Wisconsin Maternal Mortality Review Team (MMRT)

May 2026 meeting summary

Cases reviewed: 3

Preventability: 100%

Pregnancy-relatedness: 33%

Causes of death: Sepsis

MMRT recommendations*: (#) = number of cases

For Systems:

- The state of Wisconsin and the federal government should increase funding and offer incentives for rural health facilities to recruit obstetric care providers. (1)
- Health care systems should have annual trainings and ongoing work groups to improve communication in critical patient transfers. (1)
- Health systems should educate all healthcare workers on warning signs and symptoms to be aware of in prenatal care and provide education to birthing people that access any health care (modeling the Hear Her campaign). (1)
- All hospitals should ensure appropriate staffing ratios to allow for backup providers in the setting of changes in patient volume and acuity. (1)
- Health systems and payers should provide formal, in-person interpretation for all patient and family interactions, including conversations around complex medical planning (including diagnosis, treatment, and vaccination when applicable). (1)
- Health care systems should create incentives, such as part-time availability, to create appropriate staffing ratios in rural hospitals and emergency departments. (1)

For Facilities:

- Facilities should implement early sepsis protocols and broad-spectrum antibiotics when appropriate, including for maternal sepsis in the emergency department and obstetric triage (protocols should include Surviving Sepsis Protocols). (1)
- Prenatal care clinics should allow increased visit length in order to provide adequate education and care for those that require interpreter services. (1)

*Pregnancy-related only