods to a community based on common interests and shared circumstances

PREVENTION TYPE

- 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 what has become an ongoing contributing factor (i.e., management of complications)

EXPECTED IMPACT

- 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 (protocols, prescriptions)
- LARGE: Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies/LARC)
- EXTRA LARGE: Change in context (promote environments that support healthy living/ensure available and accessible services)
- GIANT: Address social drivers of health (poverty, inequality, etc.)

[6] If “Good Chance” or “Some Chance” are selected, then CDC considers this is a “Yes” in their analytic use of the preventability determination.

CONTRIBUTING FACTORS AND RECOMMENDATIONS FOR ACTION (Continued from page 2)

CONTRIBUTING FACTORS WORKSHEET

What were the factors that contributed to this death? Multiple contributing factors may be present at each level: Choose one contributing factor per row until all contributing factors have been identified and described.

RECOMMENDATIONS OF THE COMMITTEE

If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events? Develop one recommendation per row until all contributing factors have been addressed.

DESCRIPTION OF ISSUE (enter a description for EACH contributing factor listed)	**CONTRIBUTING FACTOR** (enter one per row; repeat as needed if a contributor has more than one recommendation)	**LEVEL**	**COMMITTEE RECOMMENDATIONS** [Who?] should [do what?] [when?] Map recommendations to contributing factors; repeat as needed if a recommendation has more than one contributor.	**LEVEL**	**PREVENTION TYPE** (choose below)	**EXPECTED IMPACT** (choose below)

CONTRIBUTING FACTORS AND RECOMMENDATIONS FOR ACTION (Continued from page 3)

CONTRIBUTING FACTORS WORKSHEET

What were the factors that contributed to this death? Multiple contributing factors may be present at each level: Choose one contributing factor per row until all contributing factors have been identified and described.

RECOMMENDATIONS OF THE COMMITTEE

If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events? Develop one recommendation per row until all contributing factors have been addressed.

DESCRIPTION OF ISSUE (enter a description for EACH contributing factor listed)	**CONTRIBUTING FACTOR** (enter one per row; repeat as needed if a contributor has more than one recommendation)	**LEVEL**	**COMMITTEE RECOMMENDATIONS** [Who?] should [do what?] [when?] Map recommendations to contributing factors; repeat as needed if a recommendation has more than one contributor.	**LEVEL**	**PREVENTION TYPE** (choose below)	**EXPECTED IMPACT** (choose below)

APPENDIX A. PMSS-MM CODES: IF PREGNANCY-RELATED,[7] COMMITTEE DETERMINATION OF UNDERLYING[1] CAUSE OF DEATH

Hemorrhage (Excludes Aneurysms or CVA)
10.1 - Hemorrhage – Uterine Rupture
10.2 - Placental Abruption
10.3 - Placenta Previa
10.4 - Ruptured Ectopic Pregnancy
10.5 - Hemorrhage – Uterine Atony/Postpartum Hemorrhage
10.6 - Placenta Accreta/Increta/Percreta
10.7 - Hemorrhage due to Retained Placenta
10.10 - Hemorrhage – Laceration/Intra-Abdominal Bleeding
10.9 - Other Hemorrhage/NOS

Infection
20.1 - Postpartum Genital Tract (e.g., of the Uterus/ Pelvis/Perineum/Necrotizing Fasciitis)
20.2 - Sepsis/Septic Shock
20.4 - Chorioamnionitis/Antepartum Infection
20.6 - Urinary Tract Infection
20.7 - Influenza
20.8 - COVID-19
20.10 - Pneumonia
20.11 - Other Non-Pelvic Infection (e.g., TB, Meningitis, HIV)
20.9 - Other Infection/NOS

Embolism (Excludes Cerebrovascular)
30.1 - Embolism – Thrombotic
30.9 - Other Embolism (Excludes Amniotic Fluid Embolism)/NOS

Amniotic Fluid Embolism
31.1 - Amniotic Fluid Embolism

Hypertensive Disorders of Pregnancy (HDP)
40.1 - Preeclampsia
50.1 - Eclampsia
60.1 - Chronic Hypertension with Superimposed Preeclampsia

Anesthesia Complications
70.1 - Anesthesia Complications

Cardiomyopathy
80.1 - Postpartum/Peripartum Cardiomyopathy
80.2 - Hypertrophic Cardiomyopathy
80.9 - Other Cardiomyopathy/NOS

Hematologic
82.1 - Sickle Cell Anemia
82.9 - Other Hematologic Conditions including Thrombophilias/TTP/HUS/NOS

