

CONNECTICUT'S MATERNAL MORTALITY
REVIEW COMMITTEE RECOMMENDATIONS
REPORT FOR 2020-2021 DEATHS
CONNECTICUT DEPARTMENT OF
PUBLIC HEALTH
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Definitions

Connecticut Maternal Mortality Review Committee (CT MMRC): A multidisciplinary committee convened by the Connecticut Department of Public Health to review deaths that occur during pregnancy or within one year of the end of pregnancy to determine pregnancy-relatedness, identify contributing factors, and develop recommendations to prevent future deaths.

MMRIA database: The Maternal Mortality Review Information Application (MMRIA) database serves as a repository of medical and non-medical information needed for Maternal Mortality Review Committee case review. MMRIA was developed by the Centers for Disease Control and Prevention in partnership with maternal mortality review subject experts throughout the United States. It is available, at no cost, to Maternal Mortality Review Committees in the United States.

Pregnancy-related deaths: The death of a woman while pregnant 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.

Pregnancy-associated but not -related deaths: 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-associated but unable to determine pregnancy-relatedness deaths: The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is unable to be determined if related to pregnancy.

Background

The CT Maternal Mortality Review Committee (MMRC) meets to review cases of women who have died during pregnancy or up to one year post pregnancy. When a case is determined to be pregnancy-related, the MMRC uses the CDC committee decisions form to discuss potential recommendations. The recommendations are specific for the case in trying to identify what could have been done better. The MMRC suggest recommendations for that case and after a few years of cases are reviewed, meets to create a list of recommendations to present to the public.

Methods

During the time period of 2020-2021, there were 14 pregnancy-related, 12 pregnancy-associated but not -related and 14 pregnancy-associated but unable to determine pregnancy-relatedness deaths.

Recommendations are made for Pregnancy-related deaths. Recommendations were exported from the MMRIA database for the 2020 and 2021 cases. The list contained 92 recommendations. The co-chairs reviewed and grouped common recommendations reducing the list from 92 to 56 recommendations.

The Committee met in person on April 28, 2023, and separated into teams by category: Community, System, Facilities, Provider, members were asked to select a category of interest to participate in. Before selecting the team, we consider potential biases that may exist and have impact on decision making. The teams were instructed to consider the following:

1. What is the recommendation in a “Who, What, When” CDC format (from the MMRIA Committee Decisions form).
2. Are there stakeholders that could carry out these recommendations?
 - a. Thoughts on who
3. Is the recommendation feasible?
4. What is the Expected Impact (Small, Medium, Large, Extra Large, Giant scale)
 - SMALL: Education/counseling (community-and/or provider-based health promotion and education activities).
 - MEDIUM: Clinical intervention and coordination of care across continuum of well-women visits (protocols, prescriptions)
 - LARGE: Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies/LARC)
 - EXTRA LARGE: Change in context (promote environments that support healthy living/ensure available an accessible services)
 - GIANT: Address social drivers of health (poverty, inequality, etc.)
5. Prevention type (Primary, Secondary, Tertiary)
 - PRIMARY: Prevents the contributing factor before it occurs
 - SECONDARY: Reduces the impact of the contributing factor once it has occurred (i.e. treatment)

- TERTIARY: Reduces the impact or progression of what has become an ongoing contributing factor (i.e. management of complications)

A DPH program staff was at each table to document the thoughts of the group for each category. Each group selected the top 3 recommendations in order of most important. At the end of this meeting, we reviewed and discussed with the whole group. The end goal was to compile a list of the MMRC's top 10 recommendations.

After the meeting the list of recommendations was sent to the full committee and members were asked to rank recommendations from "most important" #1 to "least important". The recommendation in each category with the highest score was considered not a priority and removed from the final list.

The list of recommendations are the CT MMRC recommendations and do not reflect the Department of Public Health. These are meant to inform and guide public, private and state agencies in their work to reduce maternal mortality.



