Report to the Legislature

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

RCW 70.54.450

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Health Division

Washington State Department of HEALTH

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Acknowledgments and Dedications

The goal of the work in this report is to prevent deaths, eliminate health inequities, and improve experiences of pregnancy, birth, and postpartum throughout Washington. This work would not be possible without the Maternal Mortality Review Panel (MMRP) members, who volunteer their time and expertise to prevent maternal deaths and improve care for Washingtonians. The Department of Health (DOH) is deeply grateful for their work. See Appendix 2, page 55, for MMRP members and additional report contributors. We also thank everyone who shared personal stories for this report, including Pregnancy Risk Assessment Monitoring System (PRAMS) respondents.

We dedicate this report to the memory of Washingtonians who died during or after pregnancy, and to all their families, loved ones, and communities. We share our deepest condolences for each loss. We acknowledge the depth of grief and pain caused by maternal mortality, which touches the lives of people statewide and impacts some communities disproportionately.

We also dedicate this report to the memory of Dr. Dale Reisner, a founding member and clinical lead of the MMRP, whose commitment to perinatal health care quality saved lives and improved care across Washington for many decades. Her work lives on, and we will never forget her.

Contents

Executive Summary

The Maternal Mortality Review Panel (MMRP, the Panel) reviews deaths of Washingtonians who died during pregnancy or up to 1 year after pregnancy. The MMRP identifies which deaths were pregnancy-related and preventable, then makes recommendations to save lives and improve care. As required every 3 years by RCW 70.54.450, this report presents the Legislature with data from 2014–2022 deaths and recommendations from reviews of 2021–2022 deaths.

KEY FINDINGS

Washington saw a rise in maternal fatalities in 2021–2022. Of the 107 maternal deaths reviewed for this report, 51 were determined to be pregnancy-related—meaning the cause of death was linked to pregnancy. **Pregnancy-related maternal mortality rates in Washington increased in 2021–2022 to 30.5 per 100,000 live births**, statistically significantly higher than the state's rate of **19.0 pregnancy-related deaths per 100,000** live births in 2017–2020.

Behavioral health-related deaths—including deaths by **suicide, homicide**, or **accidental overdose**—accounted for **nearly half (45%) of all pregnancy-related deaths in 2021–2022. Accidental overdose** was the **leading underlying cause.** Other leading causes included COVID-19 and cardiovascular conditions. Disparities persisted among Washingtonians based on age, race and ethnicity, rural residence, and Medicaid coverage status; these were driven by factors like bias, structural racism, financial inequities, and limited access to care.

The Panel found **82% of pregnancy-related deaths in 2021 and 2022 were preventable**, meaning there was a chance the death could have been prevented if at least 1 factor had been different**.** These factors included care quality, financial barriers, limited health care access, and lack of continuity of care, which were often exacerbated by social and structural drivers of health such as housing instability and systemic racism. **To address these factors, the MMRP makes 3 priority recommendations**:

1. IMPROVE HEALTH CARE QUALITY AND ACCESS

Ensure Washingtonians have **access** to **high-quality health care**—including **mental health care, substance use disorder** treatment, and **preventive** care—throughout pregnancy, birth, and postpartum by strengthening and funding **care coordination**, improving **communication** and **protocols**, and ensuring providers have the **skills**, **training**, and **professional support** they need to provide high-quality care**.**

2. STRENGTHEN COMMUNITY SUPPORT SERVICES

Invest in, develop, and expand comprehensive **community support services** that address **essential needs** during pregnancy and postpartum. These include strengthened

home visiting programs, **social work** services, **doula** care, wraparound support for **mental health and substance use disorder, and housing and food assistance.**

3. PROVIDE EQUITABLE, CULTURALLY RESPONSIVE CARE

Ensure **care and services** throughout pregnancy, birth, and postpartum are **culturally responsive**, **free from bias**, grounded in **trauma-informed** practices, and actively address **racial injustice**.

The recommendations in this report are particularly critical given pending Medicaid cuts and other challenges to the stability of maternal health and health care in the United States. Detailed legislative recommendations can be found on pages 16–27. Recommendations for providers, facilities, agencies, and organizations are in the Supplement starting on page 32.

Background

The legislature established Washington's Maternal Mortality Review Panel (MMRP, the Panel) in 2016 to review deaths of Washingtonians who died during pregnancy, birth, or up to 1 year after pregnancy, also known as the **perinatal period**. As required by RCW 70.54.450, the MMRP produces a report of findings and recommendations to guide the work of decision-makers on shared goals:

- Ending maternal deaths
- Preventing inequities that contribute to these deaths
- Reducing illness
- Improving care and support in pregnancy, birth, and postpartum

About the Maternal Mortality Review Panel

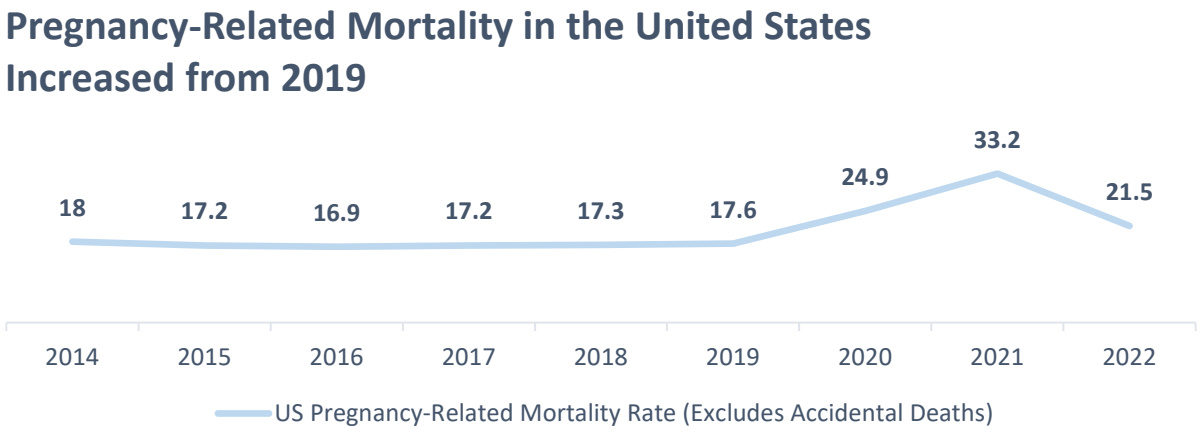
The MMRP is a panel of approximately 80 members from across Washington (listed in Appendix 2, page 55), including clinicians, nurses, doulas, midwives, Tribal health leaders, equity and social issues experts, mental health providers, patient advocates, pathologists, and others with relevant professional or lived experience. Members are appointed by the Secretary of Health and voluntarily serve a single or multiple 3-year terms.

Panel members review deaths in a way that honors each person who died and their loved ones. Using an anonymized, de-identified summary of each person's experiences of health care and support from pregnancy through death, members respectfully discuss these details and circumstances to determine which deaths were likely pregnancy-related and preventable, and to make recommendations to prevent similar deaths in the future. See Appendix 3, page 58, for more details about this process.

What is the state of maternal mortality in the United States?

The **United States has the highest maternal mortality rate among wealthy countries**. This is due to a complex set of systems-level, social, and health care access barriers.[1] **Black, Indigenous, and People of Color (BIPOC) communities disproportionately carry the burden of maternal mortality.**[2]

The U.S. Centers for Disease Control and Prevention (CDC) Pregnancy Mortality Surveillance System (PMSS) tracks maternal deaths that occur during or up to 1 year after pregnancy, from any cause complicated or aggravated by pregnancy, excluding injury deaths. According to PMSS reports, maternal mortality rates have generally increased since the 1980s. In recent years, the United States has recorded some of the highest rates in decades.[3]



Research links the rise in maternal mortality in the United States in 2020 and 2021 to the COVID-19 pandemic. This increase was due not only to the direct effects of the disease, but also to COVID-19 worsening existing health conditions and disrupting health care access.[4] A Government Accountability Office (GAO) analysis of CDC data estimated that 102 maternal deaths in 2020 and 401 maternal deaths in 2021 were related to COVID-19.[5]

National data also highlight disparities by race, ethnicity, and age. Disparities along lines of race and ethnicity are driven by long-standing, systemic racism that impacts society, well-being, and health care.[6] In 2021 and 2022, U.S. maternal mortality rates were approximately 3 to 5 times higher for non-Hispanic American Indian or Alaska Native people and non-Hispanic Black people, compared to non-Hispanic white people. People who were 40 or older at the time of pregnancy had maternal mortality rates 4 to 5 times higher than those age 25–39.[3]

Why is preventing maternal mortality so important—and so complex to solve?

✓ Every life lost has an enormous impact. So does every life saved.

Washingtonians across different political and social perspectives share a deep understanding that a death in pregnancy, birth, or postpartum is devastating, especially at a time many associate with hope and new beginnings. In addition to the person who lost their life at what is often a profoundly important time, these deaths affect children, spouses and partners, families, friends, and communities across lifetimes and into future generations. Every action to reduce maternal mortality, whether a policy change, health system improvement, allocation of funds, or effort to eliminate bias, can save lives and improve health across generations.

✓ Health during infancy sets the foundation for lifelong wellness

A healthy birth and first year set a child on a positive path for the rest of their life. Babies nurtured in safe, supportive relationships have the foundation for long-term wellness, especially during early brain development, a critical period for lifelong thriving. Harms during pregnancy, birth, and early childhood—including loss of a parent—can make it harder to thrive later in life. Investing in the stability and health of families can lead to significant returns in the form of improved health, education, well-being, and economic success across the lifespan.[7–9]

✓ Pregnancy and parenting create unique opportunities to improve the lives and health of parents and infants

Although the foundations of maternal health start prior to pregnancy—even years before—pregnancy and the postpartum period offer families unique opportunities to receive life-changing support. This may include increased health care visits, connections to social service systems that meet basic needs, peer networks that offer culturally relevant connections and social support, and public health systems that promote prevention of health conditions through early screening. Moreover, because pregnancy and new parenthood can mark a time of unique openness and positive change in parents' lives, the anticipation of a baby and raising a child often motivates parents to address physical and mental health issues, substance use disorder, or harmful relationships. Non-biased support for pregnant people and parents increases the chance of lasting positive change in parents' and children's lives.[10]

✓ Maternal mortality is the "tip of the iceberg" for maternal health concerns

Maternal mortality is called the "tip of the iceberg" because each death represents the extreme result of harmful maternal health experiences that affect many more people[11] through serious, non-fatal complications. These include illnesses in pregnancy or postpartum, or complications during birth that have serious short- or long-term health consequences. Collectively called "severe maternal morbidity," these sometimes life-threatening[12] complications can often be

prevented by the same recommendations that prevent maternal mortality, especially in communities experiencing inequities.[13]

✓ Some communities experience higher maternal mortality rates, due to systemic inequities

Maternal mortality impacts some communities in Washington at disproportionately higher rates, including American Indian and Alaska Native, Black, Native Hawaiian, and Pacific Islander communities; people over 40; those covered by Medicaid; and people in rural communities. The disparity is most striking for American Indian and Alaska Native communities, a consistent finding in every Washington state maternal mortality report. An addendum from the American Indian Health Commission at the end of this document outlines solutions from Tribal and Urban Indian leaders and communities to address these inequities.

