Maine Center for Disease Control and Prevention

Maternal, Fetal, and Infant Mortality Review (MFIMR)

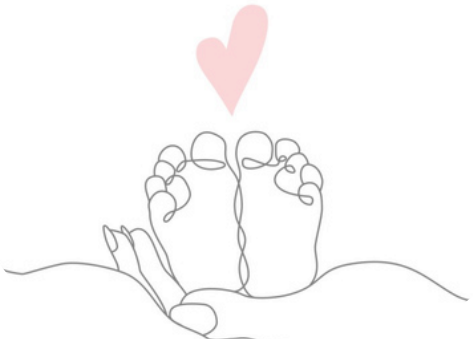
PANEL RECOMMENDATIONS

JULY 2023-DEC 2024

DISCLAIMER

These are recommendations discussed by the Panel and are not necessarily supported or endorsed by the Maine Center for Disease Control and Prevention or Department of Health and Human Services. They do not reflect policy commitments, and further do not confer support from the Executive Branch for specific legislative initiatives. Policy proposals will be reviewed and commented on as they arise.

Any state department, office or agency that is listed have been consulted and given opportunity to respond and collaborate on the recommendations directed to them.



BACKGROUND

The MFIMR Panel is made up of 35 members who review de-identified case narratives of maternal, fetal and infant deaths. The Panel identifies contributing factors and puts forth recommendations based on these case reviews.

From July 2023 through December 2024, 22 cases were reviewed and a total of 124 recommendations were made. Similar recommendations were combined. The following 97 recommendations are the end result of that process.

METHODS

At an all-day in-person annual meeting, the Panel members were given the 97 recommendations as well as an analysis of themes from conversations with community organizations.

The Panel members were asked to evaluate and prioritize recommendations after considering the following sources:

- **quantitative data** – i.e. how often each recommendation theme area (listed alphabetically on page 6) was used;
- **qualitative data** - feedback from community conversations, including a thematic analysis; and
- their **individual experience and expertise.**

Through a process of reflection, discussion, and ranking, 8 priority recommendations emerged in the topic areas of Mental Health, Substance Use, and Cultural/Linguistic Support. An additional cross-cutting recommendation around stigma reduction was also prioritized.

These priority recommendations are **bolded** amongst the others.

OBJECTIVES

The MFIMR Panel did not address the feasibility of the following recommendations. Various action groups are already in place, and the Panel hopes the recommendations will strengthen their existing efforts and support ongoing initiatives. Additionally, the Panel seeks collaborators to implement relevant recommendations within their work plans and communities.

Recommendation
THEMES

Common **ACRYNOMYNS**

alphabetical by acrynomyn

ACLS	Advanced Cardiac Life Support
AIM	Alliance for Innovation in Maternal Health
CBO	Community Based Organization
CPR	Cardiopulmonary Resuscitation
CPS	Child Protective Services
DHHS	Department of Health & Human Services
ED	Emergency Department
EMR	Electronic Medical Record
EMS	Emergency Medical Services
FDA	Food & Drug Administration
GTT	Glucose Tolerance Test
IPV	Intimate Partner Violence
LARC	Long-Acting Reversible Contraception
MFHV	Maine Families Home Visiting
MFM	Maternal Fetal Medicine
MaineMOM	Maine Maternal Opiate Misuse program
NICU	Neonatal Intensive Care Unit
OB	Obstetrics
OCME	Office of the Chief Medical Examiner
OLMC	On-Line Medical Control
PA	Prior Authorization
PCP	Primary Care Provider
PHN	Public Health Nursing
SDOH	Social Determinants of Health
SEI	Substance Exposed Infant
SUD	Substance Use Disorder
WIC	Women, Infant, Children program

Cardiovascular

- For any pregnant patient with a cardiac diagnosis, prenatal care and primary care providers should note pregnancy and need for emergent (not routine) visit on any referral and do a provider-to-provider consult to include any additional monitoring or interim plan as appropriate. Improved education on cardiac disease in pregnancy, which could be included as part of an AIM Bundle on Cardiac Conditions in Pregnancy or the Hear Her Campaign.

- Increase review of maternal and overall cardiac arrest protocols for EMS clinicians, including code drills and scenarios, and regular review of equipment location and pre-planning of equipment to bring to the patient's side. Paramedics and EMS clinicians should attend an ACLS or other cardiac arrest management class and practice skill in high performance CPR. Education for OLMC physicians and EMS clinicians for clarity in consults (patient condition, transport distance, time to transport, and operational considerations).

- Providers to treat hypertension in pregnancy acutely regardless of assumed cause, with a longer-term plan to address any underlying issues (such as anxiety).

Care Coordination / Community Care Management

- Develop a statewide care navigator/coordinator program for high-risk birthing and postpartum people to help navigate the healthcare system.