Collagen Vascular/Autoimmune Diseases
83.1 - Systemic Lupus Erythematosus (SLE)
83.9 - Other Collagen Vascular Diseases/NOS

Conditions Unique to Pregnancy
85.1 - Conditions Unique to Pregnancy (e.g., Gestational Diabetes, Hyperemesis, Liver Disease of Pregnancy)

Injury
88.1 - Intentional (Homicide)
88.2 - Unintentional
88.9 - Unknown Intent/NOS

Cancer
89.1 - Gestational Trophoblastic Disease (GTD)
89.3 - Malignant Melanoma
89.9 - Other Malignancies/NOS

Other Cardiovascular Conditions (excluding cardiomyopathy, HDP, and CVA)
90.1 - Coronary Artery Disease/Myocardial Infarction (MI)/Atherosclerotic Cardiovascular Disease
90.2 - Pulmonary Hypertension
90.3 - Valvular Heart Disease Congenital and Acquired
90.4 - Vascular Aneurysm/Dissection (Non-Cerebral)
90.5 - Hypertensive Cardiovascular Disease
90.6 - Marfan Syndrome
90.7 - Conduction Defects/Arrhythmias
90.8 - Vascular Malformations Outside Head and Coronary Arteries
90.9 - Other Cardiovascular/NOS, including CHF, Cardiomegaly, Cardiac Hypertrophy, Cardiac Fibrosis, Non-Acute Myocarditis

Pulmonary Conditions (Excludes ARDS-Adult Respiratory Distress Syndrome)
91.1 - Chronic Lung Disease
91.2 - Cystic Fibrosis
91.3 - Asthma
91.9 - Other Pulmonary Disease/NOS

Neurologic/Neurovascular Conditions (Excluding CVA)
92.1 - Epilepsy/Seizure Disorder
92.9 - Other Neurologic Diseases/NOS

Renal Disease
93.1 - Chronic Renal Failure/End-Stage Renal Disease (ESRD)
93.9 - Other Renal Disease/NOS

Cerebrovascular Accident (CVA) not Secondary to HDP
95.1 - Cerebrovascular Accident (Hemorrhage/ Thrombosis/Aneurysm/Malformation) not Secondary to Hypertensive Disorders of Pregnancy

Metabolic/Endocrine
96.2 - Diabetes Mellitus
96.9 - Other Metabolic/Endocrine Disorders/NOS

Gastrointestinal Disorders
97.1 - Crohn's Disease/Ulcerative Colitis
97.2 - Liver Disease/Failure/Transplant
97.9 - Other Gastrointestinal Diseases/NOS

Mental Health Conditions
100.1 - Depressive Disorder
100.2 - Anxiety Disorder (including Post-Traumatic Stress Disorder)
100.3 - Bipolar Disorder
100.4 - Psychotic Disorder
100.5 - Substance Use Disorder
100.9 - Other Psychiatric Conditions/NOS

Unknown COD
999.1 - Unknown COD

[1] Underlying cause refers to the disease or injury that initiated the chain of events leading to death or the circumstances of the accident or violence which produced the fatal injury.
[7] Pregnancy-related death: death 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.

APPENDIX B. CONTRIBUTING FACTOR DESCRIPTIONS

LACK OF **ACCESS/FINANCIAL** RESOURCES
Systemic barriers, e.g., lack or loss of healthcare insurance or other financial duress, as opposed to noncompliance, impacted their ability to care for themself (e.g., did not seek services because unable to miss work or afford postpartum visits after insurance expired). Other barriers to accessing care: insurance non-eligibility, provider shortage in their geographical area, and lack of public transportation.

ADHERENCE TO MEDICAL RECOMMENDATIONS
The provider or patient did not follow protocol or failed to comply with standard procedures (i.e., non adherence to prescribed medications).

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

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

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

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

LACK OF **CONTINUITY OF CARE** (PROVIDER OR FACILITY PERSPECTIVE)
Care providers did not have access to individual's complete records or did not communicate their status sufficiently. Lack of continuity can be between prenatal, labor and delivery, and postpartum providers.

CULTURAL/RELIGIOUS, OR LANGUAGE FACTORS
The provider or patient demonstrated 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).

DELAY
The provider or patient was delayed in referring or accessing care, treatment, or follow-up care/action.

DISCRIMINATION
Treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making. (Hardeman, 2022)[8]

ENVIRONMENTAL FACTORS
Factors related to weather or social environment.