Patients experience healthier births and maternal outcomes when they receive culturally aligned care, meaning their providers understand their cultures, meet their cultural needs, and speak their languages. Data show that communities of color and low-income communities experience mistreatment by health care systems.[10] Patients have improved health outcomes and experiences when health care, social service, and public health systems actively work to reduce bias and racism.[14]

✓ Meeting basic needs saves lives

Meeting basic needs significantly improves maternal health by addressing social determinants of health. These are non-medical factors that influence health, such as access to food, housing, and transportation, and they are essential for well-being. Parents can't meet their own needs or the needs of a newborn without stable housing, food, and safety, and they can face barriers meeting these needs during and after pregnancy.[15–21]

Preventing maternal deaths involves more than just responding to emergencies or improving health care. It also depends on upstream opportunities—often years earlier—to prevent conditions that could eventually lead to an overdose, medical emergency, mental health crisis, or barriers to care.

Voices from Washington

"My first pregnancy was very trying. I couldn't eat, I lost weight, and I couldn't take care of myself. No one's ready for the first trimester. The father left when I was 2 months pregnant. I became homeless. I started my prenatal care in one city and then continued in another, but they wouldn't listen to me, no matter how much I would tell them my concerns. It would have been helpful to have more safety nets."

Voices from Washington

"I experienced a miscarriage due to systemic racism.

My pregnancy could have been viable had they listened to my requests and not ignored me or told me what I was experiencing was normal, even though I knew it was not. I have to live with the loss of my baby the rest of my life, and with knowing my miscarriage could have been prevented."

Meeting basic needs to prevent maternal mortality supports other state priorities. Findings and recommendations in this MMRP report align with Washington's Blueprint for a Just & Equitable Future: The 10-Year Plan to Dismantle Poverty, emphasizing the mutually reinforcing nature of the MMRP and other statewide initiatives to strengthen social and health systems. (See Appendix 7 on page 70 for more details about the intersections between these reports.)

✓ Nearly half of maternal deaths are due to behavioral health conditions

There is an increased risk of depression, suicide, and overdose during pregnancy and the year after giving birth. This is connected to a combination of factors, including psychological changes during pregnancy and postpartum, personal or family health history of mental health issues, the stress of pregnancy and parenting on relationships, changes in tolerance and overdose risk, and experiences of childhood trauma.[22–24]

The Panel began reviewing deaths by suicide, overdose, and other factors connected to mental health and substance use in its 2019 report. In that report and each MMRP report since then, behavioral health conditions have been identified as the leading cause of death during and after pregnancy. In 2021 and 2022, these were primarily due to accidental overdose, accounting for just under half of all pregnancy-related deaths during that time.

What is Washington doing to prevent maternal deaths?

The last MMRP report, published in 2023, included **over 100 recommended actions**. Since then, decision-makers, agencies, institutions, health care practitioners, and communities across Washington have worked to accomplish many of these recommendations—from policy to practice. Much work remains, and many 2023 recommendations are still relevant.

Building on these recommendations, DOH launched the Maternal Health Innovations (MHI) program in 2023. The program established a **statewide maternal health task force** to identify strategic priorities and improve how Washington collects and uses **data on maternal mortality and morbidity**. In 2025, MHI funded 2 organizations to **expand maternal health services designed and led by American Indian and Alaska Native communities.** MHI also funded 2 **educational institutions to develop or expand rural nursing programs** to help address workforce shortages that contribute to hospital closures and gaps in rural maternity care.

Washington **helped more families receive home visiting** services by increasing home visiting funding and services. Through Start Early Washington, the state is also developing and implementing core competencies to strengthen and standardize the home visiting workforce. Also in 2025, Washington launched a **new Apple Health doula benefit**, after **DOH and Health Care Authority co-developed a statewide standing recommendation for doulas**—a necessary step to enable Medicaid reimbursement. Doulas with state certification can enroll as Medicaid billing providers, connecting more Washingtonians covered by Medicaid to doula support in pregnancy, birth, and postpartum. For more examples of implementing recommendations from the 2023 report, see Success Stories on page 28–29 and Appendix 6 on page 65.

Recent Bills Passed by the Legislature Aligned with 2023 MMRP Recommendations:

- **HB 1469** (2023) - Concerning access to reproductive health care services and gender-affirming treatment in Washington state
- **SB 5555** (2023) - Creating the profession of certified peer specialists
- **HB 1562** (2023) - Reducing the risks of lethality and other harm associated with gun violence, gender-based violence, and other types of violence
- **HB 1715** (2023) - Enacting comprehensive protections for victims of domestic violence and other violence involving family members or intimate partners
- **SB 6109** (2024) - Supporting children and families
- **HB 1143** (2024) - Concerning requirements for the purchase or transfer of firearms
- **SB 5580** (2024) - Improving maternal health outcomes
- **HB 1945** (2024) - Streamlining and enhancing program access for persons eligible for food assistance
- **HB 2230** (2024) - Promoting economic inclusion by creating the economic security for all grant program
- **HB 1956** (2024) - Addressing fentanyl and other substance use prevention education
- **HB 2415** (2025) - Expanding economic assistance for individuals who are eligible for temporary assistance for needy families

Recent Legislative Investments Aligned with 2023 MMRP Recommendations:

- $400k for DOH for the completion of work identified in the state opioid response plan related to maternal and infant health; SB 5187, Sec 222, 25 (2023)
- $7.7m for programs and grants to maintain abortion care access; SB 5187, Sec 222, 31 (2025)
- $40k for DOH to promote evidence-based breastfeeding guidelines for people with substance use disorder; SB 5950, Sec 222, 139 (2024)
- $1.5m for DOH to expand community-based harm reduction programs that provide evidence-based interventions, care navigation, and services; SB 5950 Sec 222, 158 (2024)
- $100k for Commerce to administer housing assistance for persons who are fleeing or who have recently fled intimate partner violence; SB 5950 Sec 127, 103 (2024)
- $1.5m for the Office of Crime Victims Advocacy for activities to address domestic violence; SB 5950 Sec 127, 137 (2024)
- $346k for perinatal opioid use disorder information and services; SB 5167 Sec 226, 14 (2025)
- $6.9m to expand DOH's distribution of naloxone; SB 5167 Sec 226, 20 (2025)
- $972k to expand DOH's Birth Equity Project with the goal of reducing prenatal and perinatal health disparities; SB 5167, Sec 226, 8 (2025)
- $211k to implement recommendations from the Community Health Workers Task Force; SB 5167 Sec 226, 19 (2025)

Findings

Maternal Mortality Review Definitions

We use the terms **pregnancy-associated deaths** and **pregnancy-related deaths** in this report. These terms come from the CDC and are used in maternal mortality reviews across the United States.

Pregnancy-associated deaths include *all maternal deaths from any cause* during a specific timeframe—during pregnancy or up to 1 year after—regardless of whether the death was related to pregnancy. "Pregnancy-associated" refers to the ***timing*** of death.

- **Some pregnancy-associated deaths are pregnancy-related**—they are **caused or worsened by pregnancy.** They happened because of either a pregnancy complication, a chain of events initiated by pregnancy, or an unrelated condition aggravated by pregnancy.

- **Some pregnancy-associated deaths are not pregnancy-related**—the cause had no connection to pregnancy. For some deaths, the Panel doesn't have enough information to determine if the death was related to pregnancy.

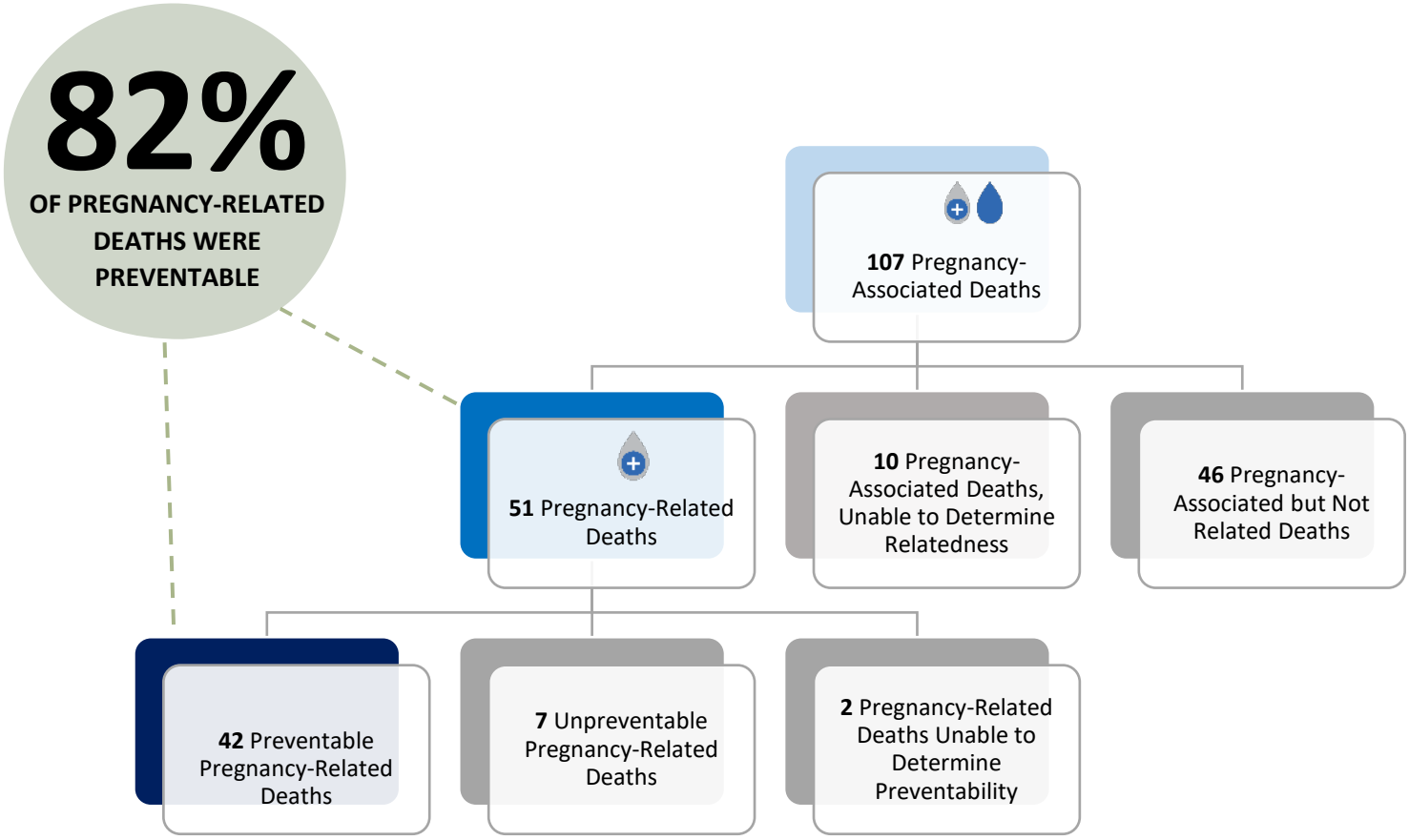
A pregnancy-related death is considered **preventable** if there was some chance the death could have been averted if at least 1 clinical or social factor had been different.