- Insurance entities and healthcare advocacy organizations to promote existing resources including care management available through their organizations.

- In the setting of prenatal diagnoses impacting infant care after delivery, care coordination to set up appointments with appropriate pediatric specialists (e.g. feeding, physical therapy, and speech therapy) prior to hospital discharge.

- Interstate and intrastate postpartum care coordination needed for the acute postpartum period if newborn is transported away from home community, including postpartum discharge information on how to access care regardless of location and a resource number to call if needed.

Compassion Fatigue/ Trauma-Informed Care

- **To combat stigma within the healthcare system - health systems need to take a multifaceted approach: educational training for healthcare staff, feedback and reporting mechanisms, establishment of consumer committee/patient advisory council that includes people with lived experience, new policy in EDs and inpatient units including labor and delivery, and long-term cultural shift as part of new and ongoing quality improvement efforts.**

- Care teams to assess barriers to an individual's ability to follow care team recommendations and address these barriers in a non-stigmatizing way.

- To combat trauma within the healthcare system - health systems need to take a multifaceted approach: trauma-informed educational training for healthcare staff, feedback and reporting mechanisms, establishment of consumer committee/patient advisory council that includes people with lived experience, policies and protocols within units, and long-term cultural shift as part of new and ongoing quality improvement efforts.

Contraception / Family Planning

- Prenatal and primary care providers to assess discussing options and document discussion of all options including LARC and permanent contraception at every visit with women of reproductive age in a culturally appropriate manner. All women of reproductive age should have access to all FDA approved contraceptives, including ensuring same day access to long-acting contraception.

- Providers working with people of reproductive age to implement the One Key Question regarding pregnancy intention as a starting point for reproductive life planning.

- All postpartum people should have in-depth discussions about the risks associated with short-interval pregnancy to ensure informed shared decision-making, including presentation of all contraceptive options and appropriate resources to obtain them.

CPS - Child Protective

- DHHS to continue family partnership and peer support work especially with new parents who are interacting with CPS for the first time or who have children already and are pregnant again.

- Prenatal providers to develop and implement the Plan of Safe Care with all pregnant people who are using substances.

- Birth facilities to provide warm hand-offs to CPS in the event of a substance exposed infant (SEI) to increase trust and transparency.

- Legal counsel should be engaged to provide education and guidance on what termination of parental right and/or guardianship means for parents.

- Statewide bereavement support resources to include grieving after complex loss via termination of parental rights.

Cultural / Linguistic Support

- **Policymakers to look at ways to support the development and ongoing funding for a statewide peer support/navigator/cultural broker program for birthing & postpartum people in Maine to help navigate the healthcare & legal systems for those new to Maine.**

- **Healthcare systems to ensure that in-person interpretation services, with training in emotional support and trauma-informed care, are provided at bare minimum during emotionally sensitive care discussions and ideally provided throughout all stages of care with an attempt for continuity of services to ensure comfort and trust between patients and healthcare teams.**

- **Policymakers to look at ways to support increasing culturally and linguistically appropriate integrated mental health services across perinatal and primary care settings, as well as infrastructure that supports better and more expedient access to mental health services including increasing access to telehealth and immediately or urgently available providers in case of emergency.**

Cultural / Linguistic Support (continued)

- Funding to ethnic Community Based Organizations (CBOs) to strengthen community outreach to ensure that newly arrived immigrant families are systematically and automatically connected to government resources that offer financial, housing, and transportation assistance.

- Clinical staff to initiate referrals to social workers and immigrant support organizations for all recently immigrated persons, especially at the ED and in postpartum care. These organizations can help with emotional support, financial assistance, and guidance in navigating healthcare systems.

Emergency Department

- ED providers to document discussion of all options when counseling following positive pregnancy result.

- Care coordination needed from EDs to PCP offices for warm handoffs.

- For pregnant patients greater than 22 weeks gestation who present to the ED, ensure protocol exists to include maternal stabilization followed by OB screening exam and fetal assessment.

Emergency Medical Services

- State policy makers to provide funding and support for increased EMS staffing for maternal responses, particularly in rural areas where additional help can be significantly distant.

- For all maternal deaths, review of incident by system medical director, as well as debriefing with EMS clinicians, hospital team and/or family.

- Increase EMS education about Narcan use during cardiac arrest.

Intimate Partner Violence

- Provider education on signs of domestic or interpersonal violence and evidence-based screening practices.

- Clinicians statewide to be trained on CUES (free universal education of IPV dynamics and response in a healthcare setting) that highlight national best practice strategies to support patients who are accessing healthcare and also experiencing domestic abuse and violence.

- Universal IPV screening and education should be part of comprehensive OB care at every prenatal visit using a validated tool.

- Prenatal care and primary care providers should include IPV assessment as part of the postpartum depression intervention guidelines, given the strong evidence behind the association between IPV and suicide.