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

INTERPERSONAL RACISM
Discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization. (Hardeman, 2022)[8]

KNOWLEDGE - LACK OF KNOWLEDGE REGARDING IMPORTANCE OF EVENT OR OF TREATMENT OR FOLLOW-UP
The provider or patient 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 lacked 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).

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

LEGAL
Legal considerations that impacted outcome.

MENTAL HEALTH CONDITIONS
The patient had a documented diagnosis of a psychiatric disorder. This includes postpartum depression. If a formal diagnosis is not available, refer to your review committee subject matter experts (e.g., psychiatrist, psychologist, licensed counselor) to determine whether the criteria for a diagnosis of substance use disorder or another mental health condition are met based on the available information.

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

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

LACK OF **REFERRAL** OR CONSULTATION
Specialists were not consulted or did not provide care; referrals to specialists were not made.

SOCIAL SUPPORT/ISOLATION - LACK OF FAMILY/ FRIEND OR SUPPORT SYSTEM
Social support from family, partner, or friends was lacking, inadequate, and/or dysfunctional.

STRUCTURAL RACISM
The systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc. (Hardeman, 2022)[8]

SUBSTANCE USE DISORDER – ALCOHOL, ILLICIT/ PRESCRIPTION DRUGS
Substance use disorder is characterized by recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems or disability. The committee may determine that substance use disorder contributed to the death when the disorder directly compromised their health status (e.g., acute methamphetamine intoxication exacerbated pregnancy- induced hypertension, or they were more vulnerable to infections or medical conditions).

TOBACCO USE
The patient's use of tobacco directly compromised the patient's health status (e.g., long-term smoking led to underlying chronic lung disease).

TRAUMA
The individual experienced trauma: i.e., loss of child (death or loss of custody), rape, molestation, or one or more of the following: sexual exploitation during childhood plus persuasion, inducement, or coercion of a child to engage in sexually explicit conduct; or other physical or emotional abuse other than that related to sexual abuse during childhood.

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

VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)
Physical or emotional abuse perpetrated by current or former intimate partner, family member, friend, acquaintance, or stranger.

OTHER
Contributing factor not otherwise mentioned. Please provide description.

[8] Hardeman RR, et al. *Developing Tools to Report Racism in Maternal Health for the CDC Maternal Mortality Review Information Application (MMRIA): Findings from the MMRIA Racism & Discrimination Working Group*. Matern Child Health J. 2022.

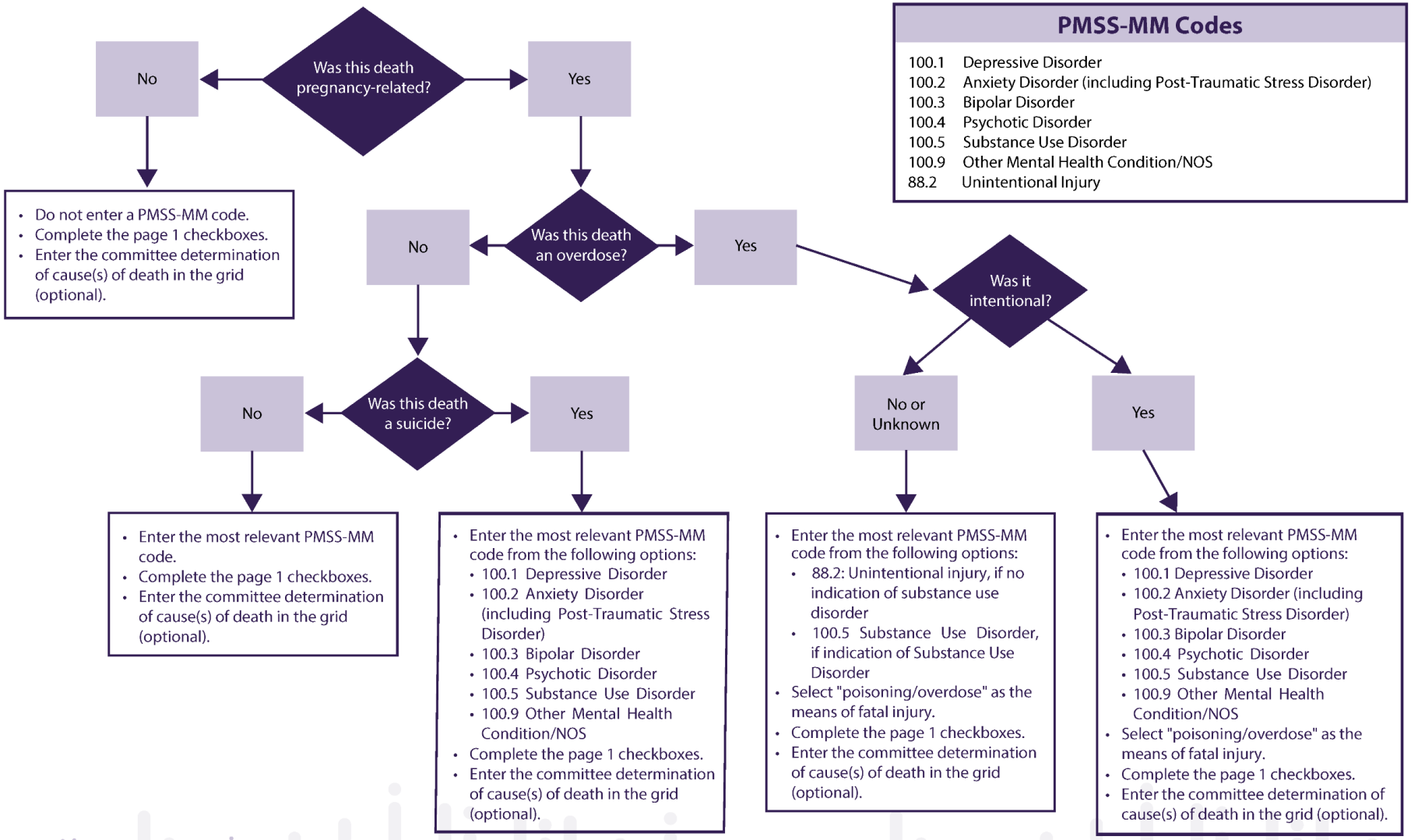
APPENDIX C. CONSENSUS PREGNANCY-RELATED CRITERIA FOR SUICIDE AND UNINTENTIONAL OVERDOSES[9, 10]