All recommendations in this report are based on pregnancy-related deaths from 2021 and 2022 that the Panel determined had a chance of being prevented.

The Panel's qualitative and quantitative methodologies are described on page 59. Additional data tables are available on page 61.

Maternal Mortality Classification, 2021–2022

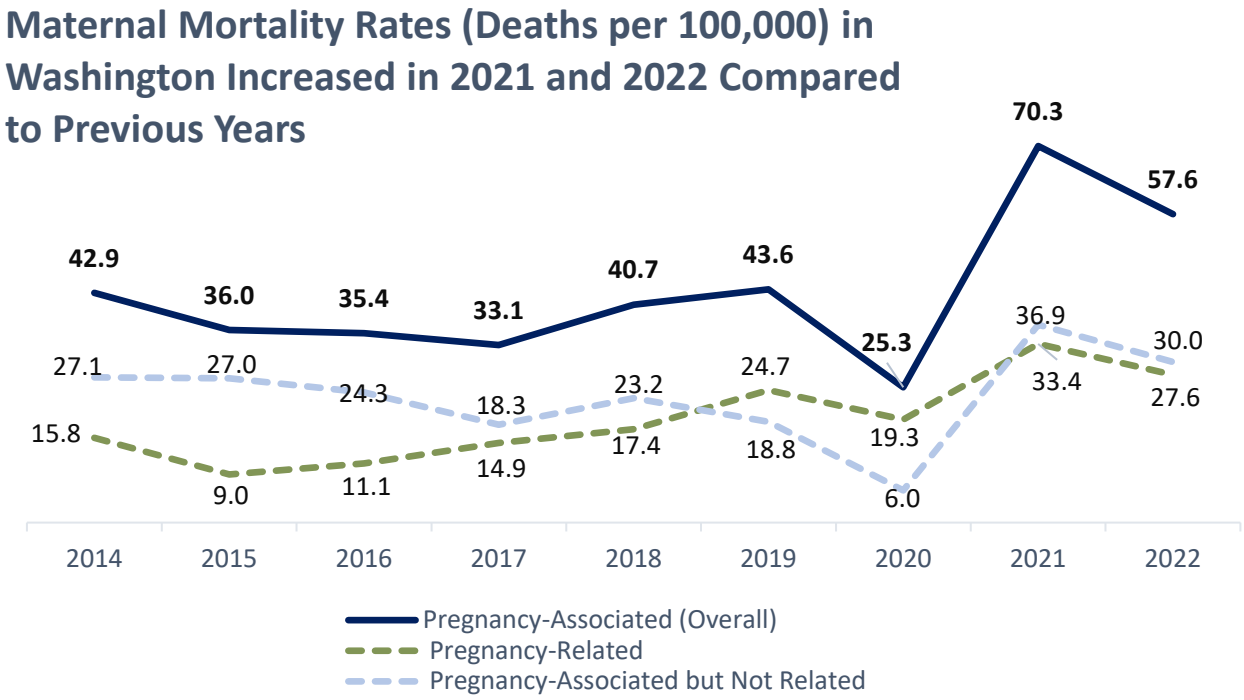
The Department of Health identified **107 pregnancy-associated deaths**. Of these, the MMRP determined that **51 were pregnancy-related.** Among the pregnancy-related deaths, **42 (82%) were preventable**.



Trends of Maternal Mortality in Washington, 2014–2022

Washington's **pregnancy-related maternal mortality rate reached its highest level in 2021, with 33.4 deaths per 100,000 live births, followed by 27.6 deaths per 100,000 live births in 2022.** These are the highest rates of pregnancy-related death in the 2014–2022 period.

Historically, Washington state's pregnancy-related maternal mortality rates have been lower than national rates. However, Washington's rates slightly surpassed national rates in 2021 (33.2 per 100,000) and 2022 (21.5 per 100,000). Washington's higher rates are due, in part, to different definitions used—the national rate excludes injury deaths, such as homicide, suicide, and accidental deaths, including overdoses. Comparisons between Washington's maternal mortality rate and the national rate should be done carefully and with clarification of differences in definitions.



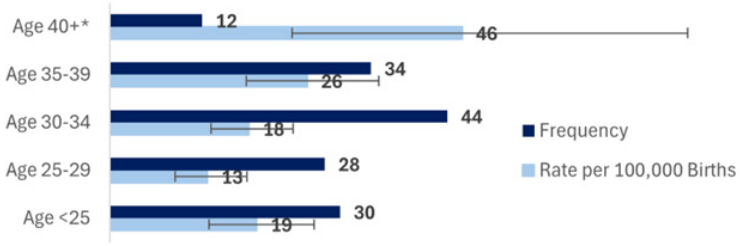
The increase in pregnancy-related maternal mortality in Washington is likely due to several factors. These include the Panel's evolving understanding of what constitutes a pregnancy-related death, resulting in more deaths being classified as such; a rise in overdose deaths,[25] particularly from non-medical use of fentanyl—which has become more widely available and lethal; and deaths related to COVID-19.

Disparities in Pregnancy-Related Maternal Mortality, 2014–2022

Pregnancy-related mortality disparities were examined over all 8 years (2014–2022) for a more reliable interpretation. As in previous maternal mortality reports, Washingtonians continued to experience inequity-driven disparities based on age, race and ethnicity, Medicaid coverage

status, and rural residence. The following graphs present both frequencies and rates. Frequency, the total number of deaths in each subgroup, shows the magnitude of deaths. Rates, the number of deaths per 100,00 live births, highlight differences in outcomes across subgroups.[i]

Pregnancy-Related Maternal Mortality Rates were Highest Among People Age 35 and Older

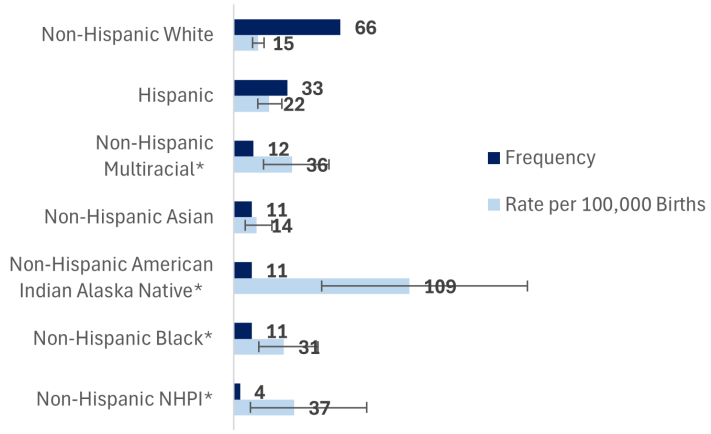


Pregnancy-related mortality was most common among the 30–34 age group.

The rate was **highest among people age 40 and older**, at 46 per 100,000 live births, followed by those age 35–39, at a rate of 26 per 100,000 live births.

These findings indicate that the risk of dying from pregnancy-related causes increases with age, especially for those over 40.

Pregnancy-Related Maternal Mortality was Highest Among non-Hispanic American Indian and Alaska Native People



*Relative standard error is 25% or over

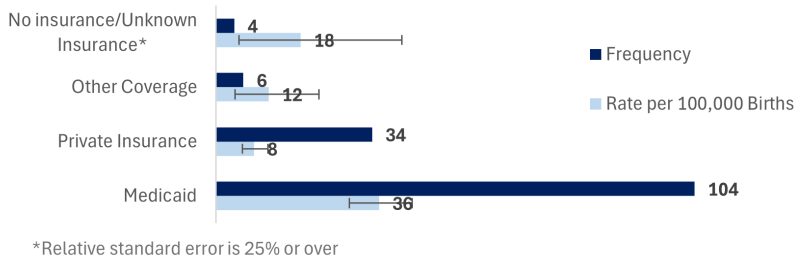
Non-Hispanic American Indian and Alaska Native people experienced higher maternal mortality rates than any other racial or ethnic group.

Their risk of dying from pregnancy-related causes was **7.3 times higher** than that of non-Hispanic white people in this period.

Although non-Hispanic white people represent the highest number of deaths, this is reflective of their larger share of the population.

[i] **Rates marked with asterisks have a standard error that is greater than 25% of the rate itself, which indicates that the estimate is statistically unstable. This level of variability suggests that the rate may not accurately represent the underlying population due to small sample sizes and maternal mortality being a rare event.** As a result, the rate should be interpreted with caution, as it may fluctuate widely with small changes in the data and may not be reliable for making definitive conclusions or comparisons.

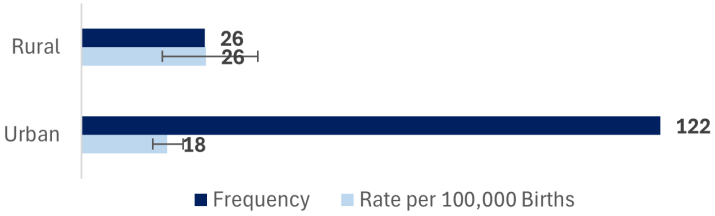
People with Medicaid as Their Primary Insurance had the Highest Rate of Pregnancy-Related Mortality



People with Medicaid as their primary insurance had both **the highest frequency** (104 deaths) and **highest rate of pregnancy-related** deaths (36 per 100,000 live births).

These figures highlight the importance of ensuring access to care and support during the perinatal period for people with Medicaid.

Pregnancy-Related Maternal Mortality was Higher for Individuals who Resided in Rural Counties



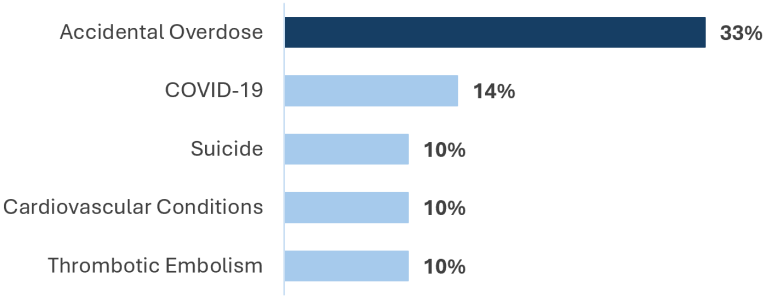
Although **122 pregnancy-related** deaths occurred among people living in urban areas, the **mortality rate was highest among people in rural areas** at 26 per 100,000 live births.

This underscores the importance of improving access to quality maternal health services in rural communities.

Cause, Timing, and Contributing Factors, 2021–2022

Behavioral health–related deaths—including by suicide, homicide, and accidental overdose—accounted for just under half (45%) of all pregnancy-related deaths during this period.

