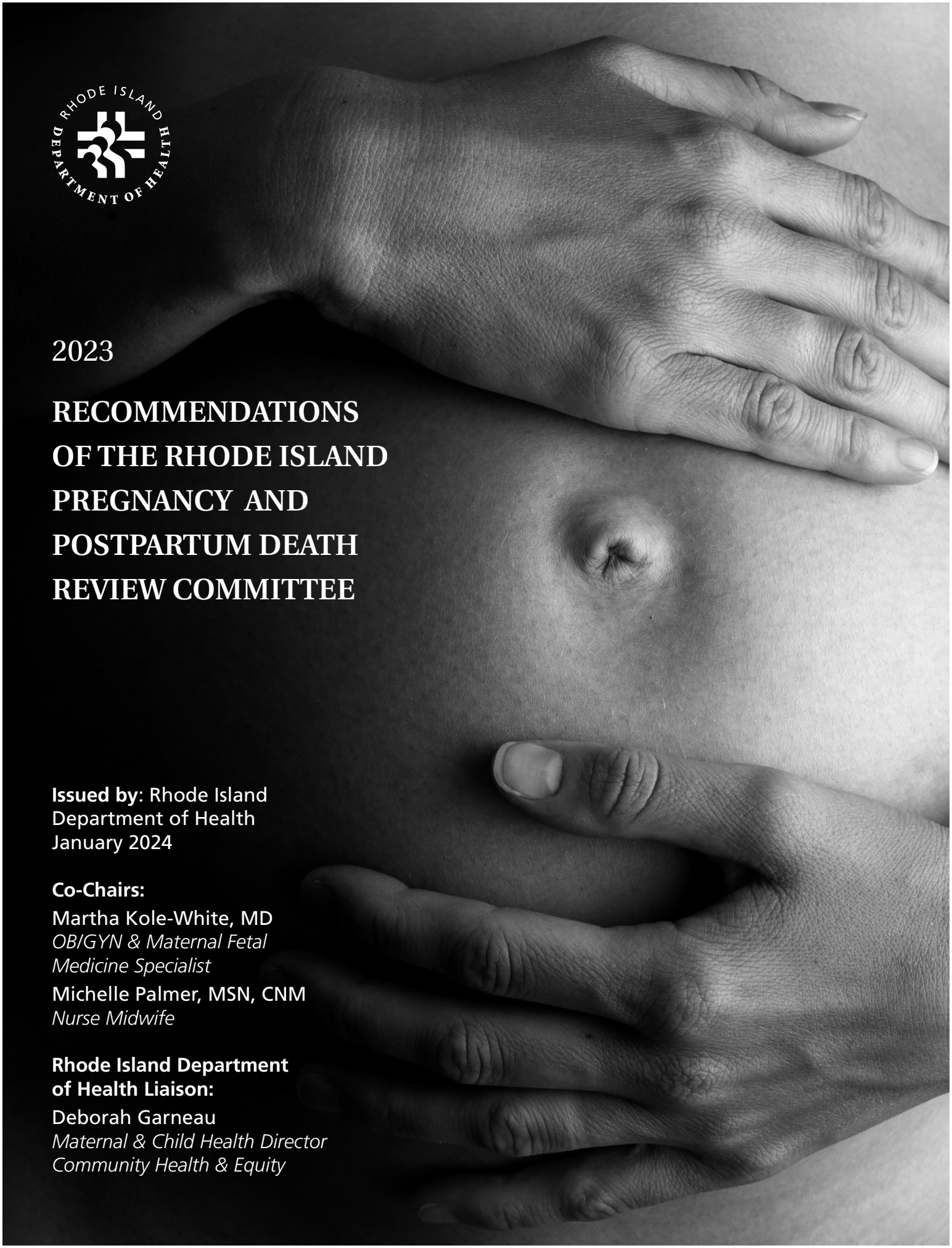

2023

RECOMMENDATIONS OF THE RHODE ISLAND PREGNANCY AND POSTPARTUM DEATH REVIEW COMMITTEE

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INTRODUCTION and BACKGROUND

The Rhode Island Pregnancy and 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 identify areas of opportunity for systemic changes that could decrease deaths in Rhode Island 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 the 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 and Postpartum Death Review Committee's vision is to eliminate preventable perinatal deaths, reduce perinatal morbidities, and improve population health for people in the pregnancy and postpartum period.