Present Y/N	Consensus pregnancy-related criteria for suicide and unintentional overdoses	Examples
	Pregnancy Complication	
	Increased pain directly attributable to pregnancy or postpartum events leading to self-harm or drug use that are implicated in suicide or unintentional drug-related death. *[consensus during pregnancy]*	Back pain, pelvic pain, kidney stones, cesarean incision, or perineal tear pain
	Traumatic event in pregnancy or postpartum (diagnosis of fetal anomaly, stillbirth, preterm delivery, neonatal or infant death, traumatic delivery experience, removal of children from custody) with a temporal relationship between the event leading to self-harm or increased drug use and subsequent death. *[consensus in all time periods]*	Stillbirth, preterm delivery, diagnosis of fetal anomaly, traumatic delivery experience, relationship destabilization due to pregnancy, removal of child(ren) from custody
	Pregnancy-related complication likely exacerbated by drug use leading to subsequent death. *[consensus in pregnancy – only time period considered]*	Placental abruption or preeclampsia in setting of drug use
	Chain of Events Initiated by Pregnancy	
	Cessation or attempted taper of medications for pregnancy-related concerns (neonatal/fetal exposure risk, fear of child protective service involvement) leading to maternal destabilization or drug use and subsequent death. Neonatal or fetal risk - *[consensus in all time periods]*. Child Protective Service involvement - *[consensus during pregnancy]*	Substance use pharmacotherapy (methadone or buprenorphine), psychiatric medications, pain medications
	Inability to access inpatient or outpatient addiction or mental health treatment due to pregnancy. *[consensus during and within 6 months of pregnancy]*	Health care professionals uncomfortable with treating pregnant women, facilities not available that accept pregnant women
	Perinatal psychiatric conditions resulting in maternal destabilization or drug use and subsequent death. *[consensus during and within 6 months of pregnancy]*	Depression diagnosed in pregnancy or postpartum resulting in suicide
	Recovery/stabilization of substance use disorder achieved during pregnancy or postpartum with clear statement in records that pregnancy was motivating factor with subsequent relapse and subsequent death. *[no consensus at any time period]*	Relapse leading to overdose due to decreased tolerance or polysubstance use
	Aggravation of Underlying Condition by Pregnancy	
	Worsening of underlying depression, anxiety or other psychiatric condition in pregnancy or postpartum period with documentation that mental illness led to drug use or self-harm and subsequent death. *[consensus during and within 6 months of pregnancy]*	Pre-existing depression exacerbated in the postpartum period leading to suicide
	Exacerbation, under-treatment or delayed treatment of pre-existing condition in pregnancy or postpartum leading to use of prescribed or illicit drugs resulting in death, or suicide. *[consensus during and within 6 months of pregnancy]*	Undertreatment of chronic pain leading to misuse of medications or use of illicit drugs, resulting in death
	Medical conditions secondary to drug use in setting of pregnancy or postpartum that may be attributable to pregnancy-related physiology and increased risk of complications leading to death. *[no consensus at any time period]*	Stroke or cardiovascular arrest due to stimulant use

[9] Smid MC et al, 2023. *Consensus pregnancy-related criteria for suicide and unintentional overdoses using a Delphi process.* Arch Womens Ment Health.

