Maternal Mortality Review Panel 2026 Report to the Legislature

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The Maternal Mortality Review Panel

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VERMONT

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Acknowledgement

The MMRP acknowledges Vermont residents who died during and after pregnancy, their loved ones, and the community who cares for them.

Executive Summary

Vermont's Maternal Mortality Review Panel (MMRP) reviews pregnancy associated deaths that occur during pregnancy or within one year after pregnancy ends to identify contributing factors and make recommendations to generate systemic change in an effort to prevent future perinatal deaths. This report examines combined data and case reviews dating back to 2012, in addition to recommendations based on maternal deaths in 2024.

The recommendations in this report are those of the MMRP alone. They do not account for potential budget or implementation concerns.

Policy Recommendations

- The Law Enforcement Advisory Board should be supported to create a model protocol to standardize law enforcement responses to Intimate Partner Violence and use of the Lethality Assessment Protocol.
- Allocate funding to support parents and families involved in Child Welfare Services with mental health and substance use resources to address trauma associated with such involvement. Proactive assessments for mental wellbeing should be integrated throughout the investigation process. Investigators should be supported with trauma-responsive care, suicide prevention and/or substance use training to better support individuals who are engaged in their services.
- Invest in trauma-informed and child-centered supervised visitation for families statewide.

- Expand equitable access to existing mental health and substance use services to include a perinatal specific lens, including evidence-based treatment, recovery services, residential facilities, community harm reduction initiatives, and community prevention programs.
- Expand the peer workforce and the availability of peer support services to diversify and promote health equity within the mental health and substance use service system.
- Explore options for enhanced obstetrical office care coordination services through the Blueprint for Health.
- Invest in the DULCE model to sustain the existing services and expand to more pediatric and family medicine practices.
- Sustain funding for the Vermont Consultation and Psychiatry Access Program (VTCPAP).
- Support universal nurse home visiting to address clinical needs of birthing Vermonters and normalize this evidence-based intervention and decrease stigma for families around accepting support.
- Support universal access to doula services statewide and timely access to Medicaid reimbursement for doula care.

Community/Provider Recommendations

- Child welfare partners and the statewide Perinatal Quality Collaborative (PQC-VT) should support enhanced education for families, birthing people and community-based and clinical providers on child welfare mandated reporting requirements in the setting of perinatal substance use.
- Child welfare partners, with the support of the PQC-VT and Vermont Department of Health should explore approaches

for supporting mental health resources and/or grief support resources for birthing people after custody loss of a child.

- The PQC-VT and Health Department staff should partner with Vermont's birthing hospitals to ensure all birthing people have access to Universal Postpartum Naloxone Toolkit resources at time of discharge from hospital.
- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should provide ongoing education for clinical and community-based perinatal providers on Alcohol Use Disorder (AUD) screening and intervention in the pregnancy and postpartum periods.
- PQC-VT faculty and staff, with the support of the Health Department staff, should provide educational and training resources to increase understanding of perinatal providers on the use of naltrexone and other medication assisted options during the perinatal period to prevent return to use to address alcohol use disorder.
- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should provide continued support for education training on bias and stigma prevention for clinical and community-based perinatal providers on substance misuse in the preconception through postpartum period, with a special focus on the risk of return to use in the postpartum period.
- The PQC-VT and the Health Department should support improved collaboration between substance use providers, obstetrical providers and community-based perinatal supports to practice warm handoffs and increase follow-up appointments for those with a history of substance use.
- All birthing hospitals in Vermont should incorporate the Alliance for Innovation on Maternal Health (AIM) safety

bundle on substance use to ensure evidence-informed best practices, with the support of PQC-VT faculty and staff and the Health Department staff.

- The PQC-VT and the Health Department in collaboration with the Vermont Consultation and Psychiatry Access Program (VTCPAP) should support continued provider training on treating perinatal psychiatric conditions.
- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should educate emergency department staff and emergency medical technicians on importance of screening for pregnancy and postpartum status and referral for obstetrical care and follow up.
- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should provide perinatal mental health and substance use screening and referral training for emergency department staff, emergency medical technicians and primary care providers.

Introduction

The Maternal Mortality Review Panel (MMRP) was established by Act 35 (2011) to conduct comprehensive, multidisciplinary reviews of maternal deaths[1] for the purpose of:

- Identifying factors associated with these deaths
- Creating system change recommendations for improving the health care and social services for Vermonters.

Act 142 (2020) amended the MMRP's charge to include in their review:

[1] In this report, "maternal" and "perinatal people" is used to be consistent with the language used in the obstetrical field. Though not all people who become pregnant, are of reproductive age, or give birth identify as mothers or women.

- Considerations of health disparities
- Social drivers of health (SDOH)
- Including race and ethnicity in maternal death reviews.

In 2024, the MMRP welcomed:

- A community member with relevant lived experience
- A Family Support Specialist, embedded in the Office of the Chief Medical Examiner, to support bereaved families and engage in trauma informed in-depth family interviews to supplement the case review process and allow for family and decedent voice.

Data Summary: Key Findings of Aggregate Data

The Department analyzed aggregate data spanning over a decade of maternal mortality case reviews of deaths occurring from 2012 to 2024. Due to relatively few annual deaths, analyzing trends in maternal mortality and perinatal complications requires aggregating data over thirteen years. This allows for better identification of trends and disparities not apparent when examining only single cases.

