# WISCONSIN MATERNAL MORTALITY REVIEW TEAM (MMRT)

January 2024 Meeting Summary

Cases Reviewed: 10

Preventability: 90% preventable

Pregnancy-Relatedness: 20% pregnancy-related

Causes of Death\*: Mental health conditions, hemorrhage

**MMRT Recommendations\*:** (#) = number of cases

## For Providers:

- Local county social workers, care coordinators should provide wrap around care for those with cognitive disability. (1)
- Primary care and obstetric providers should discuss preconception planning with all patients, including those with a history of chronic medical illness and/or a history of preeclampsia in previous pregnancies, and refer to specialty care when indicated. Providers should follow ACOG guidelines when assessing and referring for cardiac disease. (1)
- Local county social workers and care coordinators should offer pregnant patients with disabilities wrap around support to ensure they receive appropriate pregnancy care, facilitate follow up for high risk conditions, and promote health equity. (1)
- Providers should include overdose prevention planning as part of discharge planning.(1)
- Providers should screen all patients for substance use using validated verbal tools rather than chemical substance testing to decrease stigmatization and discrimination around substance use. (1)

### For Facilities:

- Domestic abuse agencies should provide wrap around services to pregnant people with history of domestic violence. (1)
- Hospitals/providers should avoid unnecessary cesarean and offer labor after cesarean/
  VBAC in order to prevent complications from multiple repeat cesareans. (1)

<sup>\*</sup> Pregnancy-related only

### **MMRT Recommendations Continued:**

# For Systems:

- Health systems should provide pregnant persons with complicated mental health history and substance use disorder with care coordinator and social workers provided by system, with 24/7 access. (1)
- States should increase access to treatment facilities that allow for pregnant and parenting persons to obtain treatment and maintain family unit. (1)
- Child protective agencies should immediately prioritize enhancing mental health support for parents who have recently learned that they will lose custody of their children. (1)
- State government should explore alternate ways to work with parents with substance use disorder in the CPS system that prioritizes keeping families together when possible. (1)

These recommendations were written by the Wisconsin Maternal Mortality Review Team (MMRT). The content of this meeting summary reflects the view and opinions of the MMRT. It may not reflect the official policy or position of DHS. For more information on the MMRT, please visit <u>our website</u>.