[10] The italicized text in brackets specify where the Delphi exercise with representatives from 48 MMRCs and eight experts in maternal mortality, substance use disorder, and maternal mental health reached consensus on the criterion. Lack of Delphi consensus as shown in brackets should not override committee consensus on a specific case. If "Yes" is chosen by the committee for at least one of the boxes under any of the three categories then that would constitute a pregnancy-related death.

APPENDIX D. CODING UNDERLYING CAUSE OF DEATH FOR SUICIDES AND OVERDOSES



PMSS-MM Codes

100.1	Depressive Disorder
100.2	Anxiety Disorder (including Post-Traumatic Stress Disorder)
100.3	Bipolar Disorder
100.4	Psychotic Disorder
100.5	Substance Use Disorder
100.9	Other Mental Health Condition/NOS
88.2	Unintentional Injury

APPENDIX E. FAQ: COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH

These frequently asked questions refer to the following checkboxes on the committee decisions form:

Did obesity contribute to the death?
Did discrimination[11] contribute to the death?
Did mental health conditions other than substance use disorder contribute to the death?
Did substance use disorder[12] contribute to the death?
Was this death a suicide?
Was this death a homicide?
If accidental death, homicide, or suicide, list the means of fatal injury.
If homicide, what was the relationship of the perpetrator to the decedent?

1. **Should the checkboxes be completed for all pregnancy-associated deaths or just those determined to be pregnancy-related?**

   The checkboxes should be completed for all deaths reviewed by your committee, regardless of relatedness. If your committee does not review a pregnant or postpartum person's death because it is considered out of your scope, there is no need to complete the checkboxes.

2. **Should the checkboxes be completed in reference to the pregnant or postpartum person, or the broader context surrounding the death?**

   The checkboxes refer to the decedent's own experience. For example, if a pregnant or postpartum person had a substance use disorder which contributed to the death, the checkbox should be marked 'yes'. In contrast, if the death was a homicide where the perpetrator had a substance use disorder that contributed to causing a death, and the victim did not have a substance use disorder, or the victim had a substance use disorder that did not contribute to the death, the checkbox should be marked 'no'.

3. **Does discrimination encompass racism and other forms of bias?**

   Yes, and more specificity may be added using the contributing factors worksheet on page 2 of the committee decisions form. Interpersonal racism or structural racism may also be documented there.

4. **If substance use was involved in the death, should we choose 'yes' for the substance use disorder checkbox?**

   This checkbox refers to 'substance use disorder', not just substance use. The committee should only choose 'yes' or 'probably' if there is indication of a substance use disorder diagnosis or an expert on the committee (e.g., psychiatrist, psychologist, licensed counselor) who feels that the criteria for a diagnosis of substance use disorder are met based on the available information. Additionally, the checkbox should only be marked 'yes' if the committee decides that the substance use disorder was a contributing factor in the death. If the pregnant or postpartum person had a substance use disorder but this did not contribute to the death, the checkbox should be marked 'no'.

   If the committee determines the death was an intentional or accidental overdose, this should be recorded as poisoning/overdose under means of fatal injury.

5. **For the substance use disorder and mental health conditions checkboxes, is a formal diagnosis required?**

   A diagnosis should ideally be indicated in the pregnant or postpartum person's medical records. However, this may underestimate the number of pregnant or postpartum people with substance use disorder or mental health conditions if persons are unable to access care or treatment. Refer to your review committee subject matter experts (e.g. psychiatrist, psychologist, licensed counselor) to determine whether the criteria for a diagnosis of substance use disorder or another mental health condition are met based on the available information.

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[11] Defined as treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping [including racism]. It can manifest as differences in care, clinical communication and shared decision-making. (Hardeman RR, et al. *Developing Tools to Report Racism in Maternal Health for the CDC Maternal Mortality Review Information Application (MMRIA): Findings from the MMRIA Racism & Discrimination Working Group*. Matern Child Health J. 2022.)

