




SOUTH DAKOTA  
DEPARTMENT OF HEALTH

South Dakota Preventable Death Committee Meeting  
June 11<sup>th</sup>, 2019

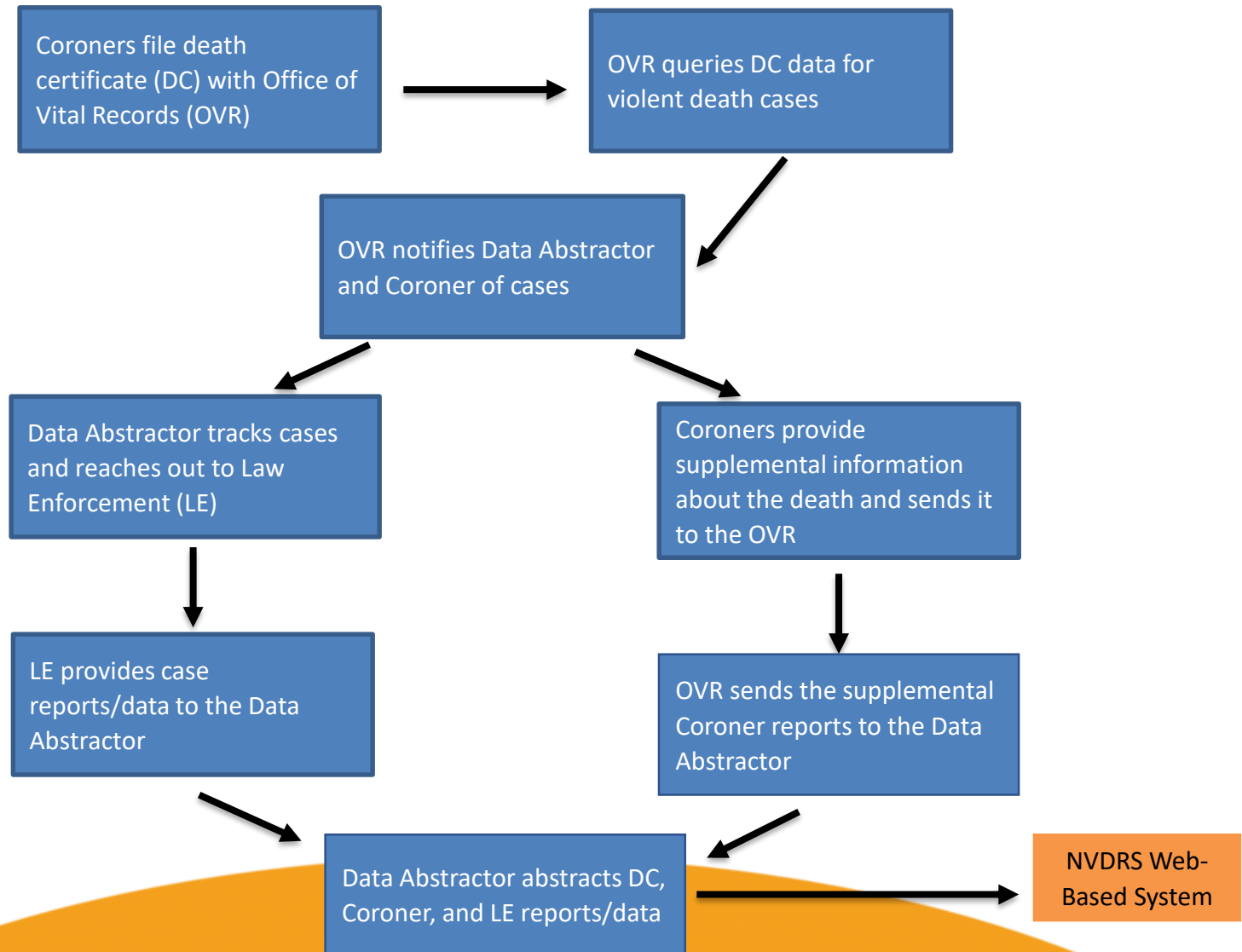
**PURPOSE:** To standardize and influence how South Dakota performs infant, child, maternal and violent preventable death reviews

- Collect information from members of the committee regarding the strengths of current review processes
  - Identify challenges in preventable death review in South Dakota.
  - Discuss ad hoc workgroups to consider specifics for infant/child, maternal and violent death review processes to bring back to the South Dakota Prevention Death Review Committee
  - Identify strategies to move forward to enhance and institutionalize preventable death review for infants/children, maternal deaths, and violent deaths in South Dakota
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# South Dakota Violent Death Reporting System (SD-VDRS)



