

Why is Maternal, Fetal and Infant Mortality Review Important to Me?

Everyone has a role to play:

- ◆ Local leaders help increase public awareness
- ◆ Health care providers and administrators provide clinical expertise and access to information
- ◆ Local agencies help develop and implement local plans
- ◆ Individuals may be asked to serve on a committee or assist with implementation of a recommendation
- ◆ Families who have experienced a still-birth or the death of an infant or a mother provide useful insight that will help improve services and prevent future deaths

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Paul R. LePage, Governor

Department of Health
and Human Services

Maine People Living
Safe, Healthy and Productive Lives

Mary C. Mayhew, Commissioner

MATERNAL, FETAL AND INFANT MORTALITY REVIEW PANEL



A PROGRAM TO REDUCE MATERNAL, FETAL AND INFANT DEATHS IN MAINE

Maternal, Fetal and Infant Mortality Review Panel

VISION: Preventable maternal, fetal and infant deaths are eliminated.

MISSION: The infant mortality rate is a measure of the health and well-being of a community.

The Maternal, Fetal and Infant Mortality Review Panel is a thoughtful, humane and careful process that promotes collaboration among health care professionals and their communities. The Panel works to reduce maternal, fetal and infant deaths and such risks as premature births and low birth weight. It takes a broad, holistic approach to improving the quality of life for all of Maine's women, infants and families.

SCOPE: Over the past decade groups like the Maine Panel have been set up all across the country. Maine's Panel is based on a national model.

The Review Panel gathers medical, demographic and community information which is not available through other efforts. This broad-based approach is essential for evaluating how well local agencies and community resources serve our women, children and families.

Why Did Maine Develop a Review Panel?

Maine lacks adequate information about what causes maternal, fetal and infant deaths in our state.

A Review Panel looks at different factors and suggests ways to improve maternal and infant health. Their goal is to ensure safe, healthy pregnancies for Maine women. Families that have suffered a death provide useful insight into how Maine can prevent such deaths in the future. The Maternal, Fetal and Infant Mortality Review Panel looks at the information they provide and suggests ways to prevent future deaths.

How is the Review Panel Unique?

Maine has several programs that support mothers and infants, including some that look at pregnancy and the health of newborns. The Maternal, Fetal and Infant Mortality Review Panel will build on the work of these other programs. It will **not** attempt to discover fault or assign blame. Other related public health efforts include:

- ◆ The Maine Injury Prevention Program
- ◆ Early Childhood Systems Initiative
- ◆ Children with Special Needs/Genetics
- ◆ Newborn Bloodspot Screening Program
- ◆ Maine Birth Defects Program
- ◆ Pregnancy Risk Assessment Monitoring System (PRAMS)
- ◆ Public Health Nursing Program
- ◆ Maine Child Death and Serious Injury Review Panel

How does the Review Panel Work?

The Review Panel is made up of health care and social service providers, parents and family members, public health officials, members of law enforcement and others. These people have personal and professional experience in maternal and infant health and mortality. They will meet to conduct a comprehensive review of case summaries.

The Panel will then suggest ways to prevent future deaths and improve the overall health and safety of Maine's infants and mothers.

How are Cases for Review Selected?

Several months after a stillbirth or an infant or mother has died, the Director of Maine CDC (State Health Officer) will send a letter to the surviving family. Mothers and families are asked to participate on a voluntary basis and are offered services that might help them cope with their loss. The process is confidential. Panel members only receive case summaries that contain no names or ways to identify a family or infant. Cases where there might be a lawsuit or where someone might be charged with a crime are not considered for review. Health and social service professionals may refer cases to the Panel. Cases may also be selected through a review of maternal, fetal and infant death