[12] Characterized by recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems or disability. The committee may determine that substance use disorder contributed to the death when the disorder directly compromised a pregnant or postpartum person's health status (e.g., acute methamphetamine intoxication exacerbated pregnancy-induced hypertension, or the pregnant or postpartum person was more vulnerable to infections or medical conditions).

6. **If substance use disorder contributed to the death, but another mental health condition did not, should we also choose 'yes' for the mental health conditions checkbox?**

   No, substance use disorder should be captured separately from other mental health conditions.

7. **Does substance use disorder include tobacco use?**

   No, substance use disorder as defined here does not include tobacco use. You would NOT mark the substance use disorder checkbox as 'yes' or 'probably' based solely on tobacco use. If the committee determines that tobacco use was a contributor to the death, ensure that Tobacco Use is noted in the contributing factor worksheet with an actionable recommendation that addresses it.

8. **When do we need to choose a means of fatal injury on the committee decisions form?**

   If the committee determines that a death was an accidental death, homicide, or suicide, they should also determine the means of fatal injury to be recorded on the committee decisions form. Unintentional and intentional overdoses should be recorded as poisoning/overdose.

9. **If the committee selects 'yes' or 'probably' for any of the checkboxes (obesity, discrimination, mental health conditions, and/or substance use disorder), should they always document the corresponding contributing factor class and an actionable recommendation?**

   Typically, we expect the circumstances surrounding a death to align with a specified contributing factor class and recommendation. However, recommendations are focused on actions that would have prevented the death. If your committee determines that a circumstance such as obesity contributed to a death that is not preventable, they do not need to document a contributing factor class and recommendation.

10. **When do we need to choose a relationship of the perpetrator to the decedent?**

    If the committee determines that a death was a homicide, they should also record the relationship of the perpetrator to the decedent on the committee decisions forms. The means of fatal injury checkbox should also be filled out for all homicides.

11. **If certain deaths are not reviewed by our committee (for example, suicides and homicides), should we still complete the checkboxes?**

    No, these checkboxes are intended to capture the committee decisions. If a death is not reviewed by the committee, the Circumstances Surrounding Death checkboxes should not be completed.

12. **What if our determination for manner of death does not match the manner indicated on the death record?**

    The checkboxes are intended to capture the decisions of the review committee, and it is expected that sometimes these decisions may differ from the death record. For example, an overdose may have an unknown manner of death on the death certificate, but relevant subject matter experts (e.g. medical examiner), could review additional information and determine that the overdose was intentional. The committee would then check 'yes' for the suicide checkbox. There is also a place on the committee decisions form for indicating whether the committee agrees with the cause of death listed on the death certificate.

13. **Are there opportunities for quality improvement with the checkbox data?**

    Yes, there are lots of opportunities using checkbox data. For example, all unintentional overdoses and overdoses of unknown intent with indication of substance use disorder should have an underlying cause of death PMSS-MM code of 100.5 (Substance Use Disorder) or 100.9 (Other Mental Health Conditions/NOS). If the substance use disorder checkbox is marked 'yes', but the PMSS-MM code is 88.2 (Unintentional Injury), there may be discrepancies in how the MMRC is selecting PMSS-MM codes.

    Another opportunity for quality improvement is to compare the obesity checkbox with the decedent's actual BMI calculated using the height and weight provided in the records. Are there instances where your committee is selecting 'yes' when the BMI suggests the person was at a healthy weight? Of note—this checkbox is intended to capture whether obesity contributed to the death, not whether the pregnant or postpartum person was obese / obesity was present.

Appendix C

Kansas Maternal Mortality Review Committee

Kansas Maternal Mortality Review Committee Reimbursement Policy

The Kansas Maternal Mortality Review Committee (KMMRC) was formed as a state-level group to advise and monitor progress addressing specific maternal health needs. Membership includes professional partners including consumers and family members. Due to varied contributing partners, the following reimbursement distinctions are described below. NOTE: Only members whose attendance is not compensated within an MCH-related employment/consultative capacity are eligible for reimbursement.

All Members are eligible for the following reimbursement:

- Out-of-Pocket (actual) expenses including parking, tolls, other expenses incurred related to participation in meetings (original receipts are required).
- Members traveling more than 150 miles (one-way) from their home/workplace to the in-person meeting are eligible for:
  - Mileage reimbursement based on the current state allowable rate per mile for automobiles and the most direct route from originating location to meeting location, which shall be confirmed by an online map service (Kansas Department of Transportation, MapQuest, Google Maps, etc.). Reimbursement requires mileage documentation.
  - Lodging reimbursement* based on the current state allowable rate for one (1) overnight stay for one-day meetings. Lodging reimbursement requires a lodging receipt.

