Welcome
Press notice for this meeting

This event is solely for partners, stakeholders, and professionals working on maternal and infant mortality prevention and is not open to the media.

Any media questions about maternal and infant health should be directed to DHSMedia@dhs.wisconsin.gov.

If there are members of the media present, we will pause and give you a moment to sign out.
Please introduce yourself in the chat

Put your name and where you are located

https://wisconsinfirstnations.org/map/
Unit introduction
Maternal and Infant Mortality Prevention Unit

Supervisor
- Kenmikiiya Terry

Outreach Team
- Robert Fontella
- Mireille Perzan
- Hannah Schmidt
- Jacqueline Sills-Ware

Maternal Mortality Review Team
- Katie Gillespie
- Caroline Hayney
- Emily Morian-Lozano
- Karen Morris
Maternal and Infant Mortality Prevention in Wisconsin

Jasmine Zapata, MD, MPH, FAAP
Chief Medical Officer for Community Health and State Epidemiologist for Maternal and Child Health and Chronic Diseases at the Wisconsin Department of Health Services

August 4, 2022
Acknowledgements

Maternal Mortality Review Program Staff
- Katie Gillespie
- Caroline Hayney
- Emily Morian-Lozano
- Karen Morris
- Dr. Angie Rohan

Maternal Mortality Review Team Co-chairs
- Dr. Jasmine Zapata
- Dr. Kathy Hartke

Maternal and Infant Mortality Prevention Unit Members and Collaborators
- Ashley Bergeron
- Charisse Daniels-Johnson
- Meg Diedrick
- Rob Fontella
- Maddie Kemp
- Mireille Perzan
- Hannah Schmidt
- Jacqueline Sills Ware
- Kenmikiiya Terry
- Fiona Weeks
Presentation Overview

Maternal Mortality
- National data
- Wisconsin Maternal Mortality Review Team
- Wisconsin data
- Recommendations

Infant Mortality
- Wisconsin data
- Data partnerships
- Perinatal Periods of Risk framework

Breakout discussion sessions will follow presentation
What changes are needed to reduce maternal and infant mortality inequities in Wisconsin?

What radical and innovative solutions do we need to consider as a state to positively impact maternal and infant mortality?

What work are you currently doing in the area of maternal and infant mortality?

What support do you need to continue and progress your work?
Maternal Mortality
Nationally, pregnancy-related mortality ratios are highest among **Black** and **American Indian/Alaska Native** birthing persons. These gaps have not changed over time.

![Graph showing racial/ethnic disparities in pregnancy-related deaths](image)

Wisconsin Maternal Mortality Review (MMR)

01 IDENTIFICATION OF MATERNAL DEATHS
MMR staff identifies maternal deaths from vital records including birth, fetal death, and death certificate records.

02 CASE ABSTRACTION
MMR staff requests additional records, abstracts the information into MMR1A, and then writes the case narrative that will be used during the review.

03 MMRT REVIEW
MMRT members conduct an in-depth review of maternal deaths, identify if the death is related to the pregnancy, and discuss the preventability of those deaths.

04 DEVELOPMENT OF RECOMMENDATIONS
MMRT members identify contributing factors and recommendations for the prevention of future maternal deaths.

05 IMPACT TEAM CALL TO ACTION
Impact team members review the MMRT’s recommendations and identify barriers and needed steps for implementation.

06 COMMUNITY ACTION
Community partners, professional organizations, and healthcare systems utilize MMR findings to reduce maternal mortality and morbidity across Wisconsin.

07 DISSEMINATION
MMR Staff, MMRT and impact team members, and community partners work together to disseminate MMR findings through media releases, reports, and presentations.
Wisconsin Maternal Mortality Review (MMR)

**IDENTIFICATION OF MATERNAL DEATHS**
MMR staff identifies maternal deaths from vital records including birth, fetal death, and death certificate records.

