2022

RECOMMENDATIONS OF THE RHODE ISLAND PREGNANCY AND POSTPARTUM DEATH REVIEW COMMITTEE

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INTRODUCTION AND BACKGROUND

The Rhode Island Pregnancy & Postpartum Death Review Committee (PPDRC) is a multidisciplinary review board, first convened in 2021, that examines the deaths of perinatal people (here used to mean those who were pregnant or within one year of pregnancy when they died). The PPDRC is made up of medical professionals (e.g., maternal fetal medicine specialists, midwives, substance use specialists), insurance representatives, breastfeeding specialists, doulas, and representatives of populations often underserved and underrepresented 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 but includes them in this report to reiterate their importance to high-quality care of pregnant and postpartum individuals. The aim of this report is to convey our findings and use them as a guide for addressing and refining the care of this population.

The PPDRC will continually 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 Pregnancy & Postpartum Death Review Committee'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 the contributing PPDRC members during the year of 2022:

Dorcas Agbozo
Eloho Akpovi
Ellen Amore
Will Arias
Leah Battista
Tanya Booker
Christine Brousseau
Joe Carr
Mara Coyle
Brian Daly
Monique De Paepe
Aidea Downie
Jerry Fingerut
Katharine French
Laura Gallicchio
Deborah Garneau
Summer Gonsalves
Preetilata Hashemi
Mohamad Hamdi
Jennifer Hosmer
Margo Katz
Martha Kole-White
Ashley Lakin
Lucia Larson
Jennifer Levy
Susanna Magee
Latisha Michel
Valerie Monroe
Luisa Murillo
Linda Nanni
Anne Murray
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
Mary Beth Sutter
Nadine Tavares
Sonia Thomas
Liz Tobin-Tyler
Andrea Tonski
Cindy Vanner
Jordan White
Jami Star
Shannon Young

2022 MEETING DESCRIPTION

During the year of 2022, the PPDRC had 52 active members. An average of 35 members attended each meeting. Cases were reviewed in four meetings, while recommendations were reviewed in one meeting, for a total of five meetings during the 2022 calendar year. During these meetings, 14 cases were reviewed. The cases reviewed in 2022 comprised deaths that occurred in 2019-2021.

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

- Death Certificates
- Infant Birth/Death Certificates
- Fetal Death Certificates
- Autopsy Reports
- Medical Records from the incident and any historical records
- Perinatal Records
- Post-mortem Toxicology Reports
- Emergency Medical Services (EMS) Records from the incident and any historical records
- Police Reports from the incident and any historical records
- Prison Records, including prison health records
- Prescription Drug Monitoring Program
- Court Records
- Obituaries
- News Articles
- Social Media Posts as relevant to the case

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 universe of maternal mortality; within that universe 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 14 pregnancy-associated deaths reviewed in 2022, three were determined to be ***Pregnancy-Related***; six were ***Pregnancy-Associated but Not Related***; and five 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. Thirteen cases reviewed were deemed ***Preventable*** and one case was deemed ***Not 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 provides the following classifications to designate:

a. ***Complete:*** All records necessary for adequate review of the case were available
b. ***Mostly Complete:*** Minor gaps (i.e., missing information that would have been beneficial but was not essential to the review of the case)
c. ***Somewhat Complete:*** Major gaps (i.e., missing information that would have been crucial to the review of the case)
d. ***Not Complete:*** Minimal records available for review (i.e., death certificate and no additional records)

The 14 pregnancy-associated deaths reviewed included three that were ***Complete***; five that were ***Mostly Complete***; and six that were ***Somewhat Complete***.

2022 RECOMMENDATIONS

When reviewing cases, 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 these deaths, as well as areas in which existing best practices could have been better implemented. These recommendations were grouped into the following categories:

- Coordination and Continuity of Care
- Behavioral Health
- Emergency Care
- Equity and Social/Structural Determinants of Health

Specifically, it was evident that perinatal care should be coordinated and continuous; perinatal behavioral health services should be expanded and sustained in the postpartum period; emergency protocols for pregnant people should be prioritized, practiced, and implemented; and all perinatal services and supports should be centered in equity to address the structural and social determinants of health. It is the consensus of PPDRC that the following specific recommendations should be addressed in Rhode Island to better care for the State's pregnant and postpartum individuals:

1. Coordination and Continuity of Care

a. Perinatal practices/clinics should strongly consider adopting an integrated, team-based model of care, as well as offering extended hours and same-day appointments. This could include case management by nurse care managers; support from social workers, community health workers, and/or peer recovery specialists; and therapy with mental health counselors as needed.

b. All inpatient, outpatient, and community settings where physical, mental and/or behavioral health care is provided—including rehabilitation, recovery, and correctional facilities—should ensure access to, and exchange of, patient information/medical records with consent, if required by law, to ensure communication and coordination of care between all healthcare providers.

c. Obstetric (OB) providers should follow American College of Obstetricians and Gynecologists guidance for Optimizing Postpartum Care, with initial postpartum check ideally at two to three weeks and a comprehensive visit by 12 weeks after delivery, with regular or periodic follow-up care as needed during the first year postpartum. This should include a tracking system and outreach to patients who do not present for postpartum care.

d. Primary care and other healthcare providers, including OB providers, should assess patients' vaccination status at initiation of care, at well visits, and at other appointments when indicated and provide counseling and education about the importance of vaccination for preventable diseases.

e. Rhode Island hospital emergency departments should develop a discharge plan and follow-up protocol for perinatal patients, including scheduling a follow-up visit prior to discharge and/or calling the patient the day after discharge to ensure outpatient follow-up care.