# SD-VDRS Data Collection Process





# SD-VDRS Data Updates

- Sioux Falls Police Department/Minnehaha County Sherriff's Office
  - Abstractor Training
- Rapid City Police Department
  - Records Office
- From January 2019 to May 2019:
  - 21 Violent Death Cases
    - Minnehaha=12; Pennington=9
    - 17 Suicide, 3 Homicide, & 1 Undetermined
  - 21 Cases Initiated Within 120 Days of Date of Death
  - 18 Cases Completed (all 3 data sources received & abstracted)
    - 100% Death Certificates received & abstracted
    - 85.71% Coroner Reports received & abstracted
    - 90.48% Law Enforcement Reports received & abstracted
    - 85.71% Toxicology Information received & abstracted



# Update from our Data Providers

- **Dr. Kenneth Snell**
  - Minnehaha county coroner/ Medical Examiner
- **Lt. Mike Colwell**
  - Sioux Falls Police Department
- **Trent Nelson**
  - Pennington county coroner



# SD-VDRS Statewide Implementation Plan

- **Data Provider Resources**
  - SD-VDRS 1 pager
  - Pocket Guide
  - Coroner Clipboard
  - Website
- **Data Provider Training and Education**
  - Dr. Snell incorporate SD-VDRS into new coroner training in October
  - DOH staff present at the SD Sheriff's Association meeting in September
  - Include information in list serves and newsletters through Vital Records office, DCI, Sheriff's association, etc.
  - Hold some Q & A sessions



# SD-VDRS Contractors

- **Sanford Research (Evaluation)**
  - Evaluation part of our federal funding
  - Gather information from data providers on the data collection process to help identifying what is working well is what is not
  - Gather information from committee members and other injury and violence prevention partners on what data is important to them and in what format to direct prevention efforts
  - Lead survey development, administration, and analysis
- **Data Abtractor (organization unknown)**
  - Need assistance with abstracting the data from the reports and inputting it into the web-based database when we go statewide





# Preventable Death Review: Obtaining and Protecting Data

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Legal Counsel  
South Dakota Department of Health



# The Details Are in the Data

Effective prevention techniques and efforts require a comprehensive understanding of the risks, indicators, and demographics surrounding preventable deaths.

Accurate and detailed information is critical in understanding the current landscape. Only after thoroughly understanding the current circumstances can we take strides in potentially targeting and preventing preventable deaths.

# Access To and Protections Of Data

## 1. South Dakota Law

- ARSD Chapter 34 – Public Health and Safety

## 2. Health Insurance Portability and Accountability Act (HIPAA)

- Public Health Activities Exception - 45 C.F.R. 164.512(b)
- Law Enforcement Exception – 45 C.F.R. 164.512(f)

## 3. Data Use Agreements

## 4. Department of Health Policies



# 1. Access To Data

# South Dakota Law

- No state law specifically allowing for or prohibiting the access to medical information for the purpose of Preventable Death Review Teams
- DOH access to confidential reports of communicable diseases – SDCL Chapter 34-22 and ARSD Article 44:20
- DOH authority over Vital Records reports and information – SDCL Chapter 34-25
- Some states have specific death review enabling statutes granting access to data

# Health Insurance Portability and Accountability Act (HIPAA)

- General Rule: The Privacy Rule deems all Protected Health Information (PHI) to be confidential and cannot be shared
- For our purposes, and to be overly cautious, let's assume all information sought by the Committee is PHI and the entities which we are seeking to obtain the information from are "covered entities" for the purposes of HIPAA applying

# HIPAA Privacy Rule Exceptions

## Public Health Activities – 45 C.F.R. 164.512(b)

“A covered entity may use or disclose protected health information for the public health activities described in this paragraph to:

(i) a **public health authority** that is authorized by law to collect and receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of . . . public health investigations. . .”

# HIPAA Privacy Rule Exceptions

## **Public Health Activities – 45 C.F.R. 164.512(b)**

### “Public Health Authority” Defined by HIPAA

“An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory or an Indian tribe or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.”



# HIPAA Privacy Rule Exceptions

**The following quote from the preamble to the Privacy Rule is a DHHS response to a public comment they received on their draft of the Rule:**

“Comment: One commenter remarked that our proposal may impede fetal/infant mortality and child death reviews. DHHS Response: The final rule permits a covered entity to disclose protected health information to a public health authority authorized by law to conduct public health activities, including the collection of data relevant to death or disease, in accordance with section 164.51.2(b). Such activities may also meet the definition of “health care operations.” We therefore do not believe this rule impedes these activities.”