**CASE ABSTRACTION**
MMR staff requests additional records, abstracts the information into MMRIA, and then writes the case narrative that will be used during the review.

**MMRT REVIEW**
MMRT members conduct an in-depth review of maternal deaths, identify if the death is related to the pregnancy, and discuss the preventability of those deaths.

**DEVELOPMENT OF RECOMMENDATIONS**
MMRT members identify contributing factors and recommendations for the prevention of future maternal deaths.
Wisconsin Maternal Mortality Review (MMR)

IMPACT TEAM CALL TO ACTION
Impact team members review the MMRT’s recommendations and identify barriers and needed steps for implementation.

DISSEMINATION
MMR Staff, MMRT and impact team members, and community partners work together to disseminate MMR findings through media releases, reports, and presentations.

COMMUNITY ACTION
Community partners, professional organizations, and healthcare systems utilize MMR findings to reduce maternal mortality and morbidity across Wisconsin.

05 06 07
Recent Wisconsin MMR Reports

Pregnancy-associated overdose deaths (2016-19)

Wisconsin Maternal Mortality Report (2016-17)
Key Definitions

- **Pregnancy-associated death** is a death during or within one year of pregnancy, regardless of the cause.
- **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.
Pregnancy-associated deaths, 2016–2017

- Pregnancy-associated deaths disproportionately affected birthing people who:
  - Were between the ages of 20–29
  - Had high school education or less
  - Lived in urban areas
  - Were enrolled in Medicaid at the time of death

- Nearly three in four pregnancy-associated deaths from 2016–2017 occurred during the postpartum period.
Just under half of pregnancy-associated deaths were determined to be pregnancy-related.

Almost all pregnancy-related deaths were preventable.
Most common causes of pregnancy-related deaths, 2016–2017

- Mental health conditions (52%)
- Hemorrhage (12%)
- Cardiomyopathy (9%)
While non-Hispanic Black, non-Hispanic Asian, and Hispanic mothers made up only one fourth (24%) of Wisconsin births in 2016-17, they represented nearly one half (42%) of all pregnancy-related deaths in the same time period.
Key Recommendations

- Policymakers should expand Medicaid eligibility for all postpartum people to one year post-delivery.

- Discuss reproductive life planning with all patients before, during, and after pregnancy, including patients with chronic conditions that may affect pregnancy, and ensure patient access to necessary services to meet their goals.
Key Recommendations

- Ensure **continuity of care** before, during, and after pregnancy, especially for those with complex medical histories, **mental health diagnoses**, and **substance use disorder**.

- Connect patients with **comprehensive mental health services** when there is a mental health diagnoses after delivery.
In December 2021, MMR staff identified an increase in pregnancy-associated deaths due to COVID-19 among unvaccinated persons.

Information was released as a part of the Wisconsin DHS Health Alert Network.

Review of 2020 maternal deaths are underway.
Preliminary Pandemic-Related MMRT Recommendations

- Despite COVID-19 restrictions, **alternative ways to stay engaged with sponsors** should be explored and prioritized by organizations providing peer treatment support/sponsorship.

- Policymakers should recognize and address systems-level issues that place certain populations at higher risk for COVID-19 or other acute community concerns. For example, ensure that all individuals have the opportunity for **supplemental financial assistance** during a pandemic.

- Providers should always arrange for **in-person postpartum visits for high-risk patients** or as soon as possible if abnormal findings (such as high blood pressure) are encountered during televisits.
Infant Mortality
Preterm birth inequities are worse in Wisconsin than many other states.
Preterm birth inequities are worse in Wisconsin than many other states.