COMMITTEE MEMBERS

The following people were the contributing PPDRC members during the year of 2023:

Ellen Amore
William Arias
Tanya Booker
Christine Brousseau
Sara Castañeda
Carrie Chandonnait
Mara Coyle
Monique De Paepe
Aidea Downie
Jerry Fingerut
Laura Gallicchio
Deborah Garneau
Preetilata Hashemi
Jennifer Hosmer
Margo Katz
Angela Kemp
Martha Kole-White
Ashley Lakin
Lucia Larson
Edouard Latortue
Jennifer Levy
Susanna Magee
Vincent McAteer
Latisha Michel
Luisa Murillo
Patricia Ogera
Olutosin Ojugbele
Collette Onyejekwe
Emerald Ortiz
Michelle Palmer
Maria Elena Prout
Sharon Ryan
Jean Salera-Vieira
Keith Scally
Danika Severino Wynn
Kayle Shapero
Jami Star
Mary Beth Sutter
Trina Swanson
Catherine Teddei
Maranatha Teferi
Nadine Tavares
Sonia Thomas
Liz Tobin-Tyler
Cindy Vanner
Jordan White
Sharnese Williams
Shannon Young
Hannah Zweig

2023 MEETING DESCRIPTION

During the year of 2023, the PPDRC had 41 active members. An average of 24 members attended each meeting. Cases were reviewed in three meetings, while recommendations were reviewed in one meeting, for a total of four meetings during the 2023 calendar year. During these meetings, 10 cases were reviewed. The cases reviewed in 2023 comprised deaths that occurred in 2018-2023.

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 10 pregnancy-associated deaths reviewed in 2023, 3 were determined to be ***Pregnancy-Related***; 2 were ***Pregnancy-Associated but Not Related***; and 5 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, healthcare professional, facility, system, and/or community factors. This definition is used by review committees to determine if a death was preventable. All 10 cases reviewed were deemed ***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 10 pregnancy-associated deaths reviewed included 3 that were considered ***Complete*** and 7 that were ***Mostly Complete***. While 3 were considered ***Complete***, the Committee felt that having information from key informant interviews would have added significantly to the review of those cases, as well as to those considered ***Mostly Complete***.

2023 RECOMMENDATIONS

When reviewing cases, the PPDRC evaluated the overall picture of health of people who died in the perinatal period, referring to the time around their pregnancy and up to a year after delivery in the postpartum period. Recommendations were synthesized 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. It is the consensus of PPDRC that the following overarching recommendations should be addressed in Rhode Island to better care for the state's pregnant and postpartum individuals:

1. The Committee found challenges in the service delivery system for perinatal people, particularly related to overall support during pregnancy and the postpartum period. Based on these findings, the Committee recommends that Rhode Island needs **improved access to care and support in the pregnancy and postpartum period, including expanding the availability of Peer Recovery Specialists, Community Health Workers, and Doulas**.

2. The Committee's review revealed that some pregnancy-associated deaths may have been prevented with more immediate attention to medical issues that are specific to pregnancy and the postpartum period. As a result, the Committee recognizes the crucial need to i**ncrease healthcare professionals' awareness, patient knowledge, and familial education regarding pregnancy and postpartum complications and care**.

3. The Committee observed that pregnant and postpartum individuals who currently or previously used substances faced significant challenges in accessing care. To ensure equitable and comprehensive care, and to promote the overall well-being of all pregnant and postpartum people, the recommendation is to **enhance the availability and accessibility of unbiased perinatal care for all individuals, regardless of their substance use history**.
4. Aiming to address notable challenges with care coordination and to strengthen the collaboration among healthcare professionals caring for perinatal patients, the committee identified the need to enhance the sharing of patient information, when appropriate, among clinicians. Thus, the recommendation is to **foster collaboration and improve timely communication among healthcare professionals involved in the care of pregnant and postpartum individuals**.
5. It is widely acknowledged that the conditions in which individuals are born, grow, live, learn, work, and play have a profound influence on their health. Extensive public health research and data reveal that longstanding social, economic, and environmental inequities, such as poverty, discrimination, and racism, have contributed to adverse health outcomes over generations. The Committee's review identified some of these inequities in areas such as housing; insurance; access to regular and coordinated healthcare; and culturally and linguistically appropriate care. The committee strongly recommends the **advancement of policy initiatives aimed at removing barriers for pregnant and postpartum individuals**.

CONCLUSIONS

The Rhode Island Department of Health is honored to have facilitated the discussions of the Pregnancy and Postpartum Death Review Committee—discussions that 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 they 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. The PPDRC hopes that by highlighting these issues, our state will ensure that they remain priorities.

Most importantly, the PPDRC recognizes and honors the 10 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.

APPENDIX –PPDRC Supporting Recommendations

The recommendations listed below were collectively formed based off the findings from the 10 pregnancy-associated death cases reviewed in 2023.

