Hawaii Department of Health Maternal Mortality Review Committee

Administrative Home/Staff:

- Hawaii State Department of Health, Maternal and Child Health Branch
- Committee Chair, Scott Harvey MD
- MMR Coordinator, Contracting out part time
- MMR Abstractor, Contracting out part time, Cindy Goto MD

Other DOH Staff:

- Kimberly Arakaki; Maternal and Child Health Branch, Branch Chief
- Candice Calhoun; Maternal and Child Health Branch, Women's Health Section Supervisor
- Donald Hayes MD MPH; Family Health Services Division, CDC-Assigned Epidemiologist
- Betty Wood PhD MPH; Office of Planning Policy and Program Development, Epidemiologist
- Alvin Onaka PhD; Office of Health Status and Monitoring, State Registrar
- Shu Liang; Maternal and Child Health Branch, Research Statistician

Introduction:

- Legislation passed in 2016 requiring the DOH to work with partners to review Maternal and Child Deaths
- Number of committee members ~20

Successes:

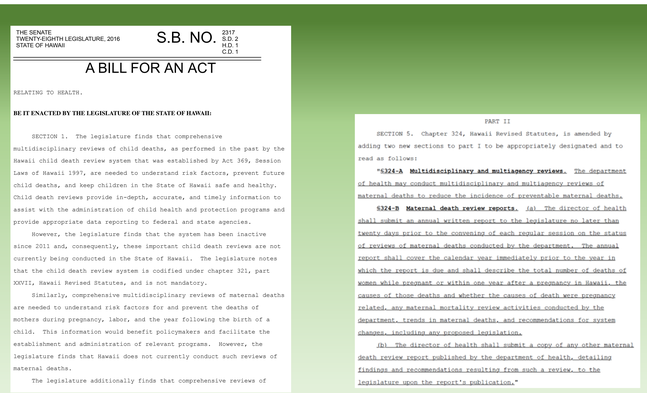
- Legislation passed supported by Hawaii Maternal and Infant Health Collaborative
- Initial meeting Nov 2016 included Mock review and other Support from CDC
- Policies and Procedures draft document developed
- Contracted with an abstractor
- Trying to secure a contractor to help with coordination
- Obtained identified death certificate records from vital statistics
- Working with medical examiner to electronically transmit data to DOH

Vision/Scope:

- Establish a sustainable process to review Maternal Deaths
- Review all pregnancy associated and related deaths within 1 year of pregnancy

Specialties, Partners, and Organizations

- American College of Obstetrics and Gynecology
- Maternal and Fetal Medicine Specialists
- Community OBGYN
- Critical Care
- Anesthesiology
- Pediatrics
- Primary Care
- Psychiatry
- Medical Examiner
- John A Burns School of Medicine
- American College of Nurse Midwifes
- Midwife Alliance
- Community Nurses
- Healthcare Association of Hawaii
- Emergency Medical System
- Public Health Nursing
- Healthy Mothers Healthy Babies
- Department of Native Hawaiian Health
- Hawaii Maternal and Infant Health Collaborative
- Department of Human Services



THE SENATE
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

S.B. NO. 2317 S.D. 2 H.D. 1 C.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that comprehensive multidisciplinary reviews of child deaths, as performed in the past by the Hawaii child death review system that was established by Act 369, Session Laws of Hawaii 1997, are needed to understand risk factors, prevent future child deaths, and keep children in the State of Hawaii safe and healthy. Child death reviews provide in-depth, accurate, and timely information to assist with the administration of child health and protection programs and provide appropriate data reporting to federal and state agencies.

However, the legislature finds that the system has been inactive since 2011 and, consequently, these important child death reviews are not currently being conducted in the State of Hawaii. The legislature notes that the child death review system is codified under chapter 321, part XXVII, Hawaii Revised Statutes, and is not mandatory.

Similarly, comprehensive multidisciplinary reviews of maternal deaths are needed to understand risk factors for and prevent the deaths of mothers during pregnancy, labor, and the year following the birth of a child. This information would benefit policymakers and facilitate the establishment and administration of relevant programs. However, the legislature finds that Hawaii does not currently conduct such reviews of maternal deaths.

The legislature additionally finds that comprehensive reviews of

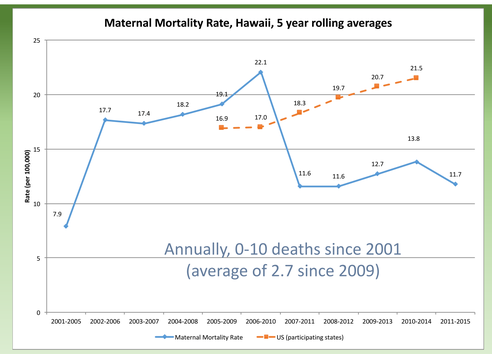
PART II

SECTION 5. Chapter 324, Hawaii Revised Statutes, is amended by adding two new sections to part I to be appropriately designated and to read as follows:

"**§324-A Multidisciplinary and multiagency reviews.** The department of health may conduct multidisciplinary and multiagency reviews of maternal deaths to reduce the incidence of preventable maternal deaths.

§324-B Maternal death review reports. (a) The director of health shall submit an annual written report to the legislature no later than twenty days prior to the convening of each regular session on the status of reviews of maternal deaths conducted by the department. The annual report shall cover the calendar year immediately prior to the year in which the report is due and shall describe the total number of deaths of women while pregnant or within one year after a pregnancy in Hawaii, the causes of those deaths and whether the causes of death were pregnancy related, any maternal mortality review activities conducted by the department, trends in maternal deaths, and recommendations for system changes, including any proposed legislation.

(b) The director of health shall submit a copy of any other maternal death review report published by the department of health, detailing findings and recommendations resulting from such a review, to the legislature upon the report's publication."



Note: Limited to Hawaii Residents, Maternal Mortality WHO definition A34, O00-O95, O98-O99 for underlying cause of death. 2015 Data is provisional. FHSD calculations of Office of Health Status Monitoring Death Certificate Data.
Note: US (participating states) from HRSA/MCHB/Title V Federally Available Data and reflects those states with revised death and birth certificate so not representative of all states (e.g., Hawaii adopted revised death certificate in 2006, but did not adopt revised birth certificate until 2014)

- Mission and Goals
  - Determine the causes of maternal mortality in Hawaii and identify public health and clinical interventions to improve systems of care
    - Determine annual number of maternal deaths
    - Identify trends and risk factors among maternal deaths
    - Develop actionable strategies for prevention and intervention
- Committee structure
  - Committee Chair
  - Multi-disciplinary volunteer membership

Challenges:

- Lack of dedicated staff
- Have not yet worked with securing hospital, provider, or other data
- Have not done a review yet (one scheduled for April 13)
- Neighbor Island representation and costs to travel
- Small number of deaths (identified 11 potential for CY 2015)
  - Have reported <5 annually to Pregnancy Mortality Surveillance System

Leadership:

- Scott Harvey MD; Clinical Chair; OBGYN and Surgical/Trauma Critical Care Fellowship
- Maternal and Child Health Branch; Hawaii State Department of Health

Contact Information

- No website
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- Scott Harvey, sharvey@hawaii.edu