Report to
The Vermont Legislature

Maternal Mortality Review Panel
2023 Report to the Legislature

In Accordance with 18. V.S.A. § 1552.

Submitted to:	**House Committee on Human Services** **Senate Committee on Health and Welfare**
Submitted by:	**Mark A. Levine, MD** **Commissioner, Vermont Department of Health**
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Maternal Mortality Review Panel Annual Report

January 2023

Introduction

The Maternal Mortality Review Panel (MMRP) was established by Act 35 (2011) to conduct comprehensive, multidisciplinary reviews of maternal deaths for the purpose of identifying factors associated with these deaths and creating recommendations for system changes for improving the health care and social services for Vermonters. Act 142 (2020) amended the MMRP's charge to include in their review, considerations of health disparities and social determinants of health, including race and ethnicity in maternal death reviews.

Summary of 2022 Activities

The Maternal Mortality Review Panel had largely been on hold due to the Vermont Department of Health's Covid-19 response efforts. In 2022, the MMRP was able to reconvene and meet three times to review cases from 2018-2021.

The MMRP reviewed eight cases, identified below according to the cause of death:

- Sudden death of undetermined etiology (seizure vs. arrhythmia)
- Presumed Cardiovascular Disease
- Acute fentanyl intoxication
- Acute mixed (heroin, fentanyl) intoxication
- Suicide
- Motor Vehicle Accident (MVA)
- MVA
- Amniotic Embolism

The Maternal Mortality Review Panel strengthened panel protocols and practices according to national best practice, developed a more robust case review process, expanded records access, and reappointed panel members. The MMRP developed an internal protocol outlining case identification, case abstraction, MMRP meeting structure, and recommendations for follow-up work. The MMRP also started the process of accessing Vermont Department of Health-owned data including Home Visiting and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) data.

Data Summary

Federal Fiscal Year	Number of maternal deaths *	Pending Review	Comments
2012	4	0	n/a
2013	3	0	n/a
2014	1	0	n/a
2015	2	0	n/a
2016	4	0	n/a

2017	3	0	n/a
2018	2	0	n/a
2019	4	0	n/a
2020	1	0	n/a
2021	1	0	n/a
2022	2	2	n/a

* defined as a death while pregnant or within a year after delivery

Planned Activities for 2023

The MMRP will convene quarterly meetings in 2023 to review maternal mortality cases and consider system changes for improving the health care and social services for Vermonters. The MMRP will partner with the Perinatal Quality Collaborative of Vermont (PQC-VT) to implement recommendations identified during case review. The PQC-VT is a partnership between the Vermont Child Health Improvement Program and the Maternal and Child Health Division at the Vermont Department of Health. The PQC-VT aims to utilize existing state networks to implement quality improvement efforts and improve care for perinatal people, infants, and their families.

More diverse representation from nonclinical partners is also a priority for the MMRP, as seven of the eight deaths reviewed in 2022 occurred in the post-partum period and in a community (non-clinical) setting: three in the first six months post-partum, and four more than six months post-partum. Additionally, one death occurred at birth in an in-patient setting. The MMRP is therefore considering changes that would expand MMRP membership to ensure representation from a diverse group of stakeholders who can better address social determinants of health.

Recommendations

The panel's case review highlighted some gaps in services and care coordination for perinatal people. The perinatal period is defined as pregnancy, birth and up to one year post-partum. The Maternal Mortality Review Panel offers the following recommendations. The Vermont Department of Health will work with the PQC-VT and other state and community partners to identify strategies and funding to implement the recommendations within the Department's purview. Other recommendations would need to be implemented by heath care sector entities.