Labs / Medications / Pharmacies

- Clinicians to reduce barriers for patients, ensuring prenatal labs get drawn as early as possible in the setting of disrupted or late entry to prenatal care.

- Inpatient pharmacies to offer expedited medication access for emergent cases with Prior Authorization (PA) waiver as needed as soon as possible.

- Providers and office staff to call pharmacies directly to get the best possible information to support the patient getting what they need. They may also add notes to say what they are intending to prescribe when the prescription is initially sent. Prescriber may also add phone number to the prescription so pharmacy can follow up directly with the provider.

- Pharmacies, pharmacy professional organizations, and schools of pharmacy to increase pharmacist education on emergency 72-hour supply statute and when to use.

- Federal policymakers to look at ways to ensure an “override” is available for all insurance types and that a 72-hour emergency medication supply can be issued by pharmacies as needed for all insurance types.

Labs / Medications / Pharmacies (continued)

- State policymakers to look at ways to ensure that there is a list of medication types and situations that are either PA exempt or that should be filled for an emergency 30-day supply while a PA is pending. The state and/or insurance companies to contribute to a “back-up fund” to cover the gap like the Maine Guaranteed Access Reinsurance Association.

- Increase consumer and provider education on existing emergency review process from insurance companies, including who to call, reasons to call, and hours of operation/what to do outside of hours of operation. At the insurance carrier level, provider 24/7 coverage for emergent situations.

- Electronic Medical Records (EMRs) to include an advisory notice about which prescriptions need separate needles to be prescribed, and which do not. Pharmacies to call providers if a prescription requires needles and there is no accompanying prescription for needles.

Mental Health

- **Universal mental health screening should be part of comprehensive OB care at the first prenatal visit, towards the end of pregnancy, and postpartum by the prenatal care provider, using a validated tool.**

- **Prenatal care providers and primary care providers to create a mental health safety plan for high-risk patients including a warm handoff to an integrated mental health clinician, external mental health clinician, or telehealth partner. Safety plans may also include involvement of trusted support people.**

- **Psychiatric, prenatal care, and primary care providers who care for women of childbearing age who take medications to treat mental health should talk with patients about safety of mental health medications and risk/benefit ratios in the event of pregnancy. Enhanced education for these providers about prescribing psychiatric medications in pregnancy, particularly as it pertains to substance use disorder (SUD).**

Mental Health (continued)

- Statewide organizations to assess ability to implement a maternal health psychiatric assessment line and assess current Maine helplines for postpartum mental health support and analyze results of pilot projects in this space.

- Public health campaign to promote national maternal mental health hotlines.

- Community level providers to promote suicidality awareness and prevention, especially among pregnant and recently pregnant people (e.g. Mental Health First Aid).

Obstetrics / Primary Care

- Discharge planning for postpartum patients to include concrete plan for communication between OB/primary care and scheduling appointments before discharge.

- Providers to not deviate from standard of care for follow up prenatal testing (ex. 3 hour GTT) unless documented discussion of risks & benefit and patient informed declination of such care.

- Prenatal care providers to refer to MFM for future pregnancies as necessary to increase surveillance for subsequent pregnancies.

- At earliest point in care and prior to discharge, staff to document through comprehensive intake forms a patient's social history, including housing, transportation, employment status, and any concerns about domestic violence, using a validated tool.

- Health systems to explore infrastructure to flag if social determinants of health (SDOH) screening is not completed during in-patient stays.

Perinatal Support / Support for Parents

- Statewide outreach campaign about Maine's Paid Family and Medical Leave Program to new or anticipating parents.
- Statewide expansion of one-on-one in-home training for parenting skills.
- For parents with intellectual disabilities, provide financial resources for overnight in-home services and establish parent navigators/peer supports.
- Statewide increase in prenatal and postpartum peer support through expansion of Centering Pregnancy model.
- Support the creation of new parent support groups and advertise existing groups in both community and hospital-based settings to address social isolation.
- Universal promotion of referrals to CradleME, including PHN and MFHV, at each touchpoint in perinatal care.
- Statewide assessment of cost of and reimbursement strategies for perinatal care delivery and plan for doula coverage.

Physical Safety

- Prenatal care providers, pediatricians, and primary care providers to discuss gun safety in the home, including who has access to guns, and safety plan in the presence of a mental health diagnosis that includes all support people.

- Distribution of seatbelt pictogram by prenatal care providers during prenatal and postpartum care.

Preconception

- Public health campaign on preconception healthy habits and nutrition.

- Prenatal care and primary care providers, PHN, and WIC to discuss risk for stillbirth with obesity for families during preconception visits.

Provider Training

- Ongoing clinician education with simulation and drills around high-risk pregnancy and difficult birth scenarios.

