2021 Recommendations of the Rhode Island Pregnancy and Postpartum Death Review Committee

JANUARY 2022

Introduction and Background

The Rhode Island Pregnancy and Postpartum Death Review Committee (PPDRC) is a multi-disciplinary review board, first convened in 2021, that examines the deaths of people who were pregnant or within one year of pregnancy when they died. The PPDRC is made up of medical professionals (maternal fetal medicine specialists, midwives, substance use specialists), insurance representatives, breastfeeding specialists, doulas, and representatives of populations often underserved and under-represented in medicine. This diverse group meets at least four times per year to review eligible deaths; determine if the deaths are related to, and/or associated with, pregnancy; and to identify areas of opportunity for systemic changes that could decrease and eliminate deaths during pregnancy and the postpartum period.

After potential areas of opportunity for change were identified, the Committee's observations were crafted into specific, action-oriented recommendations to effect change, reiterate best practices, and most importantly, support Rhode Island's systems of care in preventing deaths within this community. The PPDRC recognizes that some of these recommendations may already be in place in policy and/or practice; however, they are included in this report to reiterate their importance to high-quality care of pregnant and postpartum individuals. The aim of this report is to effectively communicate our findings and use them as a guide to work collaboratively with stakeholders to address, and continually refine, the care of this population.

The PPDRC will review cases and update its recommendations on an annual basis. Thus far, this process has expanded our understanding of pregnancy and postpartum deaths and their contributing factors, and we expect that future reviews will continue to do so.

Mission

To identify pregnancy-associated deaths, review those caused by pregnancy complications and other associated causes, identify the factors contributing to these deaths, and recommend public health and clinical interventions that may reduce these deaths and improve systems of care.

Vision

The PPDRC's vision is to eliminate preventable perinatal deaths, reduce perinatal morbidities, and improve population health for people in the perinatal period.

Committee Members

The following people were contributing PPDRC members in 2021:

Dorcas Agbozo
Eloho Akpovi
Ellen Amore
Will Arias
Leah Battista
Tanya Booker
Christine Brousseau
Joe Carr
Mara Coyle
Brian Daly
Monique Depaepe
Aidea Downie
Jerry Fingerut
Katharine French
Laura Gallicchio
Deborah Garneau
Summer Gonsalves
Preetilata Hashemi
Mohamad Hamdi
Jeffrey Hill
Jennifer Hosmer
Margo Katz
Martha Kole-White
Ashley Lakin
Lucia Larson
Jennifer Levy
Susanna Magee
Latisha Michel
Valerie Monroe
Luisa Murillo
Anne Murray
Linda Nanni
Patricia Ogera
Collette Onyejekwe
Emerald Ortiz
Quatia Osorio
Michelle Palmer
Maria Prout
Sharon Ryan
Jean Salera-Vieira
Keith Scally
Danika Severino
Wynn Wilmaris Soto-Ramos
Jami Star
Mary Beth Sutter
Nadine Taves
Sonia Thomas
Liz Tobin-Tyler
Andrea Tonski
Cindy Vanner
Jordan White
Shannon Young

2021 Meeting Description

During 2021, the PPDRC had 52 active members. An average of 35 members attended each meeting. Cases were reviewed in three meetings, while recommendations were reviewed in one meeting, for a total of four meetings during 2021. During these meetings, eight cases were reviewed. All cases reviewed in 2021 were deaths that occurred in 2019.

Determinations

1. **Pregnancy-Relatedness**
   The PPDRC is tasked with determining whether a death was associated with, and/or related to, the sentinel pregnancy. The Centers for Disease Control and Prevention (CDC) provides the following definitions as guidance in determining whether a death is pregnancy-related and/or pregnancy-associated.
   a. ***Pregnancy-associated death*** is a death during, or within one year of, pregnancy, regardless of the cause. These deaths make up the totality of maternal mortality; within that are pregnancy-related deaths and pregnancy-associated, but not related deaths.
   b. ***Pregnancy-related death*** is a death during, or within one 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.
   c. ***Pregnancy-associated, but not related death*** is a death during, or within one year of, pregnancy, from a cause that is not related to pregnancy.

   Of the eight cases reviewed in 2021, two cases were determined to be *Pregnancy-related*, three were *Pregnancy-associated but not related*, and three were *Pregnancy-associated but unable to determine if Pregnancy-related.*

2. **Preventability**
   The PPDRC is also tasked with determining whether each death was preventable. According to the CDC, a death is considered preventable if there was at least some chance of the death being prevented by one or more reasonable changes to patient, family, provider, facility, system, and/or community factors. This definition is used by review committees to determine if a death was preventable. All eight cases reviewed were deemed *preventable*.