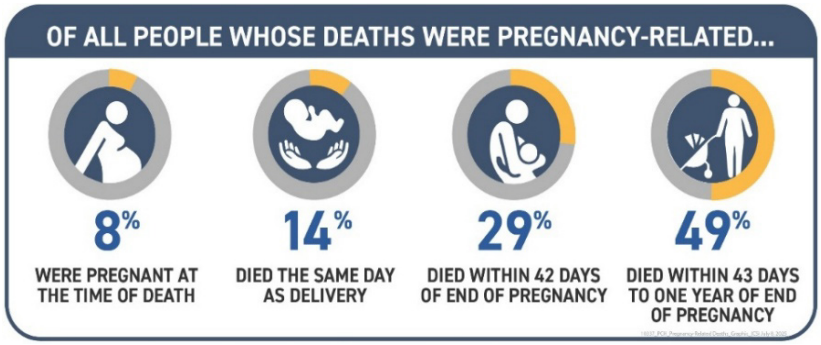
Accidental Overdose was the Leading Cause of Pregnancy-Related Deaths from 2021 to 2022



The top 5 leading causes of pregnancy-related death in 2021 and 2022 were:

- **Accidental overdose** (n=17)
- **COVID-19** (n=7)
- **Cardiovascular conditions,** including peripartum cardiomyopathy (n=5)
- **Suicide** (n=5)
- **Thrombotic embolism** (n=5)

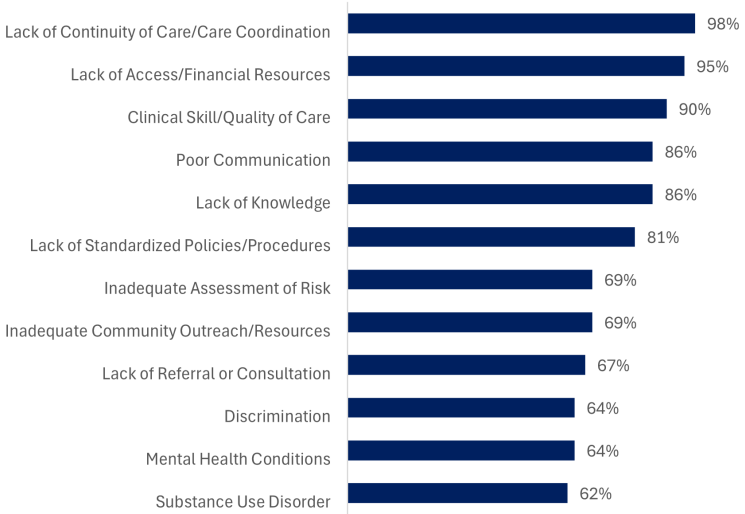
The infographic below breaks down the **timing of pregnancy-related deaths** in 2021–2022, from the end of pregnancy to death. It includes people who were pregnant at time of death (fetal demise or no birth), and people who were no longer pregnant when they died. **Nearly half of pregnancy-related deaths occurred between 43 days to 1 year** postpartum, followed by deaths within 42 days of pregnancy. These findings emphasize the importance of care, support, and health insurance coverage through 1 year postpartum.



The Panel identified **contributing factors** that led to each preventable pregnancy-related death. These factors are the **events or circumstances that, if different, the Panel believes might have prevented the pregnancy-related death.** Below are contributing factors the Panel identified for pregnancy-related deaths in 2021–2022. For each factor, the Panel made recommendations to prevent future deaths. Those recommendations are found later in this report.

Care gaps, barriers to access, and care quality were among the top factors contributing to pregnancy-related deaths.

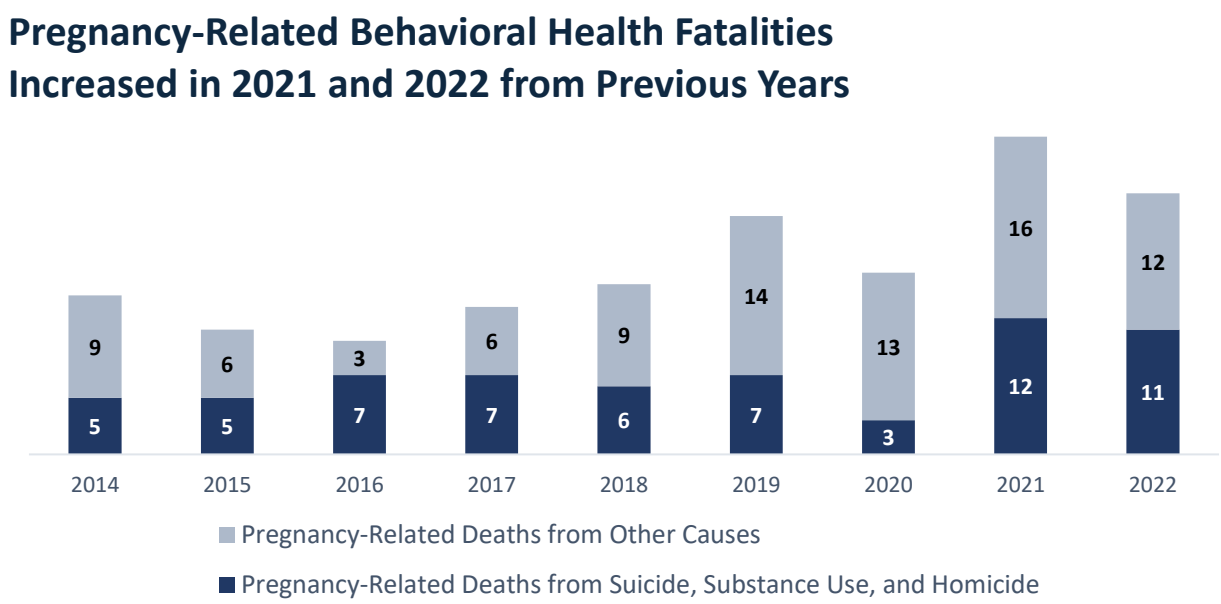
The top 12 factors identified as contributing to preventable pregnancy-related deaths, 2021-2022



The most frequently identified contributing factors in pregnancy-related deaths in 2021 and 2022 were **lack of continuity of care and/or care coordination**, which affected all but one death; **lack of access or financial resources**, which affected 95% of deaths; and **clinical skill and/or quality of care**, which affected 90% of deaths

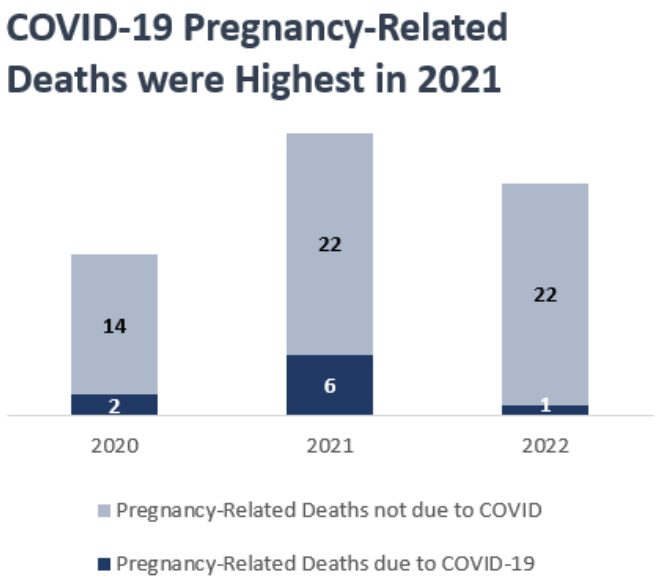
Pregnancy-Related Behavioral Health Deaths, 2014–2022

Pregnancy-related behavioral health deaths—including by overdose, suicide, and homicide—are increasing in Washington. **The majority of these deaths are due to drug overdoses (74%). Most of those overdoses involved fentanyl (76%).**



The infographic below illustrates the timing of unintentional substance overdose pregnancy-related deaths from 2021–2022 relative to the pregnancy. **82% of pregnancy-related deaths due to unintentional overdose** occurred between 43 days and 1 year after the end of pregnancy. No deaths from overdose occurred on the same day as delivery.

COVID-19 Pregnancy-Related Deaths, 2020–2022



The COVID-19 pandemic contributed to an increase in maternal mortality in Washington, particularly in 2021. COVID-19 contributed to 14% of the pregnancy-related deaths in 2021–2022.

Although COVID-19 vaccines became available in early 2021 and were widely administered throughout the year, **pregnancy-related deaths due to COVID-19 in 2021 and 2022 occurred exclusively among people who were not fully vaccinated at the time of their diagnosis.**

Notably, 78% of these deaths were among people of color.

Reviewing the new 2021–2022 data in this section, along with the MMRP's recommendations in the next section, can help decision-makers reduce maternal mortality and address the factors that cause it to impact some communities disproportionately.

Legislative Recommendations

These recommendations are based on the Panel's in-depth discussion of each pregnancy-related, preventable death in 2021–2022. The Panel made recommendations to address factors that played a role in each death, whether during pregnancy, birth, postpartum, or earlier in life. Additional context and recommendations for providers, facilities, agencies, and organizations are in the Supplement starting on page 31. Recommendations **fall under 3 priority areas:**

1. IMPROVE HEALTH CARE QUALITY AND ACCESS

Ensure Washingtonians have **access** to **high-quality health care**—including **mental health care, substance use disorder** treatment, and **preventive** care—throughout pregnancy, birth, and postpartum by strengthening and funding **care coordination**, improving **communication** and **protocols**, and ensuring providers have the **skills**, **training**, and **professional support** they need to provide high-quality care**.**

2. STRENGTHEN COMMUNITY SUPPORT SERVICES

Invest in, develop, and expand comprehensive **community support services** that address **essential needs** during pregnancy and postpartum. These include strengthened **home visiting** programs, **social work** services, **doula** care, wraparound support for **mental health and substance use disorder, and housing and food assistance.**

3. PROVIDE EQUITABLE, CULTURALLY RESPONSIVE CARE

Ensure **care and services** throughout pregnancy, birth, and postpartum are **culturally responsive**, **free from bias**, grounded in **trauma-informed** practices, and actively address **racial injustice**.

Recommendations align with Washington's Blueprint for a Just & Equitable Future: The 10-Year Plan to Dismantle Poverty, which prioritizes urgent needs, building a holistic continuum of care, and undoing structural racism.[26] (See Appendix 7, page 70.) An addendum from the American Indian Health Commission at the end of this document includes **recommendations from American Indian and Alaska Native communities and Tribal and Urban Indian leaders.**

EMERGING CHALLENGES

Since the MMRP made the subsequent recommendations, Congress approved **significant cuts to Medicaid** in July 2025. These cuts will **fundamentally alter the state's health care system and Apple Health, jeopardizing people's access to critical coverage and care**. In **rural Washington, Medicaid covers 70% of all births,** and **Medicaid enrollees account for nearly 45% of all births** statewide. Meanwhile, state funding remains limited as the most recent forecast projects revenue over the next 4 years to be even lower than previously anticipated.[26]

Considering these challenges and the uncertain times ahead, the MMRP urges the legislature to prioritize investments that protect and improve maternal health outcomes.

