Report to
The Vermont Legislature

Maternal Mortality Review Panel Findings and Recommendations

In Accordance with Act 35 (2011), Section 2(c)
An Act Relating to Insurance Coverage for Midwifery Services and Home Births

Submitted to: Senate Committee on Health and Welfare
House Committee on Health Care
House Committee on Human Services

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Maternal Mortality Review Panel Findings and Recommendations

This report on the findings and recommendations of the Maternal Mortality Review Panel, written pursuant to Act 35 of 2011 [18 V.S.A. §1553(c)], is submitted by the Commissioner of Health to the House Committees on Health Care and on Human Services and to the Senate Committee on Health and Welfare. The purpose of the report is to provide the following information about maternal deaths:

1. A description of the adverse events reviewed by the panel during the preceding 12 months, including statistics and causes. The 12-month period covered by this report begins on October 1, 2011 and ended on September 30, 2012.
2. Corrective action plans to address, in the aggregate, such adverse events
3. Recommendations for system changes and legislation relating to the delivery of health care in Vermont.

Introduction: Maternal Mortality Review Panel

In November, 2011, the Maternal Mortality Review Panel (MMRP) was established as required by 18 V.S.A. §1552. The purpose of the panel is to conduct comprehensive, multidisciplinary reviews of maternal deaths in Vermont for the purposes of identifying factors associated with the deaths and making recommendations for system changes to improve health care services for women in Vermont.

MMRP Actions During 2012

MMRP Panel: The Panel held its 2012 meeting on November 9, 2012, and reappointed Breena Holmes, MD (Maternal and Child Health Director at Vermont Department of Health) chair of the panel for a 2 year term beginning November 9, 2012.

Description of Adverse Events: During its 2012 meeting, the MMRP reviewed cases of maternal deaths for the preceding 12 months period of October 1, 2011 through September 30, 2012. Four pregnancy-associated deaths during that period were identified and reviewed from death certificate records. These deaths were identified by either a pregnancy cause of death, the pregnancy checkbox on the death certificate, and/or a match to a birth record that had occurred within 12 months of the death. All four deaths were pregnancy-associated but not pregnancy related. The common public health issue that emerged for two, and possibly all deaths, was substance abuse. Due to the small number of deaths, listing each cause of death in a public report would not respect the privacy of the families affected.

Corrective Action Plans for 2012: None

Recommendations for System Change: Efforts to address substance abuse as a public health issue should be continued. Other system changes may emerge during the rule-making process called for in 18 V.S.A. §1556, or during future investigation work outlined in the rules.

Status of Rule-Making

Act 35 calls for the Department of Health to adopt rules related to the following:

1. The system for identifying and reporting maternal deaths to the commissioner or designee
2. The form and manner through which the panel may acquire information under Title 18 §1555
3. The protocol to be used in carefully and sensitively contacting a family member of the deceased woman for a discussion of the events surrounding the death, including allowing grieving family members to delay or refuse such an interview
4. Ensuring de-identification of all individuals and facilities involved in the panel's review of cases.

Draft rules are now being written by the Department of Health and will soon go out for public comment. After the rules are adopted, the panel will have access to more in depth information about Vermont's maternal deaths.

1. In order to perform the duties of Act 35 regarding the review panel, rule making must occur.
2. Draft rules are being finalized and will then go out for public comment
3. After Rule Making is complete, the panel will have access to more in depth information about Vermont's maternal deaths.

Panel membership:

Name	Affiliation	Email address	Term
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Eleanor Capeless, MD Professor, Dept of OB/GYN & Reproductive Sciences	Fletcher Allen Health Care	Eleanor.capeless@uvm.edu	3

Ellie Kenworthy	Member of the public	ekenworthy4@comcast.net	3
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