Wyoming Maternal Mortality Committee Recommendations (2018-2020)

Wyoming Department of Health
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PREFACE

The Utah-Wyoming Joint Maternal Mortality Review Committee (MMRC) brings together multidisciplinary professionals from across the state of Wyoming and Utah to comprehensively study how and why mothers are dying and identify opportunities to prevent future deaths. Factors that contribute to maternal mortality and morbidity are complex and occur over the life course. The MMRC focused their recommendations on factors that impact maternal health at the individual, family, provider, facility, systems, and community levels.

This report's MMRC recommendations represent priority opportunities to reduce preventable maternal mortality. The Wyoming Department of Health respects these recommendations and does not alter them once provided. While the MMRC multidisciplinary professionals may name specific organizations in their recommendations, they are limited in their knowledge of Wyoming community level organizations and government structure. Just as multiple factors impact maternal health population outcomes, the protection of mothers must be a combined effort across entities, levels, and systems. The MMRC encourages stakeholders to review these recommendations and identify where they can contribute to efforts to eliminate health disparities and build a culture of maternal health and safety.

MMRC Recommendations for Preventing Pregnancy-Related Deaths

MMRC Recommendations by Contributing Factor for Preventing Pregnancy-Related Deaths

Key Decision: If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events?

For each preventable death, the Maternal Review committee identifies and describes the factors that contributed to the death. These factors form the basis for the committee's recommendations. Each factor is assigned at least one of 23 specific contributing factor classes. The committee identifies a level for each contributing factor and for each recommendation. More information on Wyoming Maternal Mortality and contributing factors can be found in the Wyoming Maternal Mortality Report (https://health.wyo.gov/wp-content/uploads/2023/05/MMRC-WY-Report-2018-2020.pdf).

The MMRC provides recommendations to the Wyoming Department of Health based on their reviews of maternal deaths. Each identified contributing factor is mapped to at least one recommendation. CDC encourages committees to craft recommendations which include "wh o" should do "what" and "when." The complete list of MMRC recommendations from 2018 - 2020 cases are listed below and ordered by contributing factor and the level of the recommendation.

Lack of Access/Financial Resources

System level recommendations

- The State of Wyoming should extend postpartum Medicaid coverage for a longer duration following delivery.
- The Department of Family Services and Wyoming Association of Mental Health and Substance Abuse Treatment Centers should provide health care providers guidance on how to coordinate support for treatment for mental health and substance use disorder, and local resources.
- The State of Wyoming should expand or facilitate access to childcare.
- State and federal funding should be made available for universal home visiting, so all women are offered visits and there is no stigma associated with receipt of home visiting services.

- WDH should increase provider and community awareness of existing mental health resources that are available remotely such as Postpartum Support International and mental telehealth.
- WDH should negotiate with insurance providers to expand substance use treatment coverage for pregnant and postpartum up to one year.
- Wyoming should develop/fund ways to increase specialized mental health, substance use, and peripartum providers within Wyoming; both in-person and telehealth access.

Community level
- Workplace policies should protect individuals with substance use disorders or mental health conditions when screening from termination of employment.

Substance Use Disorder

Provider Level
- Improve access to and use of electronic medical records (EMR) to document substance use screening and improve care coordination.

System Level
- Education should be provided to providers of maternity care regarding the effects of methamphetamines and cardiac impacts in pregnancy and postpartum.
- Continue participation in project ECHO for pregnancy and addiction with the UDOH to improve access to medication-assisted treatment for pregnant and postpartum women and to implement Substance Use Disorder Safety Bundles in Wyoming hospitals.
- Public health and health systems should disseminate evidence-based practices for validated screening tools and provide necessary training to providers.
- The WDH should develop education materials to both clinicians and patients around treatment (both medication-assisted treatment and other behavioral interventions) of SUD even in the case of not sustaining use due to the risk of relapse.
- Wyoming should continue to fund and expand peer recovery support specialist programs.
- Health systems should utilize incentives for drug screening during pregnancy.

Community Level
- Medication-assisted treatment should be available in all communities in Wyoming.

Mental Health

Facility Level
- Facilities should screen for postpartum depression immediately after birth, postpartum visit and postpartum inpatient admissions.

System Level
- Wyoming providers should implement universal mental health screening during prenatal care visits.
- Standardize drug screening in prenatal care and ER settings to identify individuals that need care.
- Wyoming and National professional societies (such as ACOG, ACNM, medical societies, primary care associations, etc.) should continue to educate providers and women of reproductive age around the safety and risks of mental health medications as compared to untreated mental health conditions

Community Level

- HHS and state 211 should work with tech companies, such as Google, Meta, etc., to require that they develop an algorithm to identify at risk individuals based on search history for key words related suicide. In addition to receiving the suicide hotline number individuals should be given local information.

Clinical Skill/Quality of Care

Provider Level

- Providers should recognize when it is appropriate to proceed to an abdominal hysterectomy.
- Providers should review clinical data regarding the specific contraindications to epidural placement in patients that may be infected.

Facility Level

- All hospitals should implement and use hemorrhage safety bundle protocols.
- Training for staff in recognition of postpartum hemorrhage and management. WDH should implement increased training on obstetric complications.

Social Support/Isolation

Provider Level

- Screen for interpersonal violence.
- Increase family and community awareness of interpersonal violence.

System Level

- Social media companies should tool their algorithms to identify at-risk postpartum/pregnant individuals and target resources relevant to the location.
- Access to childcare led to her quitting her job and becoming more isolated and at risk for interpersonal violence and alcohol abuse.

Community Level

- Communities should improve access to mental health services for parents who are living away from family supports.
- Assure access to and availability of shelter and housing for people in dangerous living situations.
- Use validated tools for screening for intimate partner violence.

Trauma

System Level

- Implement trauma-informed care in primary and prenatal care.
- Insurance companies should ensure grief support referrals and coverage for mental health services to families who have experienced the death of an infant or child.
- WDH and professional societies should expand knowledge of trauma-informed care and adverse childhood events identification for Wyoming healthcare providers and social workers.

Continuity of Care/Care Coordination

System level

- Assure care coordination for pain management/mental health using electronic records or medical home.
- Develop a safety net or care coordinator for clients at risk with missed visits.
- Hospitals should develop protocols for social work referrals for care coordination (e.g., plans of safe care) that are initiated before inpatient and outpatient hospital discharge for all mothers.

Assessment

Facility Level

- Inpatient and outpatient providers should implement universal SUD screening for pregnant and postpartum women.

System Level

- WDH should provide intimate partner violence training for screening and referral inpatient and outpatient services.

Discrimination

Facility level

- Hospitals should provide annual implicit bias related to persons who use substances training to all inpatient, outpatient, and first responders.

Communication

Facility Level

- Hospitals should communicate with a hospital with an appropriate level of maternal care when complications arise.