Substance Use

Since 2012, nearly half (48%) of the 31 cases reviewed were directly caused by accidental overdose or endocarditis related to IV drug use.[2] Additionally, the MMRP observed substance use impacting decedents even when not a direct cause of death—17 of the 31 cases (55%) involved substance use. Half of the accidental overdose deaths involved polysubstance use. Additionally, the causes of death have shifted over time as well to become primarily substance use related. Between 2012-2020, 5 out of 20 cases were due to accidental overdose. From 2021-2024, 10 out 11 cases reviewed were directly related to substance use (either accidental overdose or endocarditis related to IV drug use).

[2] Endocarditis is defined as a life-threatening inflammation of the inner lining of the heart's chambers and valves. Without treatment, the heart valves can be irreparably damaged.

Mental Health

Most of the perinatal deaths in Vermont occurred among people with a diagnosis of a mental health disorder; many with multiple diagnoses. Since 2012, 13% of deaths were identified as being caused by suicide.

Timing of Death

Since 2012, the overwhelming majority (74%) of perinatal deaths have occurred in the postpartum period.[3] Among the deaths occurring in the postpartum period, 78% occurred 43 days to 1 year after being pregnant. The MMRP has identified this time frame as a particularly vulnerable period for perinatal people in Vermont. See Appendix Figure 2: Timing of Perinatal Deaths at the State and National Level.

Social Drivers of Health

Poverty disproportionately impacts Vermonters dying in the perinatal period. At the time of birth, where data was available,[4] 93% of decedents had Medicaid as primary insurance and 67% were utilizing the Women Infant Children (WIC) program.[5] Homelessness and housing instability have been identified in previous years as impacting the decedents' lives, although this issue was not identified this year. However, Intimate Partner Violence (IPV) continues to be identified in case review, with two of the three cases reviewed this year impacted in the perinatal year by IPV.

Rurality

Of the three deaths reviewed this year, two were residents of a rural county. Since 2012, 87% of perinatal deaths have occurred among residents of rural counties. Between 2012 and 2024, the pregnancy-associated mortality ratio was nearly three times higher in Vermont's rural counties than in Vermont's metropolitan county.[6]

[3] The postpartum period is defined as the period directly after pregnancy ends and through the first year after birth.
[4] In this report only cases linked to a birth record can be reported on for Medicaid and WIC enrollment at time of birth. This data was available in 15 of 31 cases.
[5] Due to inconsistencies in the availability of data in decedent records, this report reflects data where it was accessible
[6] All Vermont counties are considered rural except for Chittenden County, according to the US Census Bureau definition of rural.

Race and Ethnicity

Racial disparities in maternal mortality have been well identified on a national level. The MMRP is unable to conclusively analyze how race impacts the risk of maternal mortality in Vermont due to small population size and Vermont-specific racial demographics. Given the national context, however, Vermont cannot be excluded from the internalized and systemic biases contributing to negative health outcomes of birthing people identifying as persons of color. Data from 2012 to 2024 reflect the following perinatal deaths, disaggregated by race and ethnicity: 28 perinatal people identified as White, non-Hispanic (90%), 1 perinatal person identified as American Indian, non-Hispanic (3%), 1 perinatal person identified as Asian, Hispanic (3%), 1 perinatal person identified as White, Hispanic (3%), and zero perinatal people identified as Black. See Appendix Figure 3: Race/Ethnicity by percent nationally and statewide in general population and perinatal deaths.

Education

A majority (71%) of Vermont perinatal deaths from 2012 – 2024 occurred in perinatal people with a high school education or less. Six percent had a bachelor's, doctorate, or professional degree.

Age

More than half (55%) of Vermont perinatal deaths from 2012 – 2024 occurred in perinatal people that were age 30 or older and 19% occurred in those that were age 20-24. There were no deaths among perinatal people younger than 20.

Key Findings from the 2025 Case Reviews

Timing of case identification and ongoing investigations impact what year a case is reviewed.[7] In 2025, the panel reviewed three deaths, one death occurred in 2022 and two occurred in 2024. The cases reviewed this year by the MMRP included two deaths

[7] The panel's ability to review cases within the same year is restricted or delayed if there are ongoing law enforcement investigations associated with the case. Additionally, the decedent identification process is done on a quarterly basis.

by accidental overdose and one from suicide. All were in the postpartum period in or near the home, involved polysubstance use and included mental health issues. Intimate partner violence and involvement with the child welfare system were also indicated in two of the reviews.

Policy Recommendations

The recommendations in this report are those of the MMRP alone. They do not account for potential budget or implementation concerns.

Intimate Partner Violence Law Enforcement Response

Throughout reviews across the years of MMRP process, the panel has identified intimate partner violence (IPV) as a comorbidity across multiple cases. Two cases reviewed this year indicated IPV was present in the home. IPV six to twelve months after delivery results in higher levels of distress and depression compared to women who are not exposed to postpartum violence.[8] In one case reviewed this year, the decedent had multiple interactions with local law enforcement for reports of IPV leading up to their death by suicide in the postpartum period. The abstraction process indicated variability in the law enforcement response across several local law agencies. In addition, the Vermont Domestic Violence Taskforce reinforces the need for a model protocol to standardize law enforcement responses to IPV in their 2024 report.[9]

Recommendation

- The Law Enforcement Advisory Board should be supported to create a model protocol to standardize law enforcement responses to Intimate Partner Violence and use of the Lethality Assessment Protocol.