## 2. Protection of Data

# HIPAA

- Portions of South Dakota Department of Health is deemed a HIPAA covered entity, so we have all the protections and processes in place
- PHI provided to DOH for the Committee doesn't lose its PHI status – all the protections apply to information and Committee members

# Confidentiality Agreements and Data Use Agreements

- Can be a powerful tool to ensure the confidentiality of information shared among the Team
- Team could require that each Team member sign a confidentiality agreement outlining the purpose of the review, consequences for breaking the agreement, and circumstances under which the information could be shared
- Could be signed once and kept on file or annually – would recommend annually to act as a reminder to all Team members of the confidentiality requirements

# Department of Health Policy

“All the HIPAA Privacy Policies and Procedures set forth in this document apply to DOH PHI, which includes any personal information that identifies a DOH client. Unless otherwise stated, all the HIPAA Privacy Policies and procedures must be followed by:

- All workforce members of DOH.
- All contractors, vendors, third parties, or other persons who may, during their association with DOH, come in contact, use, maintain or handle PHI in any form (written, electronic, or oral). These policies and procedures apply to all DOH workforce members during and after their terms of employment or contract that have access to DOH PHI.”



# Questions



- **Public Health Statistics**

- Measuring health outcomes (for example infant mortality)
- Identifying risk factors (such as smoking), planning and evaluating programs, conducting medical research
- Calculating life expectancy and measuring a population's rate of natural increase

- **Legal and Administrative**

- Proof of age, citizenship, or parentage
- Obtain identity documents such as passports and driver's licenses
- Enrollment with benefits programs
- Settle estates, obtain life insurance payments, and terminate social security, pension, and other benefits



## Strengths and Weaknesses

- Infant Death Review
- Child Death Review
- Maternal Mortality Review
- Violent Death Reporting System





# Infant Death Review

## Challenges of Infant Death Review:

- Continuity of membership and attendance at meetings
- Quality/consistent data is difficult to obtain
- Concerns with data sharing, HIPPA and confidentiality
- Difficult to obtaining data from tribal health and law enforcement
- Inconsistency in how the teams conduct their reviews
- Facilitate the use of information that the review teams gather to inform prevention recommendations that community teams can utilize



# Child Death Review

## Challenges of Child Death Review:

- Only review cases reported to DSS
- Sometimes work hand and hand with law enforcement and sometimes not
- Tribal CPS don't report to DSS



# Recommendations: Infant and Child Death Review

- Process for calling DSS-Do some training for coroners
- Some many different scenarios
- Need to utilize same language (co-sleeping vs bed-sleeping)



# Maternal Mortality

- Refers to the death of a woman during pregnancy, childbirth or in the post-partum period
- From 2000 to 2014, the United States experienced a 26% increase in the maternal mortality rate
  - Changes in death coding and addition of pregnancy checkbox
  - Increase in chronic health conditions
  - Rising maternal age
  - Changing and diverse clinical practices
    - Increase in the rate of cesarean delivery
    - Variation in the quality of hospital-based intrapartum care



## MATERNAL MORTALITY DEFINITIONS:

**Pregnancy-associated death:** The death of a woman while pregnant or within one year of the termination of pregnancy, regardless of the cause. This makes up the universe of maternal mortality. Within that universe are pregnancy-related deaths and pregnancy-associated, but not related deaths.

**Pregnancy-associated, but not related death:** The death of a woman during pregnancy or within one year of the end of pregnancy, from a cause that is not related to pregnancy.

**Pregnancy-related death:** The death of a woman during pregnancy or within one year of the end of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.