Consumer/Family Members are eligible for the following reimbursement:

Consultant Fee: $75 per review meeting

- Consultant fee will be pro-rated based upon the time the consumer/family expert is physically present in the meeting (e.g. member is only physically present for 75% of the meeting; the individual will only receive 75% of the fee).
- Consultant fee represents the total amount per family unit, if more than one family member is present, the fee only is paid to one individual representing the attending family.

Out-of-Pocket Expenses: Reimbursement in accordance with the policy for “All Members” with the following exceptions.

- Mileage: Members traveling ANY distance (no minimum miles).
- Lodging: Members traveling more than 60 miles.
- Child Care: No more than $50 per day for a scheduled meeting if the child(ren) is/are not in school and if child care is only needed to support meeting attendance; reimbursement must be requested in advance (email or telephone), will be based on actual expenses, and may be provided based on availability of funding

*NOTE: The U.S. General Services Administration (GSA) maintains the lodging rates for travel locations. Lodging reimbursement is based on the allowable rate for Topeka, Kansas by month and city. http://www.gsa.gov/portal/content/104877

Appendix C1

Kansas Maternal Mortality Review Committee Member Reimbursement Form

Kansas Department of Health and Environment

Consultant Reimbursement Request

KDHE001

ONE FORM PER EVENT OR SERVICES RENDERED

This form is to be used strictly for consultant services and **cannot** be used for any other type of reimbursement. Consultant reimbursements in which meals, lodging or other expenses will be authorized to exceed the allowable state rates **require a formal written agreement establishing expense limitations**. Expenses reimbursed on this form shall only be reimbursed at allowable state rates. **ORIGINAL** receipts are required to be submitted with this request. All fields are required to be completed. Incomplete forms will be returned unpaid.

Agency Bureau/Program Information: **A COMPLETED W-9 FORM IS REQUIRED**

Bureau/Program Name

Address

Program Contact **Telephone**

Consultant Information

Consultant Name

Address

City/State/Zip

Telephone **Tax Identification Number**

Expense Overview

Consultant Fee (if applicable)	
Total Mileage	
Mileage Reimbursement Rate	
Airfare	
Meals	
Lodging	
Other Expenses	
Total Reimbursement	

Expense Detail

Date(s) of Service

Begin End

Destination

Departure Date Time

Return Date Time

Lodging Rate (per night)

Description of Services Provided

KDHE Authorized Signature (Bureau Approval) **Date**

Number of Meals Claimed

- ☐ Breakfast #
- ☐ Lunch #
- ☐ Dinner #

Other Expense(s) (ORIGINAL RECEIPTS REQUIRED)

Parking	
Tolls	
Registration Fees	
Airfare (coach class, lowest fare available)	
Other (provide description below)	

Description

Appendix D

Kansas Maternal Mortality Review Committee

Kansas Maternal Mortality Review Committee Code of Ethics and Professional Conduct

The Kansas Department of Health & Environment (KDHE) Bureau of Family Health is responsible for administering the Title V Maternal & Child Health (MCH) Block Grant Program which involves monitoring, researching, and evaluating health status and conducting activities to identify and address community health problems through the use of the 10 essential health services (www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html).

Within the population of women of reproductive age, maternal mortality is an indicator that is monitored by KDHE pursuant to K.S.A. 65-177. Maternal mortality is considered a sentinel (patient safety) event that warrants close scrutiny. An increasing national and state trend in maternal mortality indicates the need to conduct maternal mortality review in order to gain insight into the medical and social factors leading to these events and to prevent future occurrences of maternal mortality.

The Kansas Maternal Mortality Review Committee (KMMRC) is a multidisciplinary committee whose geographically diverse members represent various specialties, facilities, and systems that interact with and impact maternal health.

As a member of the Kansas Maternal Mortality Review Committee (KMMRC), I will:

a. Support the KMMRC's work and serve as an active member-reviewing the case narratives in advance of each meeting and actively participate in committee meeting discussions.
b. Respect and support the majority decisions of the committee.
c. Attend meetings. I will respond promptly regarding my availability. If I am unable to attend a scheduled review committee meeting, I will notify the project facilitator promptly.
d. Keep well-informed of research and developments relevant to issues that may come before the committee.
e. Declare any conflict to the best interests of the committee, be it real, potential, or apparent. If a conflict of interest exists, I will appropriately modify my participation based on the recommendation of the Chair, including voting abstention. A conflict of interest can occur when a committee member is involved in multiple interests, one of which could possibly influence the motivation or interests.