[8] Hahn, C.K.; Gilmore A.K.; Aguayo, R.O.; Rheingold, A.A. (2018). Perinatal Intimate Partner Violence. *Obstet Gynecol Clinical North America, 45(3): 535-547.* *Perinatal Intimate Partner Violence - PMC*

[9] Office of the Attorney General and Council on Domestic Violence (2025). *Domestic Violence Fatality Review Commission 2024 Report (12).* Domestic Violence Fatality Review Commission

Child Welfare Supports

Involvement with Vermont's child welfare system and subsequent loss of parental custody occurred in two cases reviewed this year. Both decedents exhibited deteriorating mental health and increased substance use after the loss of their child and prior to their deaths. The trauma of this loss was specifically tied in clinical records to the deterioration of mental health and increase in substance use in one case. In another case, although the connection to subsequent substance use relapse was not specifically documented in the clinical record, the parent had clearly identified prior to birth their determination to parent despite experiences of previous custody loss with older children. Additionally, the recent Vermont Social Autopsy Report reported in 2023, 26% of the people who died of a drug overdose had a history of involvement with FSD as parents.[10]

Increased support for parents navigating the child welfare process and custody loss is indicated during this vulnerable time. Supervised visitation provides a safe setting for a parent to have monitored visits with their child. It is ordered by courts or DCF in cases for the safety of a child or non-abusive parent. There is currently inequitable access to non-profit supervised visitation programs across Vermont, leaving many families without a program in their area. To ensure statewide access, the state must sustainably fund supervised visitation programs and support them in providing high quality services. Creating consistent access statewide would promote the safety of children, promote reunification and support parenting skills.

Recommendations

- Allocate funding to support parents and families involved in child welfare services with mental health and substance use resources to address trauma associated with such involvement. Proactive assessments for mental wellbeing should be integrated throughout the investigation process. Investigators should be supported with trauma-responsive care, suicide prevention and/or substance use training to better support individuals who are engaged in their services.
- Invest in trauma-informed and child-centered supervised visitation for families statewide.

Enhanced Perinatal Substance Use Supports

Substance use continues to be a main driver of death and contributing factor to MMRP case review. Many of the substance use supports in Vermont do not have a specific

[10] Vermont Department of Health (2025) 2025 Vermont Social Autopsy Report (49).

perinatal lens. Peer recovery approaches such as recovery centers are an essential resource, but only a handful have staff trained to support pregnant and postpartum people specifically. Recovery housing for perinatal people navigating recovery, especially with availability to house children, remain very limited. The current Vermont State Health Improvement Plan (SHIP) notes the mental health and substance use provider workforce suffers from burnout and lack of capacity. The SHIP includes recommendations to support and increase the existing substance use and mental health workforce and this has been identified as an ongoing priority of the state.[11]

Recommendations

- Expand equitable access to existing mental health and substance use services to include a perinatal specific lens, including evidence-based treatment, recovery services, residential facilities, community harm reduction initiatives, and community prevention programs.
- Expand the peer workforce and the availability of peer support services to diversify and promote health equity within the mental health and substance use service system.

Enhanced Supportive Services

The decedents reviewed this year experienced the impacts of rural transportation barriers, lack of cell phone or landline access, IPV, substance use, mental health challenges and economic instability as co-occurring issues. Currently, Vermont has multiple programs serving perinatal people navigating these social issues. However, there is not adequate and sustainable funding to support these services, and many obstetrical clinics lack comprehensive care coordination to adequately connect people with preventative programs and supports.

Embedded Care Coordination

Through the Blueprint for Health Pregnancy Intention Initiative (PII), obstetrical practices can receive some care coordination supports.[12] However, PII is focused on family planning specifically and does not adequately support directing resources to those individuals in need of care coordination during pregnancy and the postpartum period.

[11] Vermont Department of Health (2025) Vermont State Health Improvement Plan 2025-2030.

[12] PII supports health and psychosocial screening, and comprehensive family planning counseling, as well as brief intervention and referral to services for health-related social needs including mental health and substance use.

Expanding models such as PII to mirror the care coordination supports in primary care settings through the Blueprint for Health Patient Centered Medical Homes[13] could help address the lack of capacity for the transition of care from OB to other care settings, including primary care and SUD treatment and recovery resources. Additionally, enhanced care coordination would help facilitate referrals to nurse home visiting, doula care and other supportive community services.

The Developmental Understanding and Legal Collaboration for Everyone (DULCE) model embeds support[14] in the pediatric primary care medical home and offers universal access to care coordination for family during the first six months of infancy.[15] This model has a high acceptance rate within practices. However, this valuable program remains unstably funded and unable to expand to further sites.

Recommendations

- Explore options for enhanced obstetrical office care coordination services through the Blueprint for Health.
- Invest in the DULCE model to sustain the existing services and expand to more pediatric and family medicine practices.

Consultation and Psychiatry Access Program

One of the decedents reported in their medical record their primary care physician had recommended the cessation of antidepressant medications during pregnancy. Studies have shown a psychiatric relapse rate of 68% in those who discontinue antidepressant therapy during pregnancy and discontinuing psychiatric medications that are safe to use during pregnancy is not advised by the American Academy of Obstetricians and

[13] State of Vermont- Blueprint for Health (2025). Pregnancy Intention Initiative (Formerly known as "Women's Health Initiative") | Blueprint for Health

[14] The program proactively addresses health-related social needs (HRSN) by bringing together three sectors: health, legal, and the early childhood system to transform the way that families with infants experience the delivery of supports and services.

[15] From July 1, 2024 to June 30, 2025, 95% of families who were offered DULCE supports accepted this resource. In this same time period, 99.8% of DULCE families were screened for PMADs and 84% of those screening positive were then connected to resources. During the same year, 91.7% of DULCE families were screened for SUD and 50% of those with positive SUD screenings were then connected to resources.

