CT Maternal Mortality Review Committee Recommendations

October 7, 2021

Note: Recommendations are based on the Connecticut Maternal Mortality Review Committee (CT MMRC) review of pregnancy-related, preventable deaths that occurred in the period between 2015 and 2019.

Increase Provider Education

#1: We recommend that the Connecticut Perinatal Quality Collaborative (CPQC) and Connecticut Hospital Association (CHA) offer, through the Alliance for Innovation on Maternal Health (AIM) Hypertension (HTN) bundle, provider training to increase awareness of health care needs, follow-up, and the significance of hypertensive disorders among pregnant and postpartum persons.

#1a: We recommend that CPQC and CHA provide obstetrics and gynecology providers with education about the importance of ensuring a referral to primary care providers, both during pregnancy and in the postpartum period, for persons with high blood pressure during pregnancy.

#1b: We recommend that CPQC and CHA educate primary care providers regarding the significance of high blood pressure during pregnancy and the importance of following up after delivery with patients who have high blood pressure during pregnancy.

#2: We recommend that the Governor's Office coordinate the development of a web-based point of access portal for primary care providers and obstetrics and gynecology providers to refer patients to community resources such as, but not limited to, mental health treatment, substance use treatment programs, and home visiting programs.

#3: We recommend that Connecticut State Medical Society (CSMS) and CHA provide training for emergency department providers to raise awareness on how to make referrals for substance use and mental health treatment for pregnant and postpartum persons.

#4: We recommend that CHA in partnership with birth hospitals provide ongoing training to obstetrics and gynecology providers on appropriate treatment for substance use during pregnancy.

#5: We recommend that CSMS and CHA in partnership with birth hospitals provide training to educate emergency department providers on the significance of Group A Strep in pregnant and postpartum persons.

#6: We recommend that CSMS and CHA educate providers about checking prescription drug monitoring programs and patients' substance use history before prescribing opioids.

Improve Coordination of Care and Community Collaboratives

#7: We recommend that the Human Services Committee, Women and Girl's Subcommittee propose a legislative mandate for all home visiting programs in Connecticut to enroll all birthing persons prenatally.

#8: We recommend that the American College of Obstetricians and Gynecologists (ACOG) chapter in Connecticut provide ongoing training to educate obstetrics and gynecology providers about the

importance of collaborating with home visiting programs to ensure outreach to pregnant persons when there is a lapse in prenatal care.

#9: We recommend that the Office of Early Childhood (OEC) home visiting program conduct outreach to all obstetric and gynecology providers to increase awareness about services offered through home visiting and how to refer patients.

Develop Medical Care (Provider) Protocols

#10: We recommend that CT MMRC lobby for an increased capacity of mobile crisis services to ensure 24/7 access.

#11: We recommend that CPQC, CHA, and birth hospitals ensure, via AIM venous thromboembolism (VTE) bundle, that hospital discharge plans provide education to patients on the importance of mobility following cesarean sections, as well as risks associated with immobility, and that providers are prescribing and documenting the use of anticoagulation and pneumatic compression boots for birthing persons at risk of VTE, including persons who have had cesarean sections and those who have had prolonged immobility.

#12: We recommend that CHA and hospitals work to flag all critical lab reports collected in emergency departments with panic values to ensure results are reported promptly to ordering providers and/or primary care providers.

#13: We recommend that CT MMRC develop a patient safety bundle for pregnant and postpartum persons with mental health disorders other than substance use disorder.

Improve Care Systems (Hospital) Protocols

#14: We recommend that CPQC ensure all birth hospitals have a policy in place about when to consult with maternal-fetal medicine.

#15: We recommend that CHA, hospitals, and physician offices work to implement policies about screening consistently for social determinants of health – including, at a minimum, intimate partner violence, perinatal depression, and adverse childhood experiences – at initial emergency department and obstetrics and gynecology visits, over the course of pregnancy, and in the postpartum period.

#16: We recommend that CHA and hospitals ensure policies are in place to provide discharge summaries and discharge instructions to primary care physicians, pediatricians, and treating obstetrics and gynecology providers.

Broader Level (State and Community) Supports

#17: We recommend that DCF provide support to all parents who are undergoing removal of a child and send a report to the patient's obstetric provider.

#18: We recommend that hospital social workers be involved with cases where the child is being removed and develop a post-partum plan and send it to the obstetric provider.

#19: We recommend that hospital social workers provide parents with contact information for therapists and counselors when there is consideration for child removal or a temporary hold on infant discharge.

#20: We recommend that CT MMRC lobby for increased inpatient psychiatric capacity in Connecticut.

#21: We recommend that CT MMRC lobby for congregate care housing for pregnant and postpartum persons with mental health disorders other than substance use disorder.