Safe Sleep

- Public health campaign on safe sleep best practices including safe feeding around-the-clock and with acknowledgement of caregiver exhaustion and targeted to all caregivers/whole family.

- Prenatal and primary care providers and community partners to provide education and resources about safe feeding around-the-clock, practices/techniques while exhausted, and infant care support during second half of pregnancy, post-delivery in hospital/home setting, and during post-partum & well child visits.

- All Maine birthing hospitals to renew and maintain Cribs for Kids safe sleep certification on a continual basis.

- CPS to clarify reporting requirements to ensure consistent and culturally informed reporting of Safe Sleep concerns across the state from birth hospitals to CPS.

Social Determinants of Health

- Policymakers to look at ways to increase funding and availability of emergency housing for individuals prenatally and postpartum and for longer-term affordable housing options for Maine residents.

- Policymakers to look at ways to increase funding for, availability of, and knowledge of public transportation options in Maine, particularly for pregnant and postpartum patients and their families.

- Health systems to expand existing pilots of healthcare outreach services to hotels where people are living to provide needed prenatal and postpartum care, included in-person interpretive services.

- Standardization of referrals to social services with information on barriers and SDOH including noting difficulty in reaching the family and having ways of outreach that do not rely on continual phone access.

Substance Use

- **Universal SUD screening should be part of comprehensive OB care at the first prenatal visit and as needed by the prenatal care provider, using a validated tool.**

- **Implement quality improvement initiatives that address SUD, including universal naloxone distribution, information about "Never Use Alone" resource, and the AIM Bundle on Care of Pregnant and Postpartum People with SUD.**

- **Statewide policymakers to look at ways to increase the number of drug and alcohol rehabilitation services, facilities, and workforce to be more accessible for people with children, have longer term options, and make them more inclusive of co-occurring disorders, particularly for those from small or rural communities.**

- Prenatal care providers to refer pregnant patients with SUD to care coordination, patient advocacy groups, and/or CradleME.

- CradleME to work with SUD providers and treatment facilities to increase referrals to the program.

Substance Use (continued)

- SUD providers to collaborate and refer to prenatal care providers for co-occurring SUD and pregnancy. Referral to MaineMOM provider and peer support providers and/or doulas to be involved in care.

- Prenatal and primary care providers to collaborate/consult with SUD providers to promote increased awareness and education around co-occurring disorders and the complexity of medication management in this setting.

- Providers to offer referrals for patients with a history of SUD to MaineMOM or other SUD provider as well as peer support services for return to use prevention during pregnancy.

- Care teams to assign a designated point person for care of those with ongoing substance use disorder to ensure adequate treatment during the perinatal period.

- Need for centralized place for SUD resources and support for ease of navigation of this resource through care navigators.

Substance Use (continued)

- Providers to ensure fentanyl is included in toxicology testing. Additionally, providers and staff should be educated on the position statement from the Governor's Office of Policy, Innovation, and the Future titled: Maine Opioid Response Clinical Advisory Committee: Proposed Position on Fentanyl Toxicology Testing.

- State policymakers to look at ways to increase funding for toxicology testing through the OCME.

- State level enforcement of existing regulations that methadone clinics be available 24/7 for dose confirmation.

- Policymakers to look at ways to increase funding and availability for housing options like McCauley house or other residential treatment/supports for women with SUD in pregnancy.

- Increased use of bed-to-bed referral system (jail to rehab) to support recovery efforts during pregnancy.

- Public health campaign on the risks of THC/ marijuana use during pregnancy and postpartum.

- Warm handoffs needed for referrals to tobacco cessation support in the perinatal period.

Telemedicine

- Telemedicine visits will be offered by outpatient practices for virtual monitoring of conditions in pregnancy as part of emergency preparedness plans.

- Improve postpartum surveillance including remote or at-home services for families of newborns with complex medical needs.

Viruses & Vaccines

- Public health officials and provider associations to partner on education and communication strategies around safety, risk, efficacy, hesitancy, and importance of vaccines and boosters during pregnancy.

- OCME to conduct COVID testing post-mortem during full autopsy at the OCME where cause of death is of unclear etiology.

Loss Support

- Hospitals to ensure discharge instructions reflect the pathways that newborns take, such as instructions for NICU babies or in the case of fetal or infant death.

- Hospitals to offer resources to parents after a stillbirth, including financial assistance for burial costs and other funeral expenses, postpartum follow-up, and process of transfer of the remains. All staff that manage any aspect of stillbirths should have comprehensive training.

- Perinatal loss stakeholder group to support integrated services and create strong partnerships between healthcare providers, funeral directors, CBOs, and faith-based groups to assist with loss support resources including financial assistance to cover mourning, burial services, and stress management.

For more information on MFIMR, including past Annual Legislative Reports and resources, visit:

https://www.maine.gov/dhhs/mecdc/population-health/mch/perinatal/maternal-infant/