Gynecologists.[16] The Vermont Consultation and Psychiatry Access Program (VCPAP) is a consultation service supporting medical providers to address and treat perinatal mental health concerns within their practice. Sustainable funding would ensure outreach to providers needing more guidance around evidence-based practices for safely treating perinatal Vermonters.[17]

Recommendation

- Sustain funding for the Vermont Consultation and Psychiatry Access Program (VTCPAP).

Equitable Access to Community Based Perinatal Supports

A majority of Vermont's maternal mortality is in the postpartum period after a decedent exits obstetrical care. Most of these deaths happen in the community, often in the home. Throughout the thirteen years of case reviews, the panel has seen multiple decedents navigate complex social issues such as IPV, housing, and mental health challenges. In one case reviewed this year, the decedent experienced transportation and cell phone challenges repeatedly impacting their ability to engage in prenatal care and their scheduled caesarean birth. Major barriers to accessing healthcare continue to exist across Vermont, and additional community-based case management support would serve perinatal Vermonters in rural regions. Community-based perinatal supports help families navigate complicated systems.

Most of the community-based maternal services are restricted by eligibility criteria based on funding sources, creating deeply inequitable access across the state. This restricted capacity due to funding gaps contributes to significant continuity of care challenges such as gaps in medical follow up after birth, weak connections to primary care and limited access to nurse home visiting, doula, mental health and substance use services in the perinatal period. Strong Families Vermont Nurse Home Visiting[18] and

[16] Armstrong, C. (2008). ACOG Guidelines on Psychiatric Medication Use During Pregnancy and Lactation. *American Family Physician,* 78(6):772-778. ACOG Guidelines on Psychiatric Medication Use During Pregnancy and Lactation | AAFP

[17] VCPAP services support intervention for individuals who are contemplating pregnancy, are pregnant, postpartum, and/or lactating and offers resources and referrals, toolkits, and training for managing complex PMADs in the medical home

[18] SFV nurse home visiting covers every region in Vermont through a mix of home health agencies and parent child centers. The SFV nurse home visiting program is one of multiple maternal child health nursing services offered by home health agencies, its

Community-based Doula Programming[19] have shown great success in Vermont with positive impacts on perinatal health and mental health outcomes for recipients of these services. However, funding instability in the current federal landscape in addition to grant limitations continue to cause access challenges and health inequities for perinatal Vermonters. Additionally, any delays in Medicaid reimbursement for doula services perpetuates inequitable access to perinatal support.

Recommendations

- Support universal nurse home visiting to address clinical needs and provide lactation support and preventative services.
- Support universal access to doula services statewide and timely access to Medicaid reimbursement for doula care.

Provider/Community Recommendations

The recommendations in this report are those of the MMRP alone. They do not account for potential budget or implementation concerns.

Child Welfare

The MMRP panelists have noted a lack of clarity in the child welfare mandated reporting requirements in relation to substance use during the perinatal period. Recent statewide maternal health strategic planning with clinical and community-based perinatal providers also revealed this ambiguity. As referenced above, the most recent Vermont Social Autopsy Report indicated that 26% of the people who died of a drug overdose in 2023 had a history of involvement with FSD as parents and 37% were also involved with FSD themselves as children.[20] Child welfare involvement and parental custody loss can have intergenerational impacts. There is a gap in support services for mental health and grief/loss in relation to child welfare involvement. Training is indicated for FSD staff, as

data reflects only a portion of families served across Vermont each year. In 2023-2024 462 families received 3551 visits in the SFV evidence-based nurse home visiting program. 94% of those screening positive were referred for tobacco cessation and 91% of those screening positive for IPV were referred for supports.

[19] From 10/1/24-9/30/25, WCMHS's Doula Project served 68 pregnant people who would otherwise have faced great challenges in accessing healthcare. During that same period, NCSS's HEART program provided doula care to 59 people.

[20] Vermont Department of Health (2025) 2025 Vermont Social Autopsy Report (49).

well as other community-based supports, around the specific trauma of custody loss through child welfare system involvement.

Recommendations

- Child welfare partners and the PQC-VT[21] should support enhanced education for families, birthing people and community based and clinical providers on child welfare mandated reporting requirements in the setting of perinatal substance use.
- Child welfare partners, with the support of the PQC-VT and Health Department staff should explore approaches for supporting mental health resources and/or grief support resources for birthing people after custody loss of a child.

Substance Use

Accidental overdose remains a key driver of maternal mortality in Vermont. Two of the three deaths reviewed this year were caused by accidental opioid overdose in the home during the postpartum period. Distributing postpartum naloxone toolkits universally to all patients at hospital discharge is an evidence-based practice to reduce stigma and prevent overdose and is recommended in the AIM patient safety bundle on perinatal SUD.

Recommendation

- The PQC-VT and Health Department should partner with Vermont's birthing hospitals to ensure all birthing people have access to universal postpartum naloxone toolkit resources at time of discharge from hospital.

Substance use topics including stigma and bias, alcohol use and translons of care were key issues for the panel in this year's reviews. Two of the cases reviewed this year included initial prenatal screenings revealing high levels of alcohol use prior to pregnancy with resumption of alcohol use postpartum. Additionally, the Pregnancy Risk Assessment Monitoring System (PRAMS) report revealed that, in 2022, 16% of

[21] The Perinatal Quality Collaborative Vermont (PQC-VT) mobilizes state networks to implement quality improvement efforts and improve care for mothers, babies and their families through various projects. This collaborative is led by the Vermont Child Health Improvement Program (VCHIP) and the Health Department. The mission is to optimize health access, treatment and outcomes in pregnancy and infancy through collaboration and continuous quality improvement

respondents reported binge drinking in the 3 months prior to pregnancy and 12% reported drinking alcohol during pregnancy, compared to the national rate during pregnancy of 7.8%.[22] MMRP panelists determined more training is needed around alternatives to treating Alcohol Use Disorder, including improving approaches to addressing pre-pregnancy use patterns and risk for resumption of use.