Percentage of live births in 2017-2019 (average) born preterm, Wisconsin

2021 March of Dimes Report Card (March of Dimes, 2021)
Trends in Wisconsin Infant Mortality, 2011–2021

Rate per 1,000 live births

- American Indian or Alaska Native population
- Black population
- Hispanic population
- Laotian or Hmong population

Statewide rate
Leading causes of infant mortality in Wisconsin (statewide), 2016–2020

- Birth defects (21%)
- Preterm birth and low birthweight (20%)
- Maternal pregnancy complications (6%)
Data Tools and Partnerships

- MMR
  - Partnership with Black Mamas Matter Alliance
  - MMR impact team to move data to action

- Pregnancy Risk Assessment Monitoring System (PRAMS)
  - 2020 oversample of Indigenous birthing persons in collaboration with University of Wisconsin and Great Lakes Inter-Tribal Epidemiology Center

- Perinatal Periods of Risk (PPOR) analysis
  - Helps to understand what causes inequities in fetal and infant deaths to better focus prevention efforts
Perinatal Periods of Risk

Deaths within a period often share similar causes

Birthweight

- 500–1499 grams (1 lb. 1 oz.–3 lbs. 4 oz.)
- ≥ 1500 grams (3 lbs. 4 oz.)

Maternal Health/Prematurity

- Fetal death ≥ 24 weeks
- Neonatal 0–27 days
- Post-neonatal 28–364 days

Maternal Care

Newborn Care

Infant Health

Deaths within a period often share similar causes.
PPOR as a Data Tool

- PPOR may help some communities identify causes of excess fetal and infant deaths

- Preliminary analyses have shown that populations greatest impacted by inequities in Wisconsin often have most excess deaths in the **Infant Health** period and **Maternal Health/Prematurity** period

- Watch for upcoming opportunities to review and discuss population-specific findings
Using PPOR Findings

- Can help to identify prevention areas
  - Causes of excess death may differ for each community

- Unjust, oppressive systems carry the blame for health inequities
  - Health outcomes impacted by racism, discrimination, socioeconomic status, access to care, insurance, housing security, support systems, and other social determinants of health
  - Consider the impacts of historical trauma and cumulative stress (weathering)
  - Prevention efforts should address systemic factors
### Potential Prevention Areas

<table>
<thead>
<tr>
<th>Maternal Health/ Prematurity</th>
<th>Infant Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stressful events and experiences</td>
<td>• Unsafe sleep environment</td>
</tr>
<tr>
<td>• Chronic and gestational disease</td>
<td>• Smoke exposure</td>
</tr>
<tr>
<td>• Lack of access to quality and culturally appropriate perinatal care</td>
<td>• Alcohol and substance use</td>
</tr>
<tr>
<td>• Reproductive autonomy and reproductive justice</td>
<td>• Infant feeding support</td>
</tr>
<tr>
<td>• Complications during delivery</td>
<td>• Lack of access to quality and culturally appropriate perinatal and postpartum care</td>
</tr>
<tr>
<td></td>
<td>• Low family income</td>
</tr>
</tbody>
</table>
Discussion
Breakout Discussion #1

25 minutes Jamboard

- What changes are needed to reduce maternal and infant mortality inequities in Wisconsin?
- What radical and innovative solutions do we need to consider as a state to positively impact maternal and infant mortality?
Movement & Mindfulness
Discussion
Breakout Discussion #2

25 minutes Jamboard

- What work are you currently doing in the area of maternal and infant mortality?
- What support do you need to continue and progress your work?
Break
Honoring Infant Loss
Infant Death Center

Children’s Health Alliance of Wisconsin

Joanna O’Donnell, Project Manager
jodonnell@chw.org
http://www.chawisconsin.org/initiatives/grief-and-bereavement/
Healing Our Hearts Foundation

583 D'Onofrio Dr Suite 103
Madison, WI 53711

608-821-0848
www.healingourhearts.net
info@healingourhearts.net

Submitting a referral?

https://tinyurl.com/hohreferral
Next Steps
Thank you!

Our Contact Information

Email: DHSMIMP@dhs.wisconsin.gov

Website: https://www.dhs.wisconsin.gov/healthybirths/index.htm
Reflection