Priority Area #1: Improve Health Care Quality and Access

Ensure Washingtonians have **access** to **high-quality health care**—including **mental health care, substance use disorder** treatment, and **preventive** care—throughout pregnancy, birth, and postpartum by strengthening and funding **care coordination**, improving **communication** and **protocols**, and ensuring providers have the **skills**, **training**, and **professional support** they need to provide high-quality care**.**

Why Health Care Quality and Access?

Of the top 5 leading causes of pregnancy-related deaths, **3 were primarily medical** (COVID-19, cardiovascular conditions, and embolism or thrombosis). The other 2 (accidental overdose and suicide) also had clinical components, both in prevention and in treatment.

Lack of **access to care,** lack of **care coordination or continuity,** and concerns about **health care quality or provider skills** were among the **top factors contributing to maternal deaths** in 2021 and 2022 in Washington.

The MMRP recommends **broad actions to improve health care quality and access across pregnancy, birth, and postpartum.**

Recommendations in this and other priority areas intersect with **recommendations from the American Indian Health Commission**, found in the addendum at the end of this document.

Voices from Washington

Preeclampsia sent me to the ICU. Years later, a wristband saved me.

"Five days after giving birth, I went to the ER with clear symptoms of preeclampsia. I was sent home with a few pills. Just hours later, I had uncontrollable seizures and was admitted to the ICU, where I spent a week—time I should have had with my newborn.

Years later, after another pregnancy, I was again at risk. But this time, I wore a blue rubber wristband from the Blue Band Initiative, designed to alert health care providers that a patient is at risk for preeclampsia. The nurse recognized the band right away and brought me to the OB, where I was admitted and treated with magnesium.

I'm grateful to have recovered without lasting damage, but I still live with PTSD from that first experience. If I had been flagged earlier and sent directly to OB triage, I could have avoided the seizures and the trauma that followed. That blue band made all the difference—it signaled to staff that I needed specialized care."

A struggle to find rural care after a miscarriage led to an expensive emergency.

"After experiencing a miscarriage in 2024, I struggled to find a provider in my rural community. When complications arose, I ended up in the ER for an emergency procedure, which insurance later deemed "voluntary" because I only had minor hemorrhaging. The miscarriage and follow-up care cost me $10,000—my entire deductible—and left me feeling dismissed, both by my doctor and by the insurance system.

The emotional toll was overwhelming. I became severely depressed and questioned everything—including my role in public health. I had spent years encouraging others to trust the health system, only to feel betrayed when I needed it most. With therapy, peer support, and family help, I eventually began to heal and regain trust."

Legislative Recommendations for Priority Area #1

1.1 The Washington State Legislature, Health Care Authority (HCA), and Office of the Insurance Commissioner should require insurers **to establish and increase reimbursement**—and eliminate reimbursement disparities—for **essential health care services and high-quality care for pregnant and postpartum people**, including specialized care for patients with mental health conditions or substance use disorders (SUD) in pregnancy, particularly opioid use disorder (OUD).

Some overarching strategies to consider include:

- Commission and fund an analysis of how the current reimbursement and payment structures in Apple Health and the private insurer market align or do not align with actual cost of care. This should include determining whether there are reimbursement disparities between Medicaid and other payors and identifying the appropriate reimbursement for specialized care for patients with mental health conditions or substance use disorders, including opioid use disorder in pregnancy.
- For outpatient SUD and OUD service providers, develop incentive-based or performance-based payment models that reward improvements in client-focused outcome measures.
- For emergency departments and acute care hospitals, incentivize the treatment and stabilization of SUD and OUD in pregnancy and postpartum.
- Fund HCA to identify Apple Health clients at the time they establish pregnancy care. This could include reimbursing providers for complying with reporting codes or for the initial

obstetrical visit outside of the obstetrical global billing code. These changes would allow HCA to identify Apple Health clients who are pregnant and ensure better care.

- Establish or maintain reimbursement rates for high-quality, specialized care. This includes:
    - Maintain Medicaid reimbursement of community health workers for navigation services for pregnant and postpartum people.
    - Fund harm-reduction counseling in hospitals by clinical and allied health providers for pregnant and postpartum patients presenting with SUD or OUD.
    - Compensate providers for administrative time to use multiple avenues of communication (e.g., patient portals, text messages, phone) with patients, including for follow-up after missed visits.
    - Commission and fund DOH to investigate barriers to following the standards of care for opioid use disorder for pregnant and postpartum people in emergency visits, labor, delivery, and postpartum units.

1.2 The legislature should protect and increase **funding and access for family-friendly, judgment-free SUD and OUD treatment and support for pregnant and postpartum patients** across Washington, including in rural areas with limited access to community services. This includes:

- Prioritize expansion of and continuous funding for the Department of Children, Youth and Families (DCYF)'s **Plan of Safe Care** (POSC) program, a family-centered prevention plan designed to promote the safety and well-being of birthing parents and their infants with prenatal substance exposure.
- Protect existing funding and provide new funding for **additional SUD and OUD residential treatment beds** for pregnant and parenting people that allow birth parents and their infants or young children to stay together during treatment.
- Maintain funding for inpatient hospital services for Medicaid clients with active substance use, which allows for 5 days of postpartum care for withdrawal management and initiation or stabilization of medications for opioid use.
- Provide funding to reduce stigma among health care providers about SUD and OUD.
- Continue to support HCA efforts to extend postpartum coverage to ensure stabilization of parents with SUD or OUD.
- Direct DOH to develop rules requiring hospitals to have a policy for the care of infants experiencing withdrawal, that enables birth parents to room-in and provides nonpharmacological supports as the first line of care unless the birth parent is in the ICU or there are medical reasons outside of Neonatal Abstinence Syndrome (NAS) for the infant to be in the NICU or special care nursery.

1.3 The legislature should provide funding to **respond to increased health care needs** by doing the following:

- Maintain or increase funding for the WA State Health Professional Loan Repayment Program and Behavioral Health Conditional Scholarship to cover partial loan repayment for behavioral health and primary care providers.
- Provide support to increase hospital bed availability, including in rural areas to avoid additional shortages.
- Support tracking, alert, and transfer systems, such as the Washington System for Tracking Resources, Alerts, and Communication (WATrac) or the Washington Medical Coordination Center to ensure visibility of where beds are available for referral.
- Fund DOH to administer the Washington State Adult Vaccine Program to ensure vaccines are available at no cost for uninsured adults. Coverage would include the Covid-19 vaccine and other vaccines advised during pregnancy.
- Investigate whether all or part of Senate Bill 5075 *Concerning cost sharing for prenatal and postnatal care* (proposed 2025, did not pass) could be implemented to reduce the cost burden of perinatal care for patients.

1.4 The legislature and HCA should work together to restructure payment models to cover and establish a **universal 2-week-postpartum in-person or virtual check-in.**

1.5 The legislature and HCA should work together to establish a **reimbursement model** to cover **necessary postpartum visits** beyond the standard global fee to ensure appropriate monitoring and treatment of hypertension, mental health disorders, lactation issues, and chronic disease. This timely approach would reduce complications and improve maternal health outcomes.

1.6 The legislature should support policies and provide financial support to address the **shortage of maternity care and emergency obstetric care in rural areas** through 3 approaches: preserving rural and critical access hospitals; increasing the **number of rural perinatal care providers**; and increasing the resources and knowledge needed to prevent and respond to **obstetric emergencies** in rural areas. Actions include:

- **Preserve rural and critical access hospitals** through financial support and incentives, such as:
    - Offer financial incentives to hospitals that maintain labor and delivery units in rural communities, such as Standby Capacity Payments, part of the Patient-Centered Payment system. These payments address the financial challenges faced by rural hospitals by covering the fixed costs associated with essential services of staffing, equipment, and infrastructure.
    - Base Standby Capacity Payments on the number of residents in a community rather than the number of services delivered. This ensures hospitals have enough revenue to support minimum costs of running a labor and delivery unit.
- **Increase the number of perinatal care providers**, particularly in rural areas, through actions such as:
    - Direct and fund HCA to identify and implement alternative payment models or increase professional fees for physicians and midwives (certified nurse midwives

and licensed midwives) delivering perinatal care in rural areas, as a strategy to recruit and retain trained perinatal clinical providers.
    - Commission and fund DOH to investigate opportunities to expand the number of midwives (certified nurse midwives and licensed midwives) practicing, especially in rural areas, to manage non-complicated vaginal births. This work should be done in close collaboration with the Office of the Insurance Commissioner (OIC).
    - Fund the Rural Nursing Education Program to educate and train people living in rural areas who are interested in serving their own communities, through online education and innovative clinical training.
    - Offer financial incentives to behavioral health providers to serve pregnant and postpartum people in areas with maternity shortages.

- **Fund hospitals and health systems to prevent and respond to obstetric emergencies in rural and remote areas** by improving the coordination of complex, multi-specialty care. This includes connecting high-risk patients with specialists and increasing capacity for consultation, training, outreach, staffing, and telehealth. For example:
    - Provide funding to establish or expand an existing resource to build a 24/7 consultation line to support rural hospitals managing obstetric emergencies, including SUD and OUD treatment and mental health crises.
    - Commission and fund OIC to investigate the cost and benefits of coverage for room and board so high-risk pregnant clients can stay within proximity (to be defined) of a hospital that meets their health care needs.
    - Fund the DOH Office of Rural Health to distribute grants to training hospitals in urban and high-volume centers that can host rural, interdisciplinary provider teams from hospitals and birthing centers. Grants should support skills development and exposure to obstetric emergency care, cover the cost of travel for trainees, backfill staff while they are away for training, support regional training opportunities, and fund on-site and mobile OB simulation and training.

Voices from Washington

"Originally, I was interested in birthing at a birthing center, but our insurance plan didn't cover one. I would like to see more options for pregnant people to choose the kind of birthing environment that feels best to them."

Priority Area #2: Strengthen Community Support Services

Invest in, develop, and expand comprehensive **community support services** that address **essential needs** during pregnancy and postpartum. This includes strengthened **home visiting** programs, **social work** services, **doula** support, and wraparound support for **mental health and substance use disorder.**

Why Social and Community Support Services?

These services matter because external **social and environmental factors** such as housing, food, neighborhoods, education, and bias impact health.[27–29] These stressors become even more challenging in pregnancy and postpartum[30,31] and are at the **root of many maternal deaths**—including from **overdose**, which is Washington's leading cause of maternal mortality.

These issues are also interconnected. Housing instability[32] and food insecurity[30,33] are linked to maternal mental health challenges[34] and increased risk of pregnancy complications. These risks are deepened by the impacts of systemic racism.[35] All of these can contribute to or be worsened by substance use disorder.

To prevent **a wide variety of pregnancy-related deaths**, the MMRP recommends **strengthening social and community support services.**

Recommendations in this and other priority areas intersect with **recommendations from the American Indian Health Commission**, found in the **addendum at the end of this document**. Recommendations in this section also align with strategies from Washington's Blueprint for a Just & Equitable Future: The 10-Year Plan to Dismantle Poverty, particularly those about prioritizing urgent needs, ensuring foundational well-being, and increasing opportunity. For more information about intersections of these reports, see Appendix 7 on page 70.

Voices from Washington

Peer support helped me after a traumatic birth. I wish I'd found it earlier.