2. Behavioral Health (Mental Health and Substance Use)

a. Providers of perinatal care should use validated screening tools to screen perinatal patients for depression, anxiety, and substance use at the initial prenatal visit, periodically during pregnancy, and in the post-partum period. Pediatric providers should routinely screen for postpartum depression during the first six months of well child visits. Support, follow-up care, and referrals should be provided when indicated.

b. Rhode Island Department of Health (RIDOH), the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), and other State agencies should further develop the perinatal public awareness campaign providing information about the prevalence and dangers of fentanyl, including possible contamination and presence in counterfeit pills and resources to detect and counter these, including fentanyl test strips and Narcan.

c. Healthcare facilities should post information about substance use disorder and treatment in multiple areas, such as waiting and exam rooms, restrooms, and hallways.

d. Primary care and other healthcare providers, including OB providers, should review and consider implementing the recommendations outlined in the Updated CDC Clinical Practice Guideline for Prescribing Opioids for Pain.

e. RIDOH should continue to promote and seek to sustain the Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN) teleconsultation line.

f. Rhode Island birthing hospitals and Rhode Island Department of Children, Youth, and Families (DCYF) should improve the provision of respectful, supportive, and compassionate care for birthing parents with substance use disorder, with a focus on encouraging treatment, decreasing family separation, and allowing for early reconciliation when appropriate.

g. The Executive Office of Health and Human Services (EOHHS), State agencies, and Rhode Island General Assembly should continue to work to expand the mental and behavioral health workforce.

h. Rhode Island health plans/insurers should provide compensation for mental and behavioral health services that is commensurate with that provided for other medical services consistent with the *Mental Health Parity and Addiction Equity Act*.

3. Emergency Care

a. Rhode Island birthing hospitals should ensure practice protocols and procedures for emergency surgery are in place, including availability of necessary equipment and seamless transportation between departments and hospitals.

b. All emergency departments should have a prompt to ask an individual of reproductive age if they could be pregnant or have delivered a baby in the last 12 months.

c. Healthcare providers in all healthcare settings that provide care to perinatal patients should inform these patients about urgent warning signs during pregnancy and postpartum.

d. The PPDRC should work with the RIDOH Center for EMS to review and consider revising the current protocol requiring cardiopulmonary resuscitation (CPR) in the field for 30 minutes in cases of cardiac arrest, to allow exceptions for pregnant individuals with a uterus at or above the level of the umbilicus. There is evidence that rapid perimortem cesarean delivery (necessitating rapid transport) can improve survival for these individuals.

e. Rhode Island birthing hospital emergency departments should consider staffing with patient advocates, such as social workers, peer recovery specialists and/or community health workers, to improve patient support and communication and facilitate connection to appropriate resources and follow-up care.

f. Rhode Island hospitals, community organizations, and schools should continue to broaden efforts to provide CPR education to families and students.

4. Equity and Social/Structural Determinants of Health

a. Rhode Island birthing hospitals and outpatient perinatal practices/clinics should create equity teams or committees to ensure that best practices are being utilized to promote respectful communication, prevent discrimination, and address racism.

b. Inpatient and outpatient healthcare facilities should provide and document provision of interpretive services for patients whose language is different than that of the healthcare provider.

c. RIDOH's professional licensing boards should consider requiring implicit bias training for initial licensure and for renewal for nurses and other healthcare professionals.

d. PPDRC members should promote the need to fund housing for pregnant and parenting individuals/families when needed.

e. Rhode Island employers should be required to provide paid family and medical leave and prenatal and postpartum job security when needed. Perinatal healthcare providers should provide information to patients about their paid leave options.

f. Primary care and other healthcare providers, including OB providers, should assess for history of environmental and occupational exposures at initiation of care, at well visits, and periodically when indicated.

CONCLUSIONS

Discussions of the Pregnancy and Postpartum Death Review Committee included a diversity of viewpoints 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 the proposed solutions may not have prevented a specific death. As such, the recommendations of the PPDRC were crafted not only to address direct factors that may have prevented a death but also to identify the systemic issues that affected a pregnant or postpartum person's health and need to be improved. It became evident that perinatal care should be coordinated and continuous; perinatal behavioral health services should be expanded and sustained; emergency protocols should be prioritized to become more fully practiced and implemented; and all perinatal services and supports should be centered in equity to address the structural and social determinants of health. The PPDRC hopes that by highlighting these issues, our state will ensure that they remain priorities.

Most importantly, the PPDRC recognizes and honors the 14 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 recognizing their stories, prevent similar deaths from occurring in the future.

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