Recommendations

- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should provide ongoing education for clinical and community based perinatal providers on Alcohol Use Disorder screening and intervention in the pregnancy and postpartum periods.
- PQC-VT faculty and staff, with the support of the Health Department staff, should provide educational and training resources to increase understanding of perinatal providers on the use of naltrexone and other medication assisted options during the perinatal period to prevent return to use to address alcohol use disorder.
- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should provide continued support for education training on bias and stigma prevention for clinical and community based perinatal providers on substance misuse in the preconception through postpartum period, with a special focus on the risk of return to use in the postpartum period.
- The PQC-VT and the Health Department should support improved collaboration between substance use providers, obstetrical providers and community-based perinatal supports to practice warm handoffs and increase follow-up appointments for those with a history of substance use.
- All birthing hospitals in Vermont should incorporate the Alliance for Innovation on Maternal Health (AIM) safety bundle on substance use to ensure evidence-informed best practices, with the support of PQC-VT faculty and staff and the Health Department staff.[23]

Treating Perinatal Psychiatric Conditions

The intersection of mental health, pregnancy and psychotropic medication prescribing was identified as an area in need of support, as stated in the Policy recommendations

[22] Vermont Department of Health (2024). Pregnancy Risk Assessment Monitoring System Phase 8 Report (13) hsi-prams-phase-8-report_6.pdf

[23] The Alliance for Innovation on Maternal Health (AIM) is a national data-driven perinatal safety and quality improvement initiative based on interdisciplinary practices to improve perinatal safety and outcomes.

section. Enhanced partnering and capacity are necessary to support the reach and expansion of VTCPAP consultation and training.

Recommendation

- The PQC-VT and the Health Department in collaboration with the Vermont Consultation and Psychiatry Access Program (VTCPAP) should support continued provider training on treating perinatal psychiatric conditions.

Connecting to Services During Emergency Care

As noted across multiple years, many decedents have accessed emergency services prior to their deaths. In a case reviewed this year, the patient accessed emergency services early in a known pregnancy but did not engage in prenatal care until weeks before birth. Screening and connection to services when accessing emergency services may have supported earlier engagement with prenatal care and access to medication for Opioid Use Disorder (MOUD) or other treatment. This is also an AIM substance use patient safety bundle recommendation.

Recommendations

- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should educate emergency department staff and emergency medical technicians on importance of screening for pregnancy and postpartum status and referral for obstetrical care and follow up.
- PQC-VT faculty and staff, with the collaboration of the Health Department staff, should provide perinatal mental health and substance use screening and referral training for emergency department staff, emergency medical technicians and primary care providers.

Response to Previous Recommendations

The Health Department is responsive to MMRP data and findings. Nurse home visiting, doula support, and peer recovery resources were identified as key interventions by the Health Department. Health Department projects will increase access to doula services in Vermont, address prenatal referral workflows to nurse home visiting and other community-based resources, provide continued intimate partner violence (IPV) education, develop perinatal peer recovery support, and engage parent advisors to develop and inform projects and interventions.

The Health Department has aligned its priorities with the recommendations from previous MMRP reports, and supports the following activities to address perinatal substance use and perinatal mental health:

- In 2024, the Vermont Department of Health received a five-year Center for Disease Control and Prevention (CDC) Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant to maintain and grow the work of the panel and to continue engaging with the Maternal Mortality Review Information Application (MMRIA) platform.[24] This funding sustains staff capacity to support the panel and engage in partnerships to follow up on MMRP recommendations.
- In this last year, the Health Department engaged and funded two additional regions to develop community-based doula programming within Parent Child Centers in Addison and Chittenden counties. Additionally, the Health Department funded two existing community-based doula partners in Washington and Franklin Counties to support workforce development, program coordination, and the provision of doula care. This work is supported by Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD), a 5-year cooperative agreement with Health Resources and Services Administration (HRSA).
- The Health Department promoted additional Perinatal Mood and Anxiety Disorder (PMAD) trainings through Postpartum Support International.
- In 2024, The Vermont Department of Health received the State Maternal Health Innovation (MHI) 5 year HRSA grant to support work across sectors to improve the health and wellbeing of perinatal people with a special focus on better care coordination, the use of data to guide perinatal system improvements, and service accessibility for everyone. During the first year of MHI, the Health Department hosted a Maternal Health Strategic Planning Summit to solicit input from clinical and community partners to develop Vermont's first draft Maternal Health Strategic Plan. Through this process, the Maternal Health Task Force will serve as a formal advisory body that informs the revision and implementation of the draft Maternal Health Strategic Plan.
- The Vermont Department of Health receives the CDC's Perinatal Quality Collaborative grant to support the Perinatal Quality Collaborative Vermont (PQC-VT). The MMRP partners with the PQC-VT on a range of quality improvement projects with all birthing hospitals in Vermont and along its border in neighboring states. Additionally, faculty from the University of Vermont are engaged as content experts on a variety of projects. In 2024/5 PQC-VT successfully

[24] MMRIA is a database maintained by the CDC and contains data on perinatal mortality from multiple states. With increased state participation in MMRIA, the CDC is able to publish more robust information on perinatal deaths and their contributing factors.

implemented a birth certificate accuracy project, enhancing the accuracy of data relied on for case review. Additionally, the PQC-VT welcomed and trained the first cohort of the Patient and Family Advisory Committee (PFAC), enhancing access to feedback and partnering with people with lived experience from a variety of birthing experiences. In 2026, the PQC will continue its work with the PFAC, engage in a variety of pilot projects focusing on integrating the clinical and community spaces and organizing and supporting six Regional PQCs to integrate regional community and clinical spaces across Vermont in support of the Vermont Maternal Health Innovation work.