3. **Completeness of Information**
   During the review process, the PPDRC had to designate the degree of relevant information that was available to complete their review. The CDC provided the following classifications to designate:
   a. ***Complete*** - All records necessary for adequate review of the case were available.
   b. ***Mostly complete*** - Minor gaps (information that would have been beneficial but was not essential to the review of the case)
   c. ***Somewhat complete*** - Major gaps (information that would have been crucial to the review of the case)
   d. ***Not complete*** - Minimal records were available for review (death certificate and no additional records)

   The eight cases reviewed included two that were *Mostly complete*, five that were *Somewhat complete*, and one that was *Not complete*.

Recommendations

The PPDRC reviewed the records for each case which included the following documents, if available:

- Death certificates;
- Autopsy reports;
- Medical records from the incident and any historical records;
- Perinatal records;
- Post-mortem toxicology reports;
- Police reports from the incident and any historical records;
- Prison records, including prison health records;
- Obituaries;
- News articles; and
- Social media posts, as relevant to the case.

When reviewing documents, the PPDRC evaluated the overall picture of health of people who died in the perinatal period, and synthesized recommendations based upon any apparent gaps in their care. The Committee focused on areas of opportunity for systemic changes that could have prevented their deaths. We also noted areas in which existing best practices could have been better implemented. These recommendations were grouped into the following categories:

- Substance Use Disorder;
- Emergency care;
- Postpartum care;
- Family visiting services;
- Stable housing;
- Diversity, equity, and inclusion; and
- Additional patient care recommendations

The recommendations generated by the PPDRC in 2021 are listed below, by category:

Substance Use Disorder (SUD)

1. Hospitals should explore partnering with federal and local law enforcement partners to institute drop boxes for drugs (possibly lobby area, patient admissions and Emergency Department). Hospitals should also make Sharps containers available for safe disposal of used drug paraphernalia.
    a. Educate public on where drop boxes are located.
    b. Provide signage in multiple languages at dropbox location.
2. Access to recovery housing for people who are pregnant, mothers, and substance-exposed newborns.
3. Continue to promote awareness of, and compliance with, existing policies and procedures at correctional facilities about supporting pregnant people and mothers who are incarcerated and have a substance use condition. Specifically, offer these individuals access to medication(s) to assist with substance use conditions, behavioral counseling, and additional related therapies before and after being released from prison, including inpatient, residential, and/or outpatient services. Ensure connection to community-based services to support recovery post-incarceration.
4. Hospitals should ensure provider training regarding adequate pain control in the setting of SUD and implement it as a mandatory training module for prescribers. Suggested topics include how to recognize intoxication, how to recognize withdrawal, naloxone resources for patients, and proper naloxone administration. Additional resource, provider trainings are available online.

5. RIDOH should continue to promote awareness about the importance of carrying the overdose reversal medicine, naloxone, to people who use drugs as well as their family members, caregivers, and friends.
6. RIDOH should educate the public about the *Good Samaritan Law* and proposed amendments to the law, including distribution of the *Good Samaritan Law* in plain language for the general public.
7. Insurers should provide resources and equitable compensation for healthcare providers to adequately screen and make referrals for depression and substance use.
8. Healthcare providers should increase access to substance use education by using multilingual resources. Multilingual resources are available on RIDOH's website.
9. RIDOH should continue to work with Rhode Island insurers to expand coverage of one type of generic naloxone with a no-cost/low-cost copayment to making all types of naloxone available to patients at no cost. Assure that Rhode Island Medicaid continues to fully cover the cost of generic naloxone for its beneficiaries.
10. RIDOH should collaborate with Medicaid managed care and accountable care entities to reimburse Community Health Workers (CHW) for screening for substance use and facilitating referrals to substance use services, including:
11. Regular substance use screening during pregnancy and postpartum period;
12. Continue to advocate for use of Peer Recovery Coaches throughout pregnancy and postpartum period that are currently provided by Parent Support Network of Rhode Island; and
13. Education for pregnant and postpartum patients regarding treatment options for SUD in this population

Emergency Care

1. All hospitals, birthing facilities, and any affiliated agencies (e.g., EMS) should create policies and procedures on how to seamlessly transition between levels of obstetric care or to increase the level of perinatal care. Procedures should include:
    a. During treatment for an emergency involving a pregnant or postpartum person, a phone consultation with a maternal fetal medicine specialist should occur when one is not present in the treatment room.
    b. Obstetrical emergency protocol training should be required, including simulation exercises.
2. Birthing hospitals should ensure that they have an obstetric emergency code (code pink) that mobilizes appropriate staff to respond according to a defined protocol, including:
    a. Specialized and quickly mobilized team for obstetric emergencies (respiratory specialist, anesthesiologist, obstetric provider);
    b. Code to be announced throughout the hospital when an obstetric emergency is identified;
    c. Frequent simulation exercises, minimally once per year; and
    d. Debriefs performed after each obstetric emergency.
3. PPDRC supports the Joint Commission requirement that all birthing facilities have a standardized hemorrhage supply kit, written and defined procedures for hemorrhage management, and frequent drills.