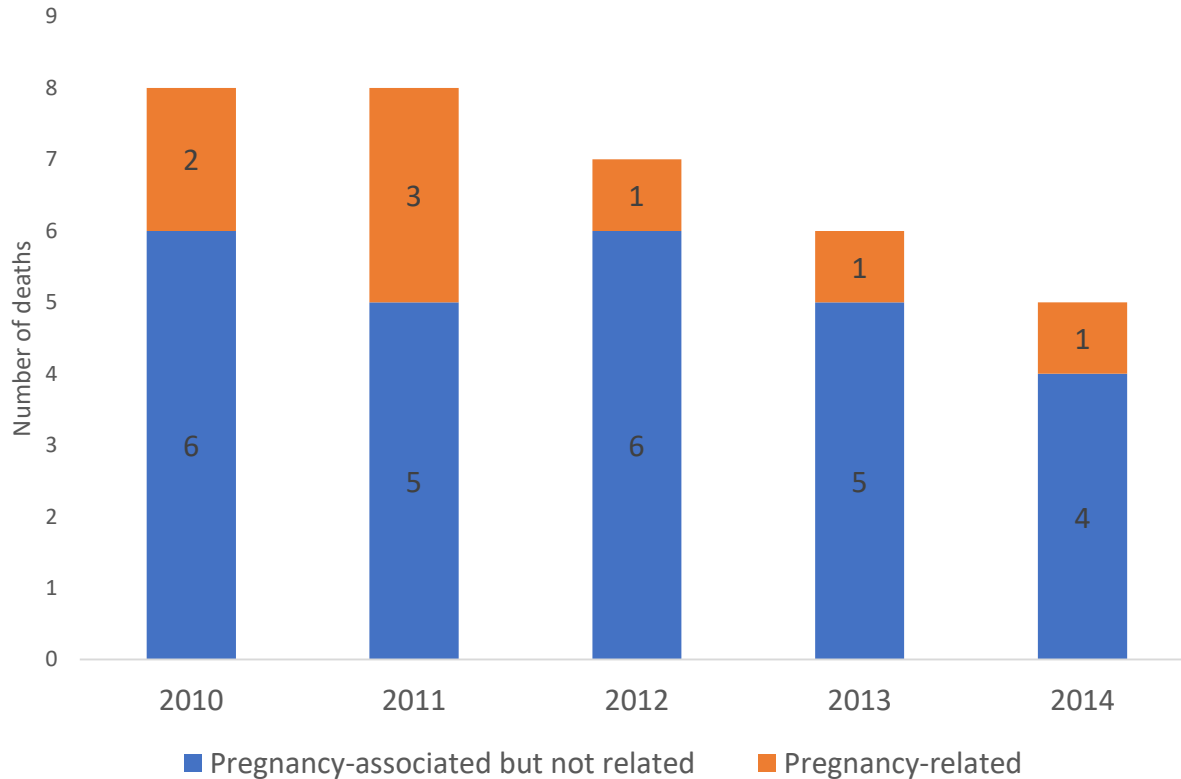


# Data Sources

- Pregnancy Mortality Surveillance System (PMSS)
  - Use death certificates linked to fetal death and birth certificates
  - Reviewed by medical epidemiologists
  - Classify as pregnancy-associated, pregnancy-related, cause of death, and injury relatedness
  - Most recent data is from 2014
  - Do not count SD resident deaths that occurred in other states

