Wisconsin Maternal Mortality Review Team (MMRT)

March 2023 Meeting Summary

Cases Reviewed: 10

Preventability: 100% preventable

Pregnancy-Relatedness: 30% pregnancy-related

Causes of Death*: Anesthesia complications, cardiovascular conditions, and undetermined cause of death (homicide)

MMRT Recommendations*: (#) = number of cases

For Providers:

- Health care staff should ask partners to leave the room for intimate partner violence screenings as a routine practice. (1)
- Prenatal providers should connect pregnant people who present in pregnancy with preexisting chronic conditions with appropriate providers after delivery. (1)
- Providers and RNs should measure and document blood loss rather than estimate. (1)
- Providers should give oral or IV iron, or blood transfusion when necessary, prior to surgery to pregnant pre-cesarean patients to treat anemia prior to surgery. (1)
- Providers should connect pregnant people who have depression and/or history of trauma to culturally appropriate mental health services beyond medication treatment as soon as they are diagnosed. (1)
- Providers should educate patients on use of insulin when clinically indicated and provide very close followup to make sure diabetes was treated adequately. (1)
- Providers should screen all patients for intimate partner violence at every visit and offer immediate referrals and resources if necessary.(1)

For Facilities:

- All facilities should implement postpartum hemorrhage bundles with emergency management plan checklists, including drills. (1)
- Emergency rooms should develop and maintain relationships with intimate partner violence shelters in their community for immediate referral and contact. (1)
- Facilities should have 24/7 access to in person or virtual interpretors to aid in emergency situations. (1)

* Pregnancy-related only

MMRT Recommendations Continued:

- Facilities should mandate intimate partner violence and trafficking training for all health care practitioners to identify suspicious situations and safely communicate with the patient to offer support and resources as needed. (1)
- Facilities should provide ongoing education regarding identification, management and treatment of postpartum hemorrhage to providers. (1)
- Hospitals should assign community health workers to all individuals who have difficulty navigating health care system (due to immigration status, disability, language barrier, financial constraints, etc). (1)
- Hospitals should continue to use new technology and advances to treat postpartum hemorrhage that can be done bedside instead of being taken to the OR when possible (for example, the intrauterine balloon or hemorrhage device can be placed in a recovery room and without general anesthesia using IV opioids). (1)
- Hospitals should provide access to a trial of labor after cesarean for people who are good candidates, especially those who plan large families. (1)
- Hospitals should work with doulas to continue to enhance communication and advocacy between patients, their families and the hospital team. (1)

For Systems:

- All payers should reimburse facilities for culturally competent care coordinators from diverse backgrounds for patients with complex medical histories. (1)
- Health systems should ensure that health education is not only in the primary language of the patient but also is culturally relevant. (1)
- Payers should incentivize health systems to provide in-person culturally competent care coordinators from diverse backgrounds as part of the care team for complex patients to make sure all health care needs are addressed. (1)
- Policymakers should make funds available to Public Health Departments so they can fund mental health support services for individuals who are the perpetrators of intimate partner violence. (1)
- Professional organizations should educate providers on culturally appropriate ways to screen for intimate partner violence. (1)

For Communities:

- Public health/community organizations/facilities should create multilingual materials and make them available in hospitals, clinics, and public places so that people know how to seek help for trafficking, abuse and controlling behaviors. (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 our website.