1. **Establish reciprocal agreements for information sharing and access to out of state medical records between the Vermont Department of Health and neighboring states (where maternal deaths of Vermonters are not uncommon) in order to facilitate more comprehensive and meaningful analyses of maternal deaths.**

2. **Establish or improve protocols for interventions in the Emergency Room or during an Emergency Medical Services intervention.**
    a. A significant number of the perinatal people who died had received care from emergency medicine departments and/or emergency medical services personnel in the time period closely preceding death. Yet in many cases, these medical providers were unaware of the individual's perinatal status. As the perinatal

period is characterized by unique physiological changes, it is important to identify if a person is in the perinatal period by implementing the following interventions:

i. Implementing universal screening for pregnancy and post-partum status in emergency medicine departments and emergency medical services.

ii. Screening all women of childbearing age for pregnancy to be able to refer to follow up obstetrical care if needed and identify those who may be unaware of pregnancy but at risk of pregnancy-related health conditions.

iii. Screening patients for whether they have been pregnant and/or gave birth in the last year.

iv. Strengthening and standardizing education for emergency medical staff regarding perinatal parameters and warning signs specific to this population. For example, elevated blood pressure in the perinatal period can be a medical emergency and parameters and treatment for a perinatal person are different from the general population.

3. **Enhance education for healthcare providers and social service providers on the unique needs surrounding substance use disorder (SUD) for the perinatal population.** A quarter of the deaths were directly attributable to opioid use disorder, and another decedent was noted to have unexplained opioids present in the post-mortem toxicology report.

4. Conduct routine SUD screenings in all places where medical care is accessed, such as emergency rooms, urgent care clinics, emergency medical services, and similar settings.

5. Conduct routine follow-up with perinatal people who have screened positive for SUD, including facilitating connections to comprehensive medical and community support services.

6. Improve care coordination between primary care providers, medication for opioid use disorders providers (i.e. MOUD/MAT) and obstetrical providers.

7. Ensure perinatal people are connected with appropriate pregnancy care including obstetric care and support services such as community-based services from prenatal period to early childhood.

8. **Establish routine and universal clinical - community linkages for support services for perinatal people, especially in high-risk populations experiencing co-occurring issues such as:**
    a. Substance use disorder;
    b. Involvement with Department for Children and Families (DCF);
    c. Pregnancy, birth, or miscarriage experiences; and
    d. Perinatal mood and anxiety disorders.

9. **Improve coordination of care between primary care providers (PCP), obstetrical providers (OB) and/or mental health providers, including:**

    a. Robust and routine PCP coordination with OB providers regarding medication management;
    b. PCP coordination and follow up for perinatal medical issues that continue past the post-partum follow-up period for OB providers; and
    c. Coordination of services and a follow up plan after discharge from a psychiatric facility or emergency department with primary care physician and obstetrical providers for perinatal people

MMRP Membership

Statute	Organization	Representative
(b)(1)A	American College of Obstetricians and Gynecologists - General Obstetrician	Till, George MD
(b)(1)A	American College of Obstetricians and Gynecologists - Maternal Fetal Medicine Specialist	Meyer, (Marjorie) Marj MD
(b)(1)B	American Academy of Pediatrics VT Chapter - Neonatology specialist	Mercier, Charles MD
(b)(1)C	American College of Nurse-Midwives VT Chapter	Schabot, Karen
(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
(b)(1)F	Director, Division of Maternal & Child Health or designee	Stalberg, Ilisa
(b)(1)F	Division of Maternal & Child Health designee	Fredette, Emily
(b)(1)G	Epidemiologist from VDH - exp. Analyzing perinatal data, or designee	Brozicevic, Peggy
(b)(1)H	Chief Medical Examiner or designee	Bundock, Elizabeth MD, PhD
(b)(1)H	Chief Medical Examiner or designee	Amoresano, Elaine MD
(b)(1)I	Representative of the Community Mental Health Centers	Lindley, Danielle
(b)(1)J	Member of the public	Kenworthy, Ellie
(b)(2)A	Licensed Clinical Provider specializing in Substance Use Disorder	Lukonis, Christopher
(b)(2)B	Expert in Pharmaceutical Management of Mental Health	Wood, Sandra
(b)(2)C	Social Worker	Knutson, Sarah
	VCHIP	Parent, Julie
	Clinical Case Abstractor	Leffel, Katy, RN