I hereby agree to abide by this code of ethics and professional conduct and understand that a violation of a provision could lead to removal from the committee.

_____ _____

Signature Date

Appendix E

Kansas Maternal Mortality Review Committee

Pledge of Confidentiality Statement: Kansas Maternal Mortality Review Committee

The purpose of the Kansas Maternal Mortality Review Committee (KMMRC) is to conduct a full examination of all pregnancy-associated deaths (both pregnancy related, and non-pregnancy related) in Kansas. In order to assure a coordinated response that fully addresses all systemic concerns surrounding a particular incident, the Maternal Mortality Review Committee must review all pertinent information on each death. This includes reviewing de-identified autopsy reports, coroner's reports, law enforcement reports, hospital and prenatal care records, and other information that may have a bearing on the involved family. The records provided to Maternal Mortality Review Committee members will be de-identified.

With this purpose in mind, members agree to all of the following:

- To maintain the confidentiality of all information secured and discussed in the maternal mortality review and to not use the information provided for reasons other than normal maternal mortality review;
- To not take materials related to case reviews with case information from the meetings; and
- To not discuss confidential Review Committee information outside of a Review Committee meeting with individuals who are not part of the Maternal Mortality Review Committee.

In signing this Agreement, I agree to keep all information gathered for this review highly confidential and to be scrupulous in safeguarding its confidentiality. Confidential information, in any format, regarding this maternal mortality review will not be discussed or divulged beyond project staff at the Kansas Department of Health and Environment (KDHE), or experts on the committee consulted for this project. Reports, presentations and publications will not include personal identifying information of the decedents. Additionally, no identifying information about the physicians or health professionals who provided care, the health care facility, or other identifiable or actionable circumstance of the maternal death will be communicated.

I understand and agree to adhere to the Confidentiality Agreement of the Kansas Maternal Mortality Review Committee.

_____ _____

Signature Date

Appendix F

Kansas Maternal Mortality Review Committee

Kansas Maternal Mortality Review Committee (KMMRC)
Member Application
Effective Date: February 2020

The Kansas Maternal Mortality Review Committee (KMMRC) is a multidisciplinary committee whose geographically diverse members represent various specialties, facilities, and systems that interact with and impact maternal health. Committee members are appointed by the Department. Recruitment of new MMRC members may occur annually as needed unless a specific type of expertise is required during the year for a case review. KMMRC members do not have a term limit for their volunteer stewardship. For additional information regarding the KMMRC, please refer to the Guidance Document (available from the KMMRC Coordinator) and information online: http://www.kansasmch.org/mmr.asp.

KMMRC Vision: To eliminate preventable maternal deaths in Kansas.

KMMRC Mission: To increase awareness of the issues surrounding pregnancy-related death and to promote change among individuals, communities, and healthcare systems in order to reduce the number of deaths.

Name			
Preferred Phone		Email	
Address		City, State, Zip	
Organization			
Position Title			
Why are you interested in participating on the Kansas Maternal Mortality Review Council?			
The KMMRC is not designed to be very time intensive (review meetings 2-3 times per year); however, a commitment to active, face-to-face participation is essential. Please provide any reason that you may have a difficult time participating in meetings. ☐ I do not anticipate having difficulties in participating in review meetings. ☐ I do not anticipate having difficulties in participating in reviews *with* accommodations. (Please describe below).			
I grant permission for my information to be posted on the website as a KMMRC member. ☐ Name and Role/Organization ☐ Photo			

Please submit questions and/or the application by email to Jill Nelson at JillElizabeth.Nelson@ks.gov.

Office Use Only
Appointment Recommendation: ____ Yes ____ No ____ Hold for future placement
Comments:

More Information

Key Contacts:

Jill Nelson
MMRC Coordinator
Bureau of Family Health
Kansas Department of Health and Environment
785-515-6717
JillElizabeth.Nelson@ks.gov

Nadyne Hagmeier
Maternal Mortality Abstractor
Kansas Foundation for Medical Care
785-276-2552 x374
nhagmeier@kfmc.org

Kansas MMRC Website:

https://kmmrc.org

National Websites/Resources:

https://www.reviewtoaction.org
https://www.cdc.gov/grand-rounds/pp/2017/20171114-maternal-mortality.html
https://safehealthcareforeverywoman.org/aim-program/