- The Vermont Department of Health invested CDC Overdose Data to Action and PQC grant funds into the creation of the Bidirectional Learning for Improved Support and Services (BLISS initiative). This PQC-VT project created five perinatal specific educational modules on substance use for community-based providers (such as nurse home visitors, doulas, peer recovery), aiming to enhance community-based organization's knowledge regarding perinatal populations with SUD, improve coordination of community services and develop cross-cutting partnerships to better serve families. In 2026, this blended funding will support continued BLISS work as well as focus on supporting and/or implementing Community Response/CHARM teams across Vermont to better coordinate care for perinatal people with SUD.
- In 2025 and into 2026, the Health Department staff will continue collaborating with the PQC-VT and the Vermont Alliance for Innovations in Maternal Health (AIM) team on the implementation of the Perinatal Substance Use Patient Safety Bundle. The bundle guides Vermont birthing hospitals through technical assistance, training, and webinars with best practices and resources to serve perinatal populations with SUD. The bundle incorporates nurse home visitors and other community services to better connect perinatal people with additional support. This implementation includes updates to both CAPTA notifications and the Family Care Plan, creating virtual platforms for both federally required activities and enhancing the care coordination and supports for birthing people with SUD. DCF/Family Services Division staff have partnered closely on this project, informing child welfare and mandated reporting aspects of this work.
- The Health Department utilized funds from the ERASE MM grant to invest in a Respectful Maternity Care project with PQC-VT and the Vermont chapter of the Association of Women's Health, Obstetrical and Newborn Nursing. This project has engaged nurse champions from every birthing hospital, home health agencies with a Strong Families Vermont program, and the Family and Child Health nurse coordinators from the Offices of Local Health. Participants have identified and supported projects to decrease stigma and bias and enhance trauma responsive and respectful care in both the clinical and community settings. PFAC members have engaged and supported the participants in this project as well.

- The Vermont Department of Health invested funds in Empty Arms Vermont in 2025, an organization specializing in perinatal bereavement peer support, emphasizing their outreach work, dissemination of materials, and relationship-building to connect with identified providers serving populations with low SES and SUD.

Appendix

Maternal Mortality Review Panelists

Statute	Organization	Panelists
(b)(1)A	American College of Obstetricians and Gynecologists, General Obstetrician	Horan, Colleen MD
(b)(1)A	American College of Obstetricians and Gynecologists - Maternal Fetal Medicine Specialist	Meyer, Marjorie MD
(b)(1)B	American Academy of Pediatrics VT Chapter - Neonatology specialist	Mercier, Charles MD
(b)(1)D	Midwife licensed pursuant to 26 VSA chapter 85	Kaplan, Jade MN, MPH, CPM, LM, APRN, CNM
(b)(1)E	Association of Women's Health, Obstetric, and Neonatal Nurses VT Chapter (AWHONN)	Panko, Kayla BSN, RNC-MNN
(b)(1)F	Director, Division of Family & Child Health or designee	Stalberg, Ilisa MSS, MLSP
(b)(1)F	Division of Family & Child Health designee	Wolfe, Kathryn LICSW
(b)(1)G	Epidemiologist from VDH - exp. Analyzing perinatal data, or designee	Maiberger, Matthew
(b)(1)H	Chief Medical Examiner or designee	Bundock, Elizabeth MD
(b)(1)H	Chief Medical Examiner or designee	Amoresano, Elaine MD
(b)(1)I	Representative of the Community Mental Health Centers	Mitchell, Danielle MSW
(b)(1)J	Member of the public	Beaulac, Arial

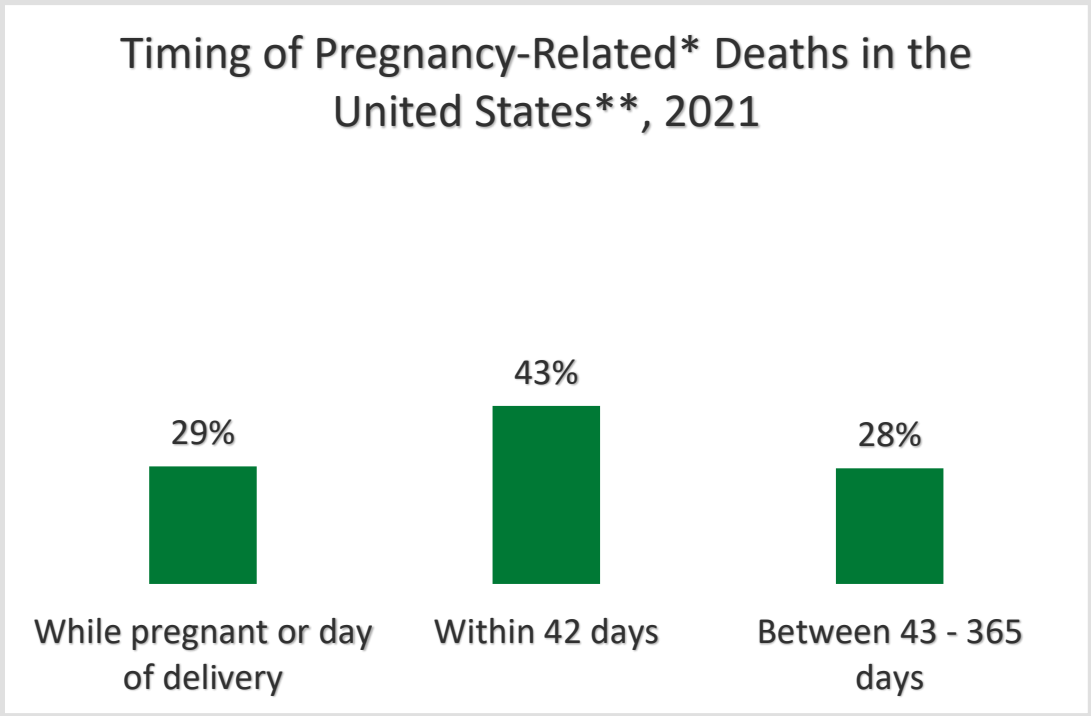
Statute	Organization	Panelists
(b)(2)B	Expert in Pharmaceutical Management of Mental Health	Guth, Sarah MD
(b)(2)C	Social Worker*	Knutson, Sarah Mental Health Counselor* LCMHC, LADC
(b)(2)A	Licensed Clinical Provider specializing in substance use disorder	Smith, Carol LADC
	MMRP Case Abstractor	Leffel, Katy RN, BSN, IBCLC
	Panel Member (Injury and Violence Prevention Program Manager)	Fredette, Emily BA
	Panel Member (Perinatal Quality Collaborative Project Director)	Parent, Julie MSW, MPH
	Informant Interviewer, Family Support Services	Naomi London, MSW