OVERARCHING RECOMMENDATIONS

- Access to Care and Support
- Increasing Awareness, Knowledge, and Education
- Bias-Free Pregnancy and Postpartum Care
- Collaboration and Communication
- Removing Barriers

GROUP(S) TO ENACT RECOMMENDATIONS

- Healthcare Professionals
- Health Plans
- Hospitals
- Patients
- Rhode Island Department of Health (RIDOH) & Other State Agencies
- Perinatal Contributor Community

ACCESS TO CARE AND SUPPORT

- Ensure the availability of peer recovery specialists for support during, after, and between pregnancies for people in recovery.

- Ensure community health workers are available, as needed, to support families throughout pregnancy.

- Increase access to care for pregnant and postpartum people who use substances, including the ability to initiate medications for opioid use disorder (MOUD) in the inpatient setting.

- Expand the mental and behavioral health workforce, to increase the availability of behavioral health resources for pregnant and postpartum people.

- Increase the number of patient advocates, such as social workers, peer recovery specialists, and/or community health workers, in emergency departments to improve referrals to the appropriate resources and timely follow-up care.

- Ensure pregnant and postpartum patients with chronic and potentially life-threatening conditions receive regular and consistent specialty care.

- Promote an integrated, team-based model of care that offers extended hours with same-day appointment scheduling capabilities.

- Increase access to and availability of culturally congruent care for Black, Indigenous, and people of color (BIPOC) who are pregnant or postpartum by utilizing resources such as the Urban Perinatal Education Center.

- Promote timely access to primary care in Rhode Island, including supporting the growth of a diverse workforce of healthcare professionals.

INCREASED AWARENESS, KNOWLEDGE, AND EDUCATION

- Continue to promote and increase awareness of the availability of treatment for pregnant and postpartum individuals who use substances.

- Continue to promote and sustain the Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN) teleconsultation line to assist with the care of pregnant and postpartum individuals with mental health and/or substance use concerns.

- Further develop pregnancy and postpartum public awareness campaign to provide more 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 naloxone.

- Maintain awareness and treatment knowledge of medical conditions and how they can present differently during pregnancy and the postpartum period.

- Advance community awareness by educating families about safe storage of over-the-counter medications including analgesics, prescription medications, and, especially, controlled substances.

- Conduct outreach to healthcare professionals in neighboring states who provide care to pregnant and postpartum individuals and their families about Rhode Island's Family Visiting eligibility and services.

- Increase awareness and educate pregnant and postpartum individuals and their families about urgent warning signs that require emergency care.

- Promote and implement CDC's *HEAR HER* campaign locally.

- Screen all people of reproductive age for pregnancy and/or parenting intention on a regular basis and provide contraceptive counseling when desired.

- Expand community education on the benefits of COVID-19 vaccination, and other vaccines recommended during pregnancy and the postpartum period, at multiple locations, including but not limited to churches, workplaces, shelters, and substance use treatment and recovery facilities.

- Increase awareness of existing laws prohibiting the purchase and possession of firearms for those with a violent criminal history.

- Increase awareness of Rhode Island's doula benefit.

BIAS-FREE PREGNANCY AND POSTPARTUM CARE

- Implement ongoing Diversity, Equity, and Inclusion (DEI) training for all staff involved in the care of pregnant and postpartum individuals at all levels of care.

- Require all healthcare professionals in Rhode Island to have education on implicit bias.

- Assure, whenever possible, healthcare professionals performing psychiatric assessments are not affiliated with the individual's employer.

COLLABORATION AND TIMELY COMMUNICATION

- Ensure access to, and timely exchange of, medical records in all settings where physical, mental, and/or behavioral healthcare is provided to pregnant and postpartum individuals.

- Ensure that standards of care are followed when ordering, reporting, and reviewing tests for pregnant and postpartum individuals.

- Support the training, provision, expansion, and documentation of interpretation services for pregnant and postpartum individuals whose language differs from that of the healthcare professionals involved in their care.

- Develop an automatic prompt within electronic health records (EHR) to inquire whether patients of reproductive age could be pregnant or have been pregnant in the last 12 months, so that specific medical risks prevalent during the perinatal time period can be identified.

- Promote a unified medical records system within Rhode Island.

- Encourage use of bracelets by pregnant and postpartum individuals so they can be clearly identified in emergencies.

REMOVE BARRIERS

- Increase public awareness recognizing and responding to an overdose, including how to obtain and administer naloxone.

- Ensure all first responders provide on-scene overdose response according to their respective protocols.

- Ensure all first responders can access real-time interpreter services.

- Review the current response protocol requiring cardiopulmonary resuscitation (CPR) in the field for 30 minutes in cases of cardiac arrest for pregnant individuals.