"After a traumatic birth that included a postpartum hemorrhage and emergency hysterectomy, I was physically saved—but emotionally adrift. Our immediate community helped with meals and frozen breast milk, and we joined a parenting group that offered support during those early weeks.

Still, I didn't meet anyone who had gone through something similar until I found an online group months later. Connecting with others who had experienced severe maternal complications was profoundly healing. I wish I'd known about those resources earlier. Providers should routinely share them—it can make all the difference in not feeling alone."

Legislative Recommendations for Priority Area #2

2.1 The legislature should increase support for programs that connect pregnant and postpartum people to **substance use disorder (SUD) and opioid use disorder (OUD) treatment and wraparound services**. Actions include:

- Fund agencies and organizations that provide community outreach or navigation to connect people to family-friendly SUD and OUD treatment and support, with particular focus on people experiencing housing instability.
- Ensure substance use treatment, including medications for opioid use disorder (MOUD), is **supplemented with longer-term wraparound services and resources as needed**, such as education, mental health support, and help transitioning to long-term housing.

2.2 The legislature should expand support for **universal access to wraparound services** through pregnancy and at least 1 year postpartum, including **home visiting, doula support, and peer support workers**. Actions include:

- Increase funding in the Home Visiting Services Account for home visiting services, including culturally tailored programs, to be available throughout the perinatal period and continuing through at least 1 year postpartum.
- Appropriate funds to enact provisions of SB 6109 (2024, passed) that mandate DCYF to provide dedicated home visiting services for families impacted by substance use disorders.[36]
- Maintain or expand funding for culturally aligned peer support workers, community health workers, and doulas to connect pregnant and postpartum people to social services and resources.
- Invest in culturally appropriate lactation support programs, including home visiting and peer breastfeeding support programs.

Voices from Washington

*"We are **not** prioritized. Our well-being isn't important in our society. Only the baby. We need a system where every single birthing parent is educated, while pregnant, about the prevalence and signs of Perinatal Mood Disorders...and the benefits of birth support such as doulas."*

2.3 The legislature should prioritize both **protecting existing and funding new** programs that **meet people's basic needs during pregnancy and postpartum**. Ideally, access to transportation, housing, income, and child care would be universally available. **Specific recommendations include:**

- Fund programs that provide tailored **housing** solutions for postpartum people experiencing homelessness. This includes housing first models (housing that is not dependent on abstinence) and temporary housing solutions for families with hospitalized newborns.
- Incentivize additional **transportation** support based on patient needs and available transportation options in each region.
- Support **guaranteed basic income or universal wage programs** during pregnancy and postpartum, along with job training opportunities, particularly for people who are unemployed.
- Support access to **high-quality, universal child care services and early childhood education**. Prioritize ensuring child care access for all **families during both routine and crisis situations**, as well as **during medical visits** to make sure child care is not a **barrier to health care access**
- At a minimum, maintain 2024-level benefits and eligibility criteria for **food assistance programs**, including Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Temporary Assistance Program for Needy Families (TANF), Fruit and Vegetable Incentive Program (FVIP), and local food banks.

Voices from Washington

"Although I had a 'healthy' pregnancy, I was severely nauseated for its entire duration and diagnosed with hyperemesis during an ER visit due to pain and blood in vomit. Pregnancy significantly impacted my quality of living and mental health. I had thoughts of self-harm. It was really HARD to see a mental health provider that was covered by insurance and affordable, available, and preferably a good match for my therapy needs—and that's with pretty good insurance coverage. Access to mental health services made a big difference for me."

2.4 The legislature should work with state agencies to **prevent** and **reduce the impact of trauma**. Mitigating childhood trauma helps prevent future maternal health complications and reduces the risk of developing SUD or OUD. Supporting birth parents who have relinquished an infant, either voluntarily or through child welfare systems, helps stabilize their behavioral health, which can reduce maternal mortality. Actions include:

- Invest in local social support systems that provide trauma-informed care for children and young adults impacted by child abuse and neglect.
- Amend the existing Safe Haven statute to extend the infant surrender period from 72 hours to at least 30 days postpartum.[37]
- Develop tailored public health messages and awareness campaigns. Messages and media campaigns should include information about the National Domestic Violence Hotline and focus on healthy relationships, consent, respect, bystander intervention, and recognizing acceptable and unacceptable behaviors.

Priority Area #3: Provide Equitable, Culturally Responsive Care

Ensure **care and services** throughout pregnancy, birth, and postpartum are **culturally responsive**, **free from bias**, grounded in **trauma-informed** practices, and actively address **racial injustice.**

Why Equitable, Culturally Responsive Care?

Discrimination, bias, interpersonal racism, or structural racism contributed to **76% of Washington's preventable, pregnancy-related deaths** in 2021–2022, including bias against people with substance use disorder. The maternal mortality rate was more than 7 times higher in American Indian and Alaska Native communities than in non-Hispanic white communities—a disparity consistent across all Washington MMRP reports to date. Rates among Non-Hispanic Black, Native Hawaiian, Pacific Islander, multiracial, and rural communities, as well as people covered by Medicaid, were also disproportionately high.

The MMRP recommends taking action to reduce inequity, bias, structural racism, and violence—including intimate partner violence and gender-based violence—that drive maternal deaths.[38] This recommendation aligns with research showing that without addressing inequities and biases, other efforts to reduce maternal mortality will have a limited impact.[39]

Recommendations in this and other priority areas intersect with **recommendations from the American Indian Health Commission**, found in the addendum at the end of this document. Recommendations in this section also align with strategies from Washington's Blueprint for a Just & Equitable Future: The 10-Year Plan to Dismantle Poverty, particularly those about undoing structural racism, ensuring foundational well-being, and building a holistic continuum of care. For more information about intersections of these reports, see Appendix 7 on page 70.

Voices from Washington

A culturally aligned midwife and a Families of Color support network helped me get the birth experience and child care I needed.

"I started my labor at a birth center, but after four difficult days, I had to transfer to a hospital. I was grateful that my midwife, someone I trusted and who shared my cultural background, helped transfer me to a hospital midwife and prepared me and my partner to advocate for a vaginal birth with minimal interventions.

What we needed most after birth was ongoing support. Child care was unaffordable, and I had to return to work just four months postpartum while still managing depression and milk supply challenges. My husband and I lived apart during the week, and child care options felt out of reach. Through a Families of Color network, we were able to join a nanny share—without that connection, I don't think I could have kept my job or accessed the therapy I needed."

Legislative Recommendations for Priority Area #3

3.1 The legislature should support **culturally aligned care** for pregnant and postpartum people. Actions include:

- Increase funding for culturally adapted home visitation, peer support, and care navigation programs embedded in communities experiencing the greatest disparities in maternal outcomes.
- Maintain and expand multi-year funding for community organizations that provide culturally specific, trauma-informed care programs, through models such as the DOH Parenting and Birth Support program's support of community organizations.
- Support Tribal and Urban Indian communities in leading mental health and healing initiatives that honor the unique cultural and historical contexts of American Indian and Alaska Native communities.
- Fund education and training for Indigenous midwifery and ancestral birth practices.
- Expand and improve certified medical interpretation services across Washington by allocating funding to grow the interpreter workforce.
- Invest in a diverse maternity service and behavioral health workforce to increase the availability of counselors, therapists, and psychiatrists serving people across clinics, hospitals, and communities statewide.

Voices from Washington

"I'm of African descent and it's really hard to find a provider of color in Washington. It is also hard to find any practitioner that even inquired about LGBTQ patients or that was knowledgeable about the queer community. The understanding and language was not there."

3.2 The legislature should support pregnant and postpartum people experiencing **intimate partner violence** by providing low-barrier access to services and making systems changes to **increase safety**. Actions include:

- Expand long-term transitional housing opportunities for pregnant and postpartum people experiencing, or with a history of experiencing, interpersonal violence.
- Promote universal training for clinical providers regarding the risks of relational violence during the perinatal period, and the importance of screening and counseling for relational health in all pregnant and postpartum patients.
- Fund primary prevention initiatives, including community-based organizations and coalitions working in gender-based violence prevention.

- Ensure that people who perpetrate violence are required to participate in rehabilitation services, including counseling and peer support services. Enforce consequences for not completing mandatory requirements.
- Ensure county governments properly enforce Extreme Risk Protection Orders (ERPO) and Domestic Violence Protection Orders (DVPO) to prevent homicide and suicide.
- Require mandatory training for law enforcement and other parts of the criminal legal system regarding preventing intimate partner violence. Topics should include:
    - Increased risks of intimate partner violence in pregnancy and postpartum.
    - Requirements of enforcing Extreme Risk Protection Orders (ERPO) and Domestic Violence Protection Orders (DVPO) to remove access to firearms in cases of suicidality or intimate partner violence.
    - Prevalence of homicide and suicide among pregnancy-related deaths in Washington.
- Fund an awareness campaign for pregnant and postpartum people about legal protections for people experiencing interpersonal violence, including information on how to apply for an Extreme Risk Protection Order (ERPO) and Domestic Violence Protection Order (DVPO) through the court system. This must be combined with efforts to strengthen infrastructure for and enforcement of ERPOs and DVPOs to avoid putting the onus only on survivors.
- Fund DSHS, the Washington State Coalition Against Domestic Violence, or a similarly connected organization to work with intimate partner violence survivors to develop further recommendations for the state to improve service delivery and create systems change within the intimate partner violence support system, ensure accountability, and remove the burden of finding safety from survivors.

Success Stories: Implementing 2023 MMRP Recommendations

Implementing MMRP recommendations happens statewide through both centralized and decentralized efforts. These include, but are not limited to, the legislature's policy and funding actions; coordinated efforts by the Washington State Perinatal Collaborative (WSPC), DOH, HCA, health systems, and professional associations; and local efforts led by local health departments, providers, facilities, and community organizations.

Here are some stories from perinatal health and public health professionals across Washington about their experiences implementing 2023 MMRP report recommendations. For more examples of implementing 2023 MMRP recommendations, see Appendix 6 on page 65.

✓ Success Story: A Birthing Center Distributes Naloxone to Save Lives

MMRP 2023 Recommendation 2.9: Facilities should give birth parents who use or have used opioids or other prescribed substances take-home doses of naloxone—not just a prescription—before they discharge from the hospital. Patients and families should be trained on its use. Ensure that Medicaid and private plans fully reimburse facilities for the purchase of naloxone.

"Our birthing center cares for 3–5 patients a month who meet the criteria for naloxone at discharge. Thanks to a donation from WSHA (Washington State Hospital Association) and direct recommendations from a pilot study led by the Naloxone Project, as of March 2024, we are now able to hand patients a take-home pack of two doses of naloxone and review education on its use before discharge.

The MMRP recommendation led to statewide initiatives that removed significant barriers—such as cost and awareness—allowing inpatient pharmacies to send patients home with naloxone rather than only providing a prescription."

✓ Success Story: Hospitals Follow Best Practices for Substance Use-Affected Newborns

MMRP 2023 Recommendation 2.14: Facilities should implement best practices in supporting the parent–infant dyad after delivery. This includes implementing practices like the Eat-Sleep-Console model and the Compassionate Care Model, which allow for the dyad to remain together throughout the hospital stay while plans for treatment and recovery are initiated.

