Purpose:

The goal of the Delaware Maternal Mortality Review (MMR) is to identify and conduct an in-depth, multidisciplinary review of pregnancy-related deaths and selected pregnancy-associated deaths occurring among Delaware residents in Delaware. The ultimate purpose of these reviews is to describe and track factors associated with maternal deaths, identify systems-wide issues that may have contributed to the deaths, develop recommendations for change, disseminate information and assist in the implementation of recommendations that will improve the health of mothers and infants in Delaware.

Policy:

A maternal death is defined as a death of a woman while pregnant or within one year of the end of pregnancy, irrespective of cause. This is also known as a pregnancy-associated death. Pregnancy-associated deaths can be further divided into two categories: those that are pregnancy-related, and those that are not pregnancy-related. Delaware’s MMR program will strive to identify and review all pregnancy-related deaths and those deaths—whether pregnancy-related or not—that involve domestic violence, substance abuse suicide or homicide. Other cases that are deemed not pregnancy-related based upon the information provided in the death certificate or by the medical examiner will not be reviewed by the panel, but basic demographic information on these cases will be tracked for completeness of reporting. An MMR case that involves pending litigation will be reviewed once litigation is complete.

Legislative Authority:

31 Del. C. 320-324

Definitions:

Maternal death/Pregnancy-associated death: The death of a woman while pregnant or within 1 year of the end of her pregnancy, irrespective of cause.

Pregnancy-related death: The death of a woman while pregnant or within 1 year of the end of her pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes.
Pregnancy-unrelated death: The death of a woman while pregnant or within 1 year of the end of her pregnancy due to a cause unrelated to pregnancy.

Maternal mortality review panel (MMRP): A multi-disciplinary team composed of medical, social service professionals, and other experts from the community who review a de-identified summary of the maternal death and the information from the family interview, if available. The panel identifies factors and system issues that may have contributed to the death, makes recommendations to address these issues and determines if the death was pregnancy related or unrelated.

De-identified: Information that is stripped of data elements that can lead to the identification of the woman, the family, and service providers involved in the case.

Family interview: A voluntary interview with the partner/spouse or other close family member or friend of the deceased woman to learn more about the context of the woman’s life and the events surrounding her death. The family interview is conducted by the CDNDSC Senior Medical Social Worker.

Medical abstraction: A comprehensive medical record review of relevant medical records by a case abstractor, who is usually a physician or nurse with expertise in obstetrics. Review of records include prenatal/postpartum records, outpatient/inpatient visits, hospital admissions related to the pregnancy, delivery records, and primary care records up to 2 years prior to the death.

Procedure:

1. Prior to the Maternal Mortality Review Panel (MMRP) reviews, the CDNDSC Senior Medical Social Worker will secure criminal history checks concerning family members to be interviewed through the Prothonotary’s office. The information gathered will be reviewed to determine the appropriateness for family interview as well as provide a measure of security for the Senior Medical Social Worker. The CDNDSC staff will internally document the findings of the background checks.
2. CDNDSC staff will subpoena all pertinent medical records dating up to 2 years prior to the death.
3. A DPH (Division of Public Health) case summary will be requested by the CDNDSC staff via the DHSS (Delaware Health and Social Services) liaison to request any relevant visit records up to two years prior to the death.
4. If maternal mental health issues are identified prior to the case review, those records will also be subpoenaed.
5. If additional records are determined to be necessary to complete the review, those records will be subpoenaed.
6. A Family Interview will be initiated by the CDNDSC Senior Medical Social Worker via an initial letter, one follow up letter, and three follow up telephone calls (if a telephone number is available) for the spouse/partner, next of kin or emergency contact listed in the medical records. The partner/family member/friend will be contacted and invited to participate in the interview.
   a. If he or she chooses to decline, the person will be encouraged to participate; if he or she still chooses to decline, that decision will be respected.
   b. If he or she chooses to proceed, the interview will be conducted by the Senior Medical Social Worker.
   c. The Family Interview will be based on a structured questionnaire. A follow up letter and evaluation will be sent to the interviewee after the visit.
   d. A family interview will not be conducted if the partner/informant has an active warrant for his or her arrest, if the case is in litigation, or if psychiatric conditions deem the person a threat to the Senior Medical Social Worker. However, a medical abstraction and case review will occur once the litigation process, if any, is complete.
   e. The case will be reviewed by the MMRP whether or not the family member declines to be interviewed.

7. The MMR case abstractor (a health care provider with obstetric expertise) will review and summarize the medical and public agency records and complete a case abstraction form. Some or parts of the abstraction form will be entered into a secured computerized database. A comprehensive, de-identified case summary will be presented to the MMRP.

