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

**December 21, 2016, Kent WA**

(DOH and 5-6 Panel Members)

1. Review high-level summary of all maternal deaths; confirm categorizations of death
2. Determine cause of death for pregnancy related cases, or if more information is needed
3. Prioritize 10 pregnancy-related cases for Level 3 Review
	1. Complexity
	2. Education potential
	3. Recommendations potential
4. Identify gaps in information and records, and any consults required

\*Process guided by use of CDC case discussion form

**Level 1 Review: Case Identification**

**May-August (Complete)**

(DOH and CHS)

* 1. Link birth and death records
	2. Link records to hospitalizations
	3. Identification of maternal deaths in WA
	4. Begin with 2014 and 2015
	5. Begin identification/analysis of demographic trends

**Pregnancy associated deaths – not related**

Death of a women while pregnant or within 365 days of termination of pregnancy from any cause and that is not related to the pregnancy itself

* This includes MVA, cancer, homicide, suicide, overdose, other accidents, some seizure

**Pregnancy Related Deaths**

Death of woman while pregnant or within 365 days of termination of pregnancy that is directly related to pregnancy

* Specific diagnoses/timelines based on cause of death decision tree

DOH initial categorization based on **Cause of Death Decision Guidelines**

All Maternal Deaths 2014 2015

Case Follow Up and Preparation for Level 3 Review

1. DOH MMR Team abstract data from records, populate data into MMRDS on prioritized cases
2. Consult with panel members as necessary for expertise
3. Update case narratives and core summaries

\

DOH begins MMRDS data population

**Ongoing Processes:**

* Data analysis, trending
	+ Populate MMRDS
	+ Generate core summary reports
* Records management
	+ Records requests
	+ Chart abstraction
	+ Case narrative development, review, and updates
	+ MMRDS data population
* Record deidentification

**Possibly Pregnancy Related Deaths**

Death that may be pregnancy related – more investigation required

* Panel members to review/make determination

**Final Product: Report Development, Approval, and Submission**

DOH and panel members (as available and needed)

* Submit to DOH Executives by May 1, 2017
* **Submit to legislation by July 1, 2017**

**Level 3 Review: In-Person Case Review and Preventability Discussion**

**February 7, 2017, Kent, WA**

(DOH and 20 Panel Members)

10 cases: 20-30 minutes per case

1. Review findings of Level 1 and Level 2 Review
2. Review pregnancy related cases based on Level 2 Review findings
	1. Quick review/explanation of cases not prioritized
	2. In-depth review of more complex cases
3. Preventability discussion using **CDC definition**
4. Risk factors, gaps/medical errors
5. Recommendations for prevention

\*Process guided by use of CDC Case Discussion Form

Identify cases which were preventable

Identify gaps in records or information for follow up

**Level 4 Review: High Level and Systems Changes Discussion and Recommendation Development**

**March 7, 2017**

(DOH, All Panel Members, Community Stakeholders)

Review of data on maternal deaths to include demographic data and review findings from Level 1, 2 and 3 Review

1. Discuss Level 1, 2 and 3 review findings and data
2. Identify and discuss risk factors
3. Discuss systems changes recommendations

Identify risk factors

Identify gaps, error in medical or community care, services

**Recommendations for prevention**