Figure 1: Maternal mortality among Vermont residents by cause of death and year, Vermont Vital Statistics, 2012 – 2024.*

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	**Total**
Accidental overdose			1		1	1	1	1		1	5	2	1	**14**
Complications of pregnancy, childbirth, and the puererium				2	4	1		1						**8**
Motor vehicle accident	2								1					**3**
Suicide		1				1	1					1		**4**
Diseases of the heart							1							**1**
Acute and subacute endocarditis											1			**1**

*Note: As of 2023, Vermont resident deaths occurring out of state are included in panel review and are reflected

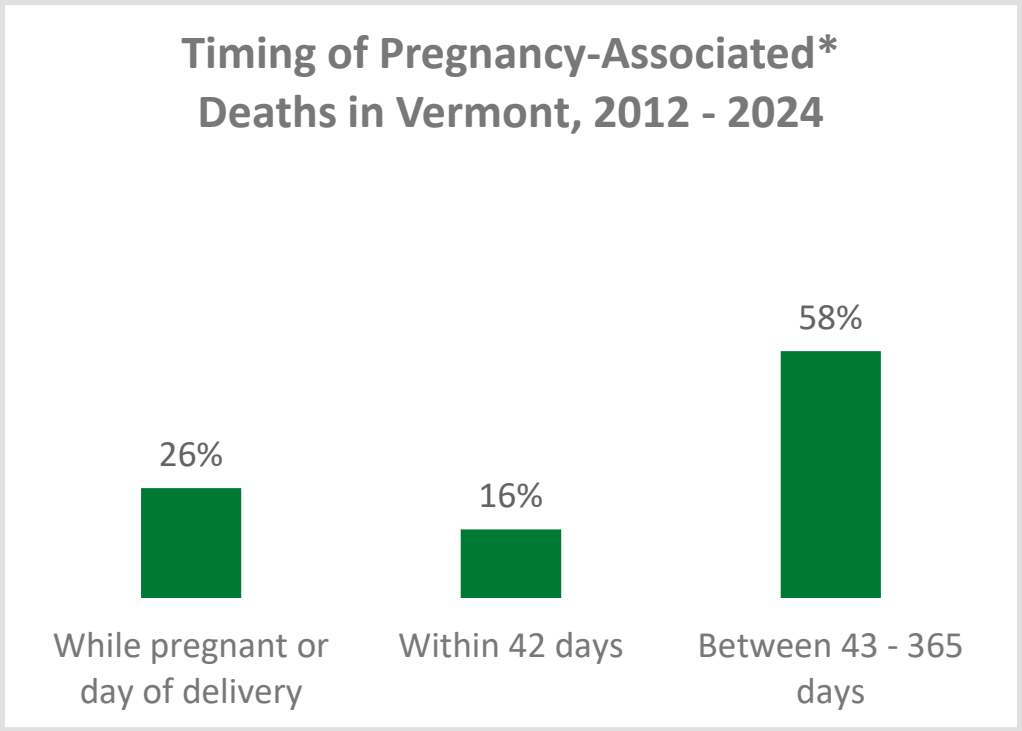
Figure 2: Timing of Perinatal Deaths at the State and National Level



Source: U.S. Centers for Disease Control and Prevention

* Deaths during or within 1 year 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.