"In June 2023, DOH announced that hospitals must adopt best practices for caring for newborns affected by substance use, following the MMRP report's February 2023 recommendation. These practices include using non-pharmacologic approaches as the first-line treatment, such as the Eat, Sleep, Console model of care.

This announcement gave hospitals an increased incentive to implement internationally recognized best practices and align with state policy. DOH also funded consultants to support

hospital leaders in implementation. All Washington hospitals are expected to have fully adopted this standard in 2025."

✓ Success Story: Supportive Services Now Covered by Apple Health CHW Benefit

MMRP 2023 Recommendation 5.11: Strengthen care coordination systems that connect pregnant and postpartum patients to appropriate, culturally relevant social supports, navigators, and other service options.

"Washington implemented a new Community Health Worker (CHW) benefit that became live on July 2025, as part of a State Plan Amendment (SPA). The Apple Health CHW benefit is designed to support community-based health initiatives and improve access to care by providing preventive health services.

Now, Washingtonians with Apple Health insurance plans can receive supportive services covered by insurance when performed by CHWs within the scope of their practice. Those services include person-centered assessment, goal setting, and care planning; care coordination and health system navigation; facilitating behavior change; and health education and promotion."

✓ Success Story: Pediatricians Connect Families to Mental Health Care and Support

MMRP 2023 Recommendation 2.12: Providers across the perinatal service continuum, including pediatric and family practice providers offering well-child visits, should routinely screen all patients for behavioral health issues, including alcohol, nicotine, and other substance use and suicide risk.

"In 2024, our pediatrics practice read the sobering findings of the 2023 MMRP Report, especially the number of deaths occurring 6 to 12 months after birth. In response, we added mental health screening for parents at the 9- and 12-month well-child visits. We use this as a chance to check in—an invitation to ask how parents are coping and what support they need.

When a concern comes up, our care team, including CHWs, helps families connect to mental health care and social support. We're now co-designing this program with family leaders to offer two caregiver screenings in the first year—because the mental health of all parents and caregivers matters deeply, and follow-up should never be left to chance."

Although these stories reflect how Washington has worked to save lives and improve care, the state experienced an increase in maternal mortality in 2021–2022, due to ongoing and emerging challenges during pregnancy, birth, and postpartum, as well as stressors from social and economic factors, an ongoing pandemic, a rise in substance use disorder, and other factors.

Legislative Conclusion

The Washington State Legislature is recognized nationally for investments, innovation, and legislation to prevent maternal mortality and improve perinatal health. In uncertain times, these investments must be strengthened to maintain a deep commitment to the well-being of all pregnant people, parents, and infants in Washington. This report highlights critical opportunities to save lives and improve maternal health outcomes for current and future generations through policy reform, health system improvement, and strategic investment.

Maternal mortality is on the rise in Washington, and most pregnancy-related deaths are preventable. These deaths disproportionately affect American Indian, Alaska Native, Black, Native Hawaiian, and Pacific Islander communities, as well as multiracial people, people living in rural areas, those age 40 and older, and those enrolled in Medicaid. The recommendations of the Maternal Mortality Review Panel in this report aim to address the root causes of maternal deaths, including the elimination of systemic bias and barriers to basic needs; to maintain and strengthen access to high-quality care; and to improve health and well-being for all during the critical perinatal period.

This report will hold particular importance in the coming years as we navigate challenges such as reductions in health and social services, particularly those that impact reproductive and maternal health.

The Washington State Department of Health is committed to working in partnership with the legislature, health care providers, researchers, other agencies, and community members to implement sustainable, effective, and equitable solutions and initiatives aligned with the recommendations outlined in this report.

Recommendations for health systems, agencies, providers, institutions, and organizations can be found in the supplement following this conclusion.

RECOMMENDATIONS SUPPLEMENT

Detailed Recommendations for

- ***Health Systems***
- ***Health Care and Support Providers***
- ***State and Local Agencies***
- ***Academic Institutions***
- ***Organizations***

Detailed MMRP Recommendations

The Panel makes the following recommendations to health care and support providers, facilities, health systems, agencies, organizations, and other entities working to save lives by preventing future maternal deaths in Washington. These recommendations are based on the Panel's in-depth discussion of every pregnancy-related, preventable death of a Washington resident, including identifying what factors may have played a role in each death.

These build on the broader legislative recommendations found on pages 16–27.

This icon indicates a recommendation that would require legislative funding support.

Priority Recommendation #1: Improve Health Care Quality and Access

Why Health Care Quality and Access?

The MMRP recommends **broad actions to improve health care quality and access throughout pregnancy, birth, and postpartum**. Complementing the legislature's policy-level actions, health systems, health care facilities, and providers can implement critical improvements.

MMRP findings underscore the importance of improving health care quality and access throughout the perinatal period—and even years before. Of the top 5 leading causes of pregnancy-related deaths in 2021–2022, 3 were primarily medical (COVID-19, cardiovascular conditions, and embolism or thrombosis). The other 2 (accidental overdose and suicide) have clinical components to both prevention and treatment. Lack of **access to care,** lack of **care coordination or continuity,** and concerns about **health care quality or provider skills** were **among the top factors contributing to maternal deaths** in 2021 and 2022 in Washington.

Maternal mortality is worsened by **health care system limitations,** due in part to:

- **Shortages** of funding, health care providers, hospital beds, expertise, and care in certain regions.
- **Gaps** in coordination, communication, referral, training, or appropriate care.
- **Disparities** in resources, reimbursement, funding, care availability, and other areas.
- **Misaligned priorities—**such as placing profit over care access.
- **Missed opportunities** in making decisions about care.

For example, health system factors and low reimbursement rates also contribute to **closure of hospitals, obstetric units**, and clinics, particularly **in rural areas and maternity care deserts**—closures that may be exacerbated by **provider shortages**[40,41] and financial pressures related to insurance costs and profit-driven business decisions.[42] Obstetric care services in rural areas are declining at an alarming rate, with over half of hospitals no longer offering obstetric care—[43] raising concerns about and increasing risk of maternal mortality, as well as delayed care.[44,45]

Amid these systemic challenges, pregnant and postpartum people face **barriers to accessing high-quality care, even when services are available in their region.** Barriers include limited access to **family-friendly substance use disorder treatment**[46,47] that supports birth parents staying with their children; delays in **receiving timely and appropriate care** to respond to life-threatening symptoms; and **lack of specialized care options** for high-risk patients in **rural areas.**

Addressing these barriers requires **coordinated, comprehensive solutions at the policy level and across the continuum of care**. Research suggests combined approaches with both short-term and long-term strategies can more effectively improve health care quality and access, by

responding to urgent issues while tackling systemic challenges and root causes. For example, reimbursement changes can improve care quality and access when combined with broader systems-level reforms, especially for mental health outcomes,[48] and payment restructuring can improve access to postpartum care.[43]

At the individual level, too, some short-term treatments hold longer-term benefits. For example, increasing access to family-centered treatment for substance use disorder can reduce harm from intergenerational trauma.[49,50] And state laws that support harm-reduction strategies such as widespread distribution or availability of naloxone and fentanyl testing strips are among the most effective methods to reduce overdose deaths.[51]

These examples suggest a breadth of strategies can maintain and improve health care quality and access—whether to improve clinical preparedness for obstetric emergencies, protect vaccine availability, address provider shortages, or improve rural care access. **The recommendations that follow, in addition to legislative recommendations presented previously, offer solutions to address many of these systemic barriers.**

RECOMMENDATIONS FOR HEALTH SYSTEMS, PROVIDERS, AGENCIES, INSTITUTIONS, AND ORGANIZATIONS

Obstetric Emergencies

1.7 DOH, in partnership with the Washington State Perinatal Collaborative (WSPC), should develop time-limited **workgroups to focus on systems changes for obstetric emergencies**, with the following goals:

- Increase quality of obstetric emergency care through strategies to improve practice documents, strengthen treatment plans, and expedite consultations and assessment by obstetric providers, Emergency Medical Services (EMS), and urgent care providers.
- Explore regional perinatal care models, such as a "hub-and-spoke" model.
- Draft professional guidelines to help determine by risk level when a patient should be referred to midwifery or to obstetric care.

1.8 Hospital systems should provide training and develop policies and procedures to ensure that providers and staff, including emergency department and urgent care providers and staff, **recognize, respond to, and manage pregnancy-related emergencies across settings**. This includes all hospitals that offer emergency services, regardless of whether they provide obstetric services.

Management of Cardiovascular Disease, Sepsis, and Hemorrhage

1.9 The Washington State Perinatal Collaborative should expand awareness, **early identification, prevention, and management of cardiovascular disease (CVD) and hypertension during pregnancy and the postpartum period**. Examples include:

- Improve monitoring of cardiac health during the perinatal period, especially for patients with substance use disorder.
- Expand the Blue Band Initiative for hypertensive management.
- Develop recommendations for a more **sensitive and specific screening tool for CVD-related pregnancy risk.**
    - In the interim, the WSPC could adopt the California Maternal Quality Care Collaborative cardiovascular screening guidelines.
- Expand education for rapid hypertensive episode treatment.

1.10 Health care facilities should have a practice in place that supports **prompt and evidence-based lifesaving care for patients with sepsis.** This practice should align with recommendations on maternal sepsis from the Society for Maternal-Fetal Medicine and RCW 70.41 requirements to include obstetric and post-abortion considerations.

1.11 Health systems, facilities, and providers should ensure **people at risk for pregnancy-related complications** due to hypertension, diabetes, and severe or unmanaged asthma have the **knowledge and resources they need to monitor and maintain their health** during pregnancy to avoid complications. This includes:

- Health systems should ensure patients with chronic diseases who are planning a pregnancy should receive guidance on the management of their conditions during pregnancy, and that all pregnant patients are screened for chronic conditions upon entry into prenatal care.
- Facilities and providers should ensure patients have **access to health supplies and medications to manage their health conditions**. These health supplies include blood pressure cuffs, glucose monitors and test strips, antihypertensive medications, or insulin, including ways to ensure access even when a patient's insurance does not.
- Health systems should ensure pregnant and postpartum patients with chronic conditions such as hypertension, asthma, or diabetes receive **coordinated, comprehensive care and wraparound interventions**.
- DOH, HCA, and MCOs should **raise awareness among providers and billing staff about current policies allowing for Medicaid reimbursement outside of the global codes for additional pregnancy monitoring visits** for patients with high-risk medical conditions when more frequent visits are medically necessary.

1.12 Health systems, facilities, and providers should prioritize **management of postpartum hemorrhage** to minimize impact of blood loss on pregnant and postpartum patients. Practices should ensure prompt hematology and blood bank consultation when complex antibodies or blood types are identified, with early blood product requests if transfusion is likely. Additionally, 24/7 access to specialists in hematology, blood bank, coagulopathy, and maternal-fetal medicine must be universally available to support timely, expert care.