8. At each meeting of the MMRP, panel members must comply with and sign the confidentiality statement for the review process. The confidentiality sheets are collected and maintained by the CDNDSC staff.

9. Narrative case summaries will be distributed at the start of each MMRP meeting for the cases on the agenda that day.

10. The MMRP discussion will include, but not limited to, the following issues: individual/community factors, system factors, clinical factors, death review process.

11. Following presentations of information and discussion by the MMRP, the Chair asks the panel the following:
   a. Is this death pregnancy-related, not pregnancy-related or undetermined?
   b. Were reasonable standards of practice met by the systems involved?
   c. What factors, if any, contributed to the death?
   d. Are there changes to community behaviors, technologies, agency systems and/or laws that could minimize these risk factors and prevent another death?
   e. Are there recommendations that would affect the changes necessary to minimize risk and prevent future deaths?
i. If yes, the panel should move the discussion to developing recommendations.

ii. If not, the panel should proceed with the conclusion of the review.

12. If recommendations are put forth, the following criteria should be considered:
   a. The recommendation is clearly related to the case.
   b. There is enough expertise among the panel to evaluate this issue.
   c. No further research is needed on this issue.
   d. The recommendation does not need to be referred to another body.
   e. An anticipated result from the recommendation is identified.
   f. An entity to take the lead on implementing the recommendation is identified.

13. Recommendations shall be clearly written with enough information so that others not involved in the review will understand the intent and how the recommendation logically relates to the death. Recommendations must be meaningful, action-oriented, and focused. Recommendations should seek solutions not blame and be broad (system-wide or prevention focused) and not agency specific.
   a. In some cases, there may be no system failures; however, if the MMRP believes there are public policy issues or preventive strategies that need to be monitored, these issues will be monitored and tracked by the CDNDSC staff. These issues may be included in an annual report when there is sufficient supporting data and if agreed upon by a vote of the Commission.
   b. System issues or safety concerns that have occurred after the death will be directed to the specific agency or entity to implement a recommendation as appropriate.
   c. An affirmative vote of 60% of those present is needed to adopt any recommendation.
   d. MMRP members are asked to abstain from voting upon recommendations if they were not present for the case presentation and discussion.

14. If a review cannot be completed due to lack of information or expertise, the following should be considered:
   a. Defer the review.
   b. A request is made by the MMRP for more information. The CDNDSC staff will attempt to obtain the information (via subpoena if necessary.)
   c. The case abstractor will summarize the additional information received and reschedule the deferred case as quickly as possible.

15. At the completion of a review, all MMRP members will turn over all documentation related to that review to the CDNDSC staff for shredding. All data sheets, case discussion forms and other related review materials will be stored in a locked file maintained by the CDNDSC staff. All
necessary data will be entered into a secured computerized database, which will be maintained by the CDNDSC staff.

16. The Executive Director or staff designee will prepare the MMRP report and de-identified case summaries for the MMRP Chair to submit at the next scheduled Commission meeting.

17. The MMRP Chair and Executive Director will ensure the recommendations are reported to the Commission. Recommendations must be approved by the Commission prior to documenting the recommendations in the secured computerized database.

18. Recommendations are reported to the Governor, the General Assembly, and the public through the CDNDSC annual report when there are a sufficient number of cases to support the recommendations and maintain confidentiality of any individual case.

19. Upon Commission approval of the MMRP’s recommendations the appropriate Community Action Team, under the CDNDSC or the Delaware Healthy Mothers and Infants Consortium, will be asked to begin implementation of action steps. All MMRP recommendations and action steps will be documented in the secure computerized database.

20. Progress on the action steps will be reviewed with the appropriate Community Action Team during meetings as scheduled. Action steps will be documented in the CDNDSC annual report.

21. CDNDSC staff will regularly update the MMRP on action steps from the various Community Action Team meetings.
Case identification based on:
1. Pregnancy check box on Delaware death certificate
2. Passive reporting by Medical Examiner’s Office, hospitals and health care providers

Review death certificates and any information provided by Medical Examiner to select cases for full review that are:
1. pregnancy-related
   OR that may involve
2. domestic violence, substance abuse, suicide or homicide

Selected cases of maternal deaths for full review.

Subpoena medical records up to 2 yrs prior to death.

Identify further records for review.
Complete case abstraction.

Identify next of kin who may be contacted for a family interview.

Background check prior to family interview.
Contact for family interview if appropriate.

Conduct family interview.
Interview declined or unable to contact.

Prepare de-identified case narrative.

MMR Panel reviews case.

Case summaries & recommendations to CDNDSC for approval.

Enter recommendations into MMR database.
Report recommendations to community action teams for action steps & implementation.