- Advance work on eliminating critical barriers in the prior authorization process, which can contribute to delays in care and result in potentially life-threatening circumstances.

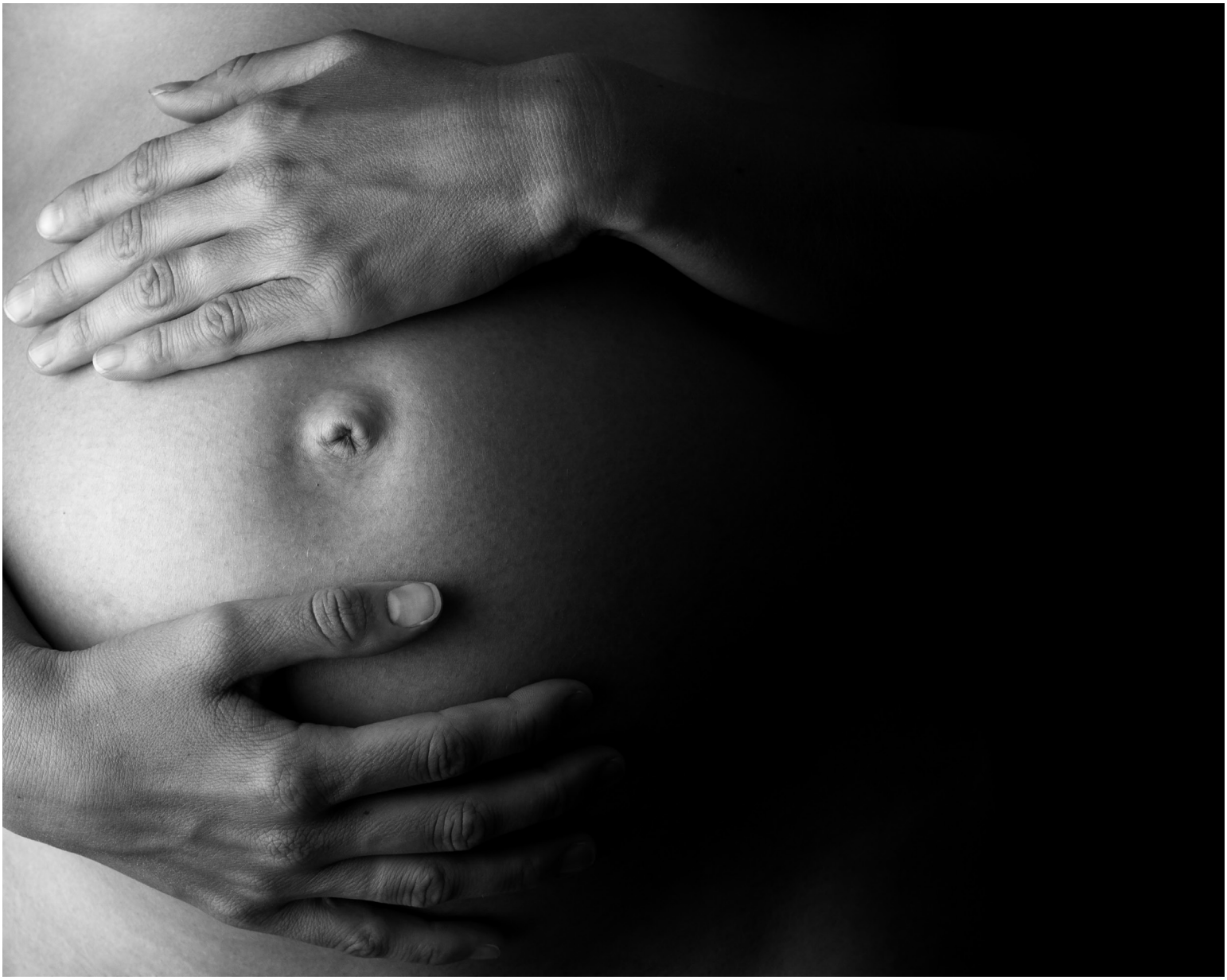
- Conduct routine intimate partner violence (IPV) screening in a private setting for all pregnant and postpartum individuals; resources should be offered and safe methods of contact for follow-up should be obtained.

- Improve the provision of respectful, supportive, and compassionate care for pregnant and postpartum people with substance use disorder.

- Refer pregnant and postpartum individuals in need of emergency, transitional, or long-term housing to social services for assistance on obtaining safe housing.

- Promote harm reduction centers, treatment, and recovery programs that include access to wraparound services to aid in obtaining employment and assisting individuals with extensive legal and/or criminal history.

- Improve statewide resources for pregnant and postpartum individuals who are experiencing financial challenges surrounding the continuation of their care by providing counseling and connection to financial resources.



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