Recommendations for Deaths that Occurred in 2020-2021

Facilities

Who: Birthing Hospitals, all Birthing Centers, and Department of Mental Health and Addiction Services (DHMAS) should work together

What: Ensure systems are in place so that emergency department (ED) staff can connect pregnant patients with current or a history of substance use disorders to Recover, Engagement, Access, Coaching & Healing (REACH) navigators or Connecticut Community for Addiction Recovery (CCAR). Referrals should be made to home-visiting programs experienced in maternal health, for on-going supports throughout pregnancy and the postpartum period.

When: Prior to discharge from the ED

Expected Impact: Medium

Prevention type: Secondary

Who: Hospitals and all Birthing Centers

What: Hospital policies should strongly recommend social services consult for all birthing persons with active or a history of substance use or mental health disorders

When: Prior to or within three days of discharge with at least 2 attempts to follow-up if no-contact

Expected Impact: Medium

Prevention type: Secondary

Who: Hospital ED and all Birthing Centers

What: Should have a process in place where an obstetrics (OB) provider is contacted for any pregnant patient seen in an emergency context and ensure follow-up with a prenatal or other healthcare provider is scheduled or a referral is placed for a skilled nursing, home visit

When: Prior time of discharge

Expected Impact: Medium

Prevention type: Secondary

Who: Hospitals and all Birthing Centers

What: Should provide training to ED and OB nurses, providers, and staff on pregnancy triage, education, and how to best utilize electronic medical records (EMR) to have standards of care and follow-up including pregnancy-related illnesses, substance use, mental health, perinatal mood and anxiety disorders (PMAD's), intimate partner violence, and addressing those concerns while protecting patient privacy.

When: Annually and ongoing

Expected Impact: Medium

Prevention type: Primary

Who: Hospitals, all Birthing Centers, and OB clinics

What: Hospitals and OB clinics should ensure training to all providers and nurses on mental health, substance use, and available resources specific to medication management in pregnancy

When: Annually and ongoing

Expected Impact: Small

Prevention type: Primary

Who: Hospitals, all Birthing Centers and OB clinics

What: Should provide access to social workers and family advocates who have updated knowledge and training on services and resources available for intimate partner violence, substance use and mental health conditions and social determinants

When: Ongoing

Expected Impact: Large

Prevention type: Tertiary

Community

Who: Educational advocates and pediatric providers

What: Should make it a priority to educate children and young adults about intimate partner violence starting in school and community settings, including doula and any programs serving young pregnant/parenting families.

When: 2024 and ongoing

Expected Impact: Extra Large

Prevention type: Tertiary

Who: CT Perinatal Quality Collaborative (CPQC) and CT Hospital Association (CHA) and other state agencies as appropriate

What: Examine existing trainings to ensure implicit bias training and trauma informed care practices to hospitals and community partners incorporate structural racism, mental health bias, substance use bias, gender bias, and LGBTQ bias into training with subject matter experts to inform training. Ensure this is available as a web-based option and can be accessed asynchronously.

When: 2024 for all new staff, renew training every other year.

Expected Impact: Giant

Prevention type: Tertiary

System

Who: Hospitals, birthing centers and Provider clinics

What: All providers should be trained on screening for Intimate Partner Violence and Perinatal Mood and Anxiety Disorders (PMAD's), identify available local resources and incentives adherence for those screenings.

When: Initially and ongoing

Expected Impact: Large

Prevention type: Tertiary

Who: Hospitals and birthing center providers in partnership with the Department of Social Services and the Department of Mental Health and Addiction Services

What: Strongly encourage obstetrical staff to connect with a Perinatal Husky Intensive Care Management (ICM) worker if a patient with HUSKY insurance is being sent home without their infant. In addition, have staff trained on utilizing Access Mental Health for Moms.

When: Ongoing

Expected Impact: Large

Prevention type: Secondary