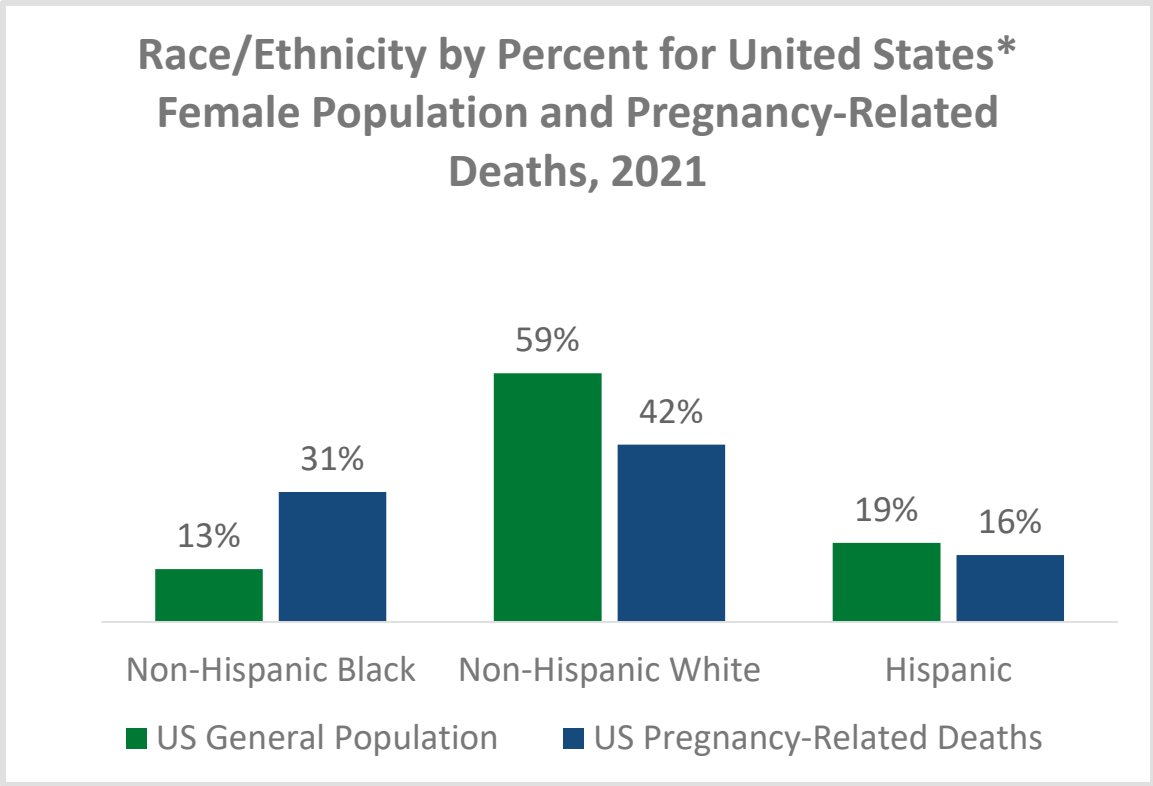
**At the time of data collection, 46 states were reporting maternal deaths.



Source: Vermont Department of Health Vital Statistics System

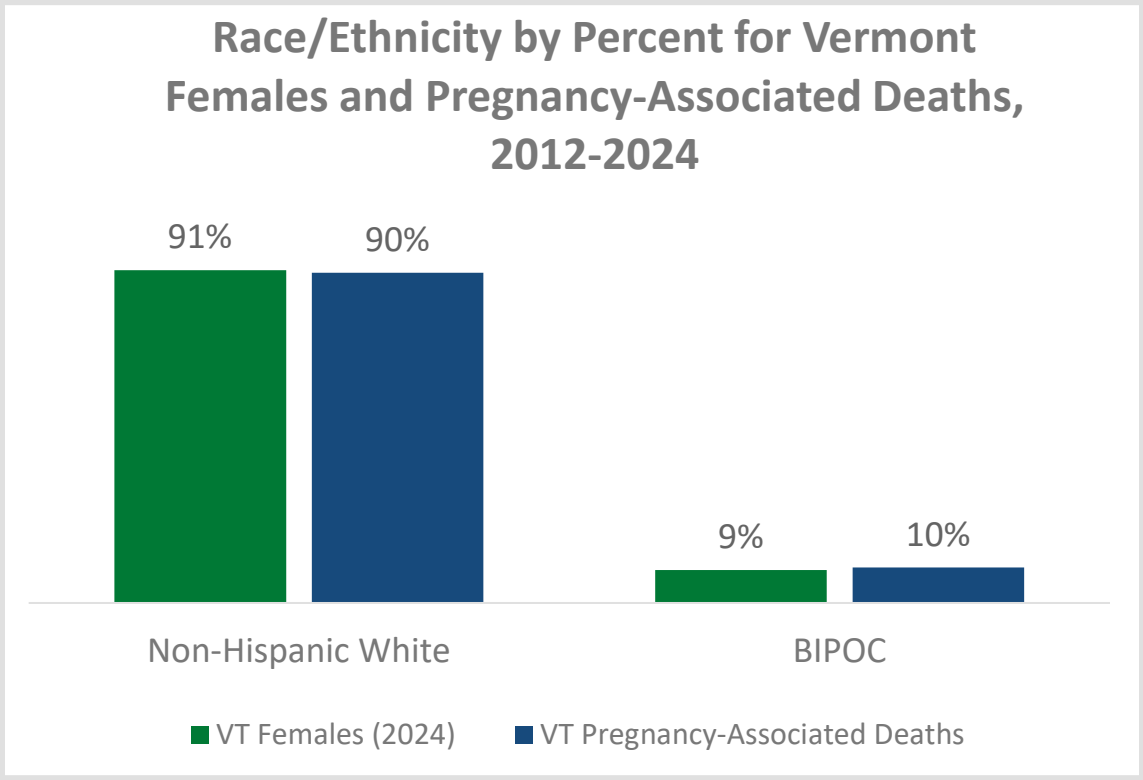
* Death during or within 1 year of pregnancy, regardless of the cause.

Figure 3: Race/Ethnicity by percent nationally and statewide in general population and perinatal deaths



Sources: U.S. Centers for Disease Control and Prevention, U.S. Census Bureau

*At the time of data collection, 46 states were reporting maternal deaths.



Sources: Vermont Department of Health Vital Statistics System, Vermont Population Estimates