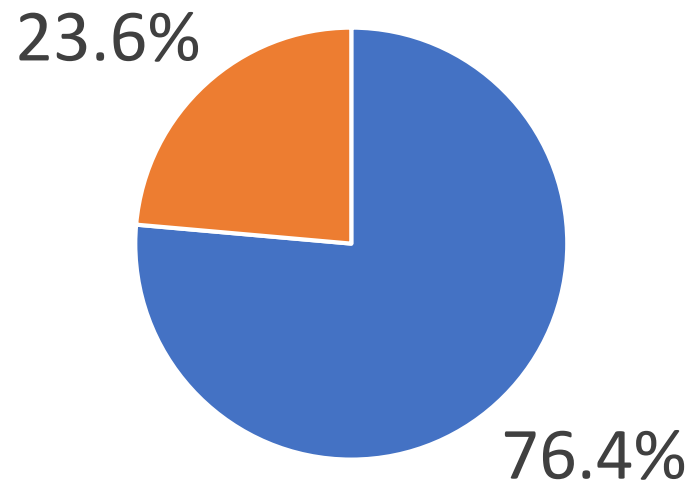


## Pregnancy-Associated but not Related vs. Pregnancy-Related Deaths, South Dakota, 2010-2014





## Percent of Pregnancy-Associated but Not Related vs. Pregnancy-Related Deaths, 2010-2014



- Pregnancy-Associated but Not Related
- Pregnancy-Related





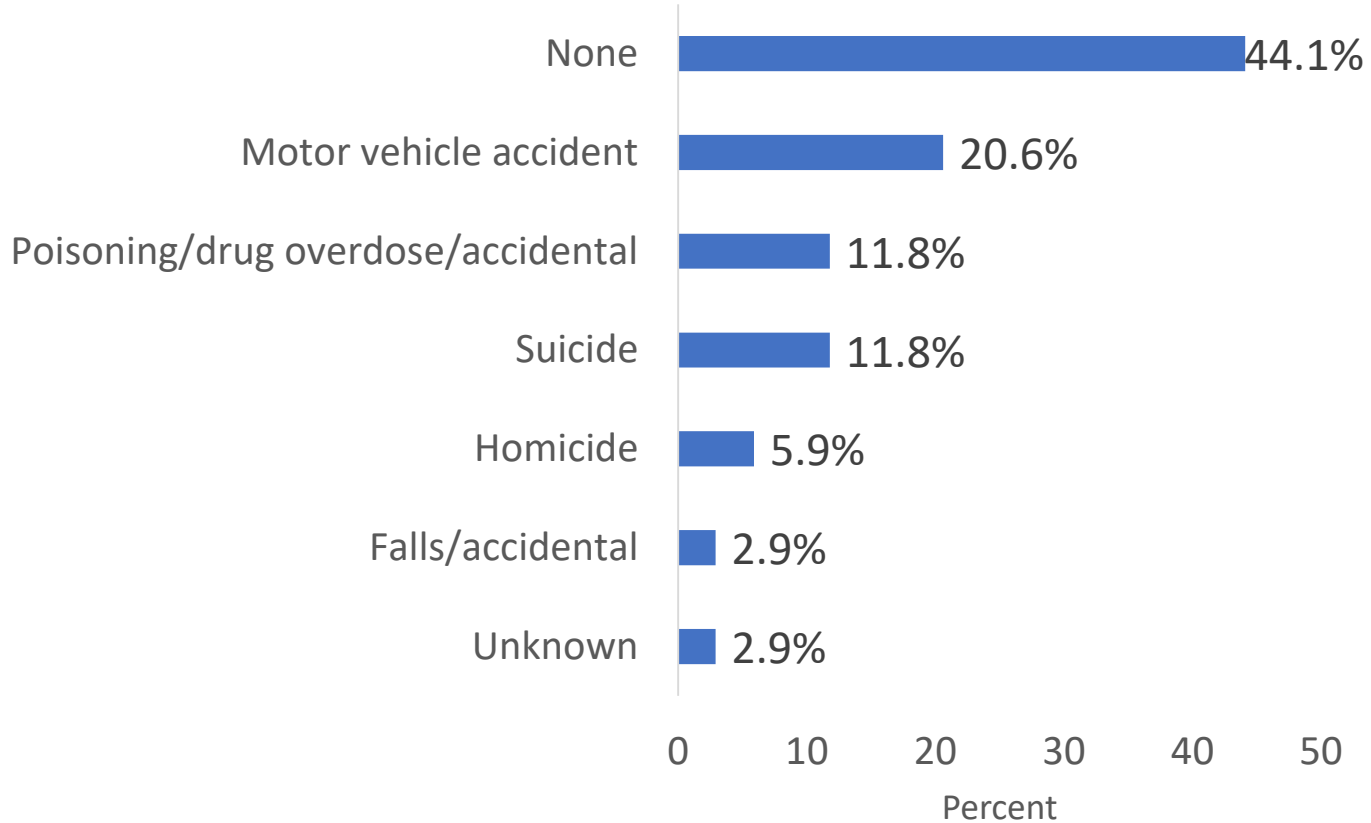
# Pregnancy-Related Mortality Ratio

United States (2011-2015): 17.2

South Dakota (2010-2014): 12.6



## Pregnancy-Associated Deaths by Type of Injury, 2010-2014





# Data Sources

- South Dakota Vital Records
  - Death certificates linked to fetal death and birth certificates
  - Reviewed by SDDOH staff
  - More current data (2017)
  - Takes into account SD residents that died in other states



# Maternal Mortality Review Committee (MMRC)

- Interdisciplinary team that reviews maternal deaths
- Use clinical data, vital records, law enforcement records, etc.
- Many states use Maternal Mortality Review Information Application (MMRIA) to guide MMRC process
- Translate data into action



# Challenges

- Lack of authority and protections
  - Confidentiality
  - Immunity
  - Access to records



# Recommendations: Maternal Mortality Review

- Need to be a state owned process especially with the amount of clinical data



# Violent Death Reporting System

## Challenges of Violent Death Reporting System:

- Statewide data collection;
  - Not knowing the willingness to share data from different law enforcement agencies, especially FBI and tribal law enforcement



# Recommendations: Violent Death Reporting System





# Next Steps