Postpartum Care

1. Perinatal professionals should improve continuity, and coordination of, care through all stages of pregnancy and postpartum.
2. Hospitals should ensure that birthing staff schedule an initial postpartum visit before a new parent leaves the delivery facility (as a component of discharge).
3. Obstetrical care providers should introduce group-care models for postpartum care.
4. Medicaid eligibility should be extended to one year postpartum.

Family Visiting Services

1. Family Visiting should educate pre, peri, and post-natal providers about the Family Visiting Program's services, expected outcomes, and how families can access services.
2. All obstetrical providers should educate patients and their families about Family Visiting services during every visit throughout pregnancy and the initial postpartum year, specifically:
    a. Available resources through the Family Visiting Program; and
    b. Anticipated outcomes of Family Visiting services.
3. The Perinatal Quality Collaborative, or similar body, should work to establish a safety net for families who decline Family Visiting services by:
    a. Ensure Level 1 Family Visiting Coordinators are stationed at birthing hospitals.
    b. Promote Family Visiting services in third-party locations and healthcare providers' offices.
    c. Provide resources in multiple languages (English, Spanish, and other languages based on community needs).

Stable Housing

1. Ensure CHWs are available through healthcare providers' offices, as needed, to support families throughout their pregnancies.
2. Pre, peri, and post-natal providers should identify pregnant and postpartum patients who are in need of housing and should refer these families to social services for assistance with housing.
3. Maternal and Child Health (MCH) stakeholders should advocate for the Governor to acknowledge new families as a priority population and allocate funding for stable housing for this population. Housing plans should include emergency housing, transitional housing, and long-term housing.

Diversity, Equity, and Inclusion (DEI)

1. Birthing facilities should create clear criteria regarding equitable implementation of safety protocols.
2. Obstetrical care providers should ensure that any existing or new family support protocols incorporate cultural and/or spiritual traditions of individual families.
3. Birthing facilities should implement ongoing training regarding DEI for all inpatient and outpatient maternal health staff (all levels of care).
4. The Perinatal Quality Collaborative, or similar body, should work with hospitals and birthing facilities to implement DEI protocols and standards in care, including:
    a. Development of data systems to evaluate DEI in care and document progress and accountability;
    b. Review of universal screening processes to evaluate for DEI; and
    c. Creation of DEI dashboards for hospitals.

Additional Patient Care Recommendations

<u>Perinatal Care</u>

1. All healthcare providers should screen all pregnant/postpartum people for Intimate Partner Violence (IPV) at every visit, including Emergency Department visits.
2. All healthcare providers should refer perinatal patients to smoking cessation resources and education.
3. All healthcare providers should refer perinatal patients to morbid obesity resources and education.
4. All healthcare providers should ensure perinatal patients have advanced care directives.

<u>Emergency Care</u>

1. All healthcare providers should be educated on emergency phone consultation services (such as MomsPRN) available for case management, behavioral health supports and medical supports.

2. All healthcare providers should receive education and (potentially simulation) training on appropriate consultation for obstetric emergencies, including cardiopulmonary concerns and the need for perimortem cesarean.
3. All facilities involved in an obstetric death should have a safety officer or risk manager ensure that a debrief occurs for the care team, immediately after the death.

Patient Feedback

1. All healthcare providers should institute a process for patients to address any concerns regarding their care and treatment, with a process that is: confidential, easily accessible, available in multiple languages, and publicized (e.g., signage, social media).
2. Obstetric providers and birthing facilities should create and institute a system to solicit and evaluate patient feedback. The system should be ongoing, anonymous, independent, and integrated with technology (e.g., accessible via social media platforms).
3. RIDOH should require use of a patient feedback system for licensure of providers and birthing facilities.

Conclusion

RIDOH is honored to have facilitated the discussions of the PPDRC, discussions that included a diversity of viewpoint and perspectives. Throughout the year, members have comprehensively reviewed cases and collaboratively determined the direct and indirect causes of these tragic deaths.

Additionally, members observed systems-level gaps associated with each case, and suggested solutions that could address these issues, while recognizing that they may not have prevented a specific death. As such, the recommendations of the PPDRC were crafted to not only address direct factors that may have prevented a death, but also the systematic issues that clearly impacted a pregnant person's health and could have improved their care overall. Among other issues it was evident that access (or lack thereof) to coordinated healthcare, stable housing, and/or perinatal resources all affected patients' abilities to thrive during their pregnancies, and the PPDRC hopes that by highlighting these issues, our state will ensure that they remain priorities

Most importantly, the PPDRC recognizes and honors the eight individuals whose records of life and death were reviewed by the Committee. Theirs were stories of resilience, in addition to being those of premature death. By sharing these recommendations, we hope to honor these individuals and their families, and by learning their stories, prevent similar deaths from occurring in the future.