Vaccines

1.13 State and local agencies, health care systems, facilities, providers, and community organizations should **follow best practices in health communication to counter health misinformation and disinformation** about vaccines or other topics relevant to health in pregnancy and postpartum. Priority messaging should focus on communities with lower vaccine rates and a higher prevalence of vaccine hesitancy, using best practices to help patients build vaccine confidence.

1.14 DOH should continue to **recommend vaccines aligned with science-based vaccine policies for pregnant and postpartum people**.

1.15 DOH should promote its **standing order for COVID-19 vaccine** for all pregnant people.

1.16 Providers, pharmacies, and DOH should promote and maintain **access to vaccines during pregnancy** for vaccine-preventable diseases, in alignment with science-based vaccine recommendations and policies:

- Providers should increase access to vaccines for preventable diseases especially in communities with lower vaccination rates.
- Health care providers and pharmacies should maintain vaccine availability in their facilities.
- Providers and pharmacies should enroll in the DOH Adult Vaccine Program, which increases access to vaccines.
- Providers should use patient navigators to help build vaccine access and confidence.

Behavioral Health

1.17 Health systems, behavioral health facilities for mental health treatment, and inpatient psychiatric care providers should **increase and prioritize access to judgment-free, family-friendly care programs for pregnant and postpartum people, including increasing available beds in existing and new facilities providing treatment that keep birthing parents and infants together.** Health care systems and facilities should also **increase provider training on perinatal SUD and OUD treatment practices**.

1.18 Providers should **establish collaborative-care or team-based models of care that ensure coordination of behavioral health care across the perinatal period**. This coordination is especially important in cases where patients experience co-occurring behavioral health disorders to support comprehensive and integrated treatment.

1.19 Health care systems and facilities, including emergency, urgent care, and pediatric care settings, should have **processes in place for diagnosis, referral, transfer, and treatment in cases of acute postpartum depression and postpartum psychosis**.

1.20 Health care systems should ensure all providers, including those in emergency care settings, **deliver comprehensive, compassionate, timely, and evidence-based care for pregnant and postpartum people with known or suspected** SUD or OUD, including **pain management**. Care should be non-judgmental, coordinated, and documented clearly.

1.21 Health care systems should implement, standardize, and document **universal behavioral health screenings across all perinatal care settings**, including prenatal and postpartum visits, emergency departments, and pediatric clinics.

1.22 DCYF should help health care systems and providers **strengthen support for pregnant and postpartum people experiencing substance use disorder who may not otherwise seek care if they fear intervention by Child Protective Services (CPS)**. This includes:

- Strengthening collaborative relationships between health care providers and CPS to **ensure pregnant and postpartum people seeking treatment for substance use disorder or mental health concerns can receive care without fear of unnecessary child removal**.
- Offering widespread **implementation of Plan of Safe Care pregnancy and at-birth community pathways to equip SUD-exposed families** with a prevention plan and connection to voluntary, wraparound services.

1.23 State and local health departments, health systems, health care providers, and relevant community organizations should **raise awareness about urgent maternal warning signs, perinatal mood and anxiety disorders, and SUD or OUD in pregnancy** through public health messaging strategies and patient education.

1.24 DOH should explore legislative and rulemaking opportunities to **strengthen hospital implementation of best practices in withdrawal management** for birthing parents and newborns, including the Eat, Sleep, Console model, and adult **treatment of opioid use disorder**.

1.25 DOH should identify additional naloxone distribution points in public spaces.

1.26 DOH, other state agencies, and providers should **promote the safety and efficacy of naloxone, buprenorphine, and methadone use during pregnancy**.

Care Coordination

1.27 Health care facilities should follow and enforce discharge protocols to **ensure patients are not discharged prematurely from emergency care or labor and delivery** and that they **receive appropriate care before, during, and after discharge**, particularly for patients with complex or high-risk conditions. For additional information, visit the DOH MMRP webpage.

1.28 Health care systems and facilities should establish a streamlined approach to **ensure providers have 24-hour access to specialty consultations, care, and help with referrals, as needed**.

1.29 Health systems and facilities should implement integrated **patient-centered models for pregnant and postpartum people, especially for those with high-risk conditions or complex needs**. Actions include:

- Provide coordinated, **co-located care** for pregnant and postpartum people with mental health and substance use concerns, including a history of suicidal thoughts or attempts.

- **Provide support resources** such as maternity support services (MSS), infant case management (ICM), doulas, counseling, and social workers, and conduct external evaluation by caregivers and recipients of services for continuous improvement, consistency, and quality.
- **Maintain multi-faceted or universal care coordination teams** consisting of health care providers, social services providers, substance use disorder treatment providers, and Child Protective Services workers for pregnant and postpartum people experiencing substance use issues.
- **Integrate midwives (certified nurse midwives and licensed midwives) into obstetric practices**, hospital settings, and residency programs alongside physicians to allow for triaging and coordination of care.
- **Provide early collaboration between perinatal care providers** (e.g., OBs, FP-OBs, CNMs, LMs) and **specialty providers** (MFM, oncologists, endocrinologists, psychiatrists, psychologists, etc.), allowing for early transfer to a higher level of care when recommended or clinically indicated (OB, MFM, inpatient, etc.).
- Ensure prenatal care teams have access to **care coordination and referral options** for patients with perinatal mood disorders.
- Expand **use of the Team Birth approach** in which all team members are in discussion with the patient throughout their care.
- Increase **availability of Centering Pregnancy** or other culturally appropriate group prenatal care models.
- Ensure **appropriate and timely follow-up** after missed or "no-show" appointments, positive screenings, high-risk diagnoses, referrals, or care transitions.

1.30 Health systems should join and actively participate in the state **Health Information Exchange (HIE)** to ensure providers have access to a patient's complete health history, social determinants of health information, and treatment plans. This includes:

- Confirm and use a nationally certified electronic health record system, as required by U.S. Centers for Medicare & Medicaid Services (CMS).
- Join the state HIE and authorize data-sharing across WA health systems and with DOH.
- Join the Trusted Exchange Framework and Common Agreement (TEFCA) and authorize national data-sharing to support treatment, individual access, and public health.

Patient-Centered Care

1.31 Health care systems should implement a comprehensive training framework to **ensure providers use consistent screening tools to assess trauma history and mental health; embrace shared decision-making; and prioritize listening to and validating pregnant, birthing, and postpartum patient experiences**. Include stories from patients with lived experiences in training frameworks.

1.32 Providers and payors should allow for **alignment with recommendations from the American College of Obstetricians and Gynecologists (ACOG) to adapt visit frequency and monitoring schedule** as determined by the medical and social needs of the individual.

1.33 Payors should make sure providers are **aware of the flexibility in patient care modifiers to receive extra payment for higher risk pregnancies**.

1.34 Agencies, health care systems, facilities, and providers should increase **access to low-barrier comprehensive sexual and reproductive health care** along the entire reproductive health continuum in a range of settings, including SUD and OUD treatment facilities, local health departments, pharmacies, mobile units, community clinics, and home visits.

Serving Unhoused People

1.35 State and local agencies, including HCA, DOH, Department of Commerce, local health departments, health systems, and community organizations should follow strategies for medical outreach and workforce development to **increase access to prenatal, postpartum, and primary care for unhoused people**. Examples include:

- Health systems should expand care to include **certified nurse midwives** (CNM), **licensed midwives** (LM), and **advanced registered nurse practitioners** (ARNP) as needed, due in part to physician shortages.
- DOH should work with local health jurisdictions to fund and organize **mobile medical outreach teams** to deliver prenatal and primary care to unhoused people and people with transportation access challenges. This includes following promising models such as Public Health - Seattle & King County's Street Medicine Program or DOH's Care-a-Van.
- DOH should develop **a training** to increase the number of **specialty-trained perinatal health care professionals** providing postpartum care to **unhoused people**.

Rural Maternity Services and Workforce

1.36 State and local agencies, academic institutions, and health systems should **address the rural provider shortage** by offering **loan repayment programs**, **employee housing**, or other **creative compensation benefits** to make **rural health care roles** more enticing to potential candidates.

1.37 Health care systems should **expand virtual health care options** (a.k.a. telehealth), particularly for patients in rural and remote areas.

1.38 Academic institutions and health care systems should **collaborate to recruit and retain rural students for medical and nursing programs, establish training programs within rural communities, and invest in training local nurses, midwives (including certified nurse-midwives and licensed midwives), and community health workers.** These efforts will increase the number of health care providers from and familiar with rural populations. These providers are also more likely to return to and remain in underserved areas, helping address critical needs such as primary care, maternal health, and community outreach.

1.39 Health systems, educational institutions, and relevant agencies should **expand and support the midwifery workforce** of certified nurse-midwives (CNMs) and licensed midwives (LMs) to provide care for low-risk pregnancies. This can help ensure obstetricians focus on more complex cases, while helping patients access culturally aligned midwifery care.

Emergency Preparedness

1.40 Agencies, particularly DOH and HCA, as well as health systems, facilities, and providers should **plan and train proactively for future pandemics, health care interruptions, and other disasters** to ensure high-quality perinatal care will be available, especially for high-risk patients. This includes:

- Including **obstetrical representation in the emergency planning** process.
- Establishing **contingency plans** to maintain access to essential health care.
- Prioritizing obstetric, reproductive, and gynecological services during times of limited health care availability.
- Ensuring **reimbursement for virtual health care (aka telehealth)** services.

Priority Recommendation #2: Strengthen Community Support Services

Why Social and Community Support Services?

To prevent **a wide range of pregnancy-related deaths**, the MMRP recommends **strengthening social and community support services**. These include doula care, social work, home visiting, family-friendly mental health and substance use disorder treatment, and community-based organizations that connect people to housing, food, financial assistance, and other basic needs.

These services matter because external **social and environmental factors** such as housing, food, neighborhoods, education, and racism affect health,[30,52] as do commercial factors like systems prioritizing profits over health equity.[27] These stressors are even more pronounced in pregnancy and postpartum,[30] and are at the **root of many maternal deaths**—including deaths from **overdose**, Washington's leading cause of maternal mortality.

Barriers to access, especially financial barriers, were identified in 95% of preventable, pregnancy-related deaths. **Nearly one-third** of pregnancy-related deaths were among people who faced **housing instability** or **were unhoused**; of those, **over half** were associated with **substance use**. Pregnant people who are unhoused face significant barriers to receiving prenatal care.[53]

These issues are interconnected. Housing instability[32] and food insecurity[30,33] are linked to maternal mental health challenges[34] and increased risk of pregnancy complications—a risk deepened by impacts of racism.[35] These factors can both worsen or be worsened by substance use disorder.

Maternal mental health is on the decline.[54] Perinatal depression is linked to increased substance use disorder[55] and is a strong predictor **of suicide risk** in pregnancy, postpartum, and even years after.[56] **Yet access to mental health care and substance use treatment is already limited**, and it's **getting harder** to access due to a shortage of mental health providers, many of whom no longer accept insurance.[57] Medicaid enrollees face additional barriers, as even fewer mental health providers accept Medicaid, often due to low reimbursement rates.[58]

Research suggests support services like **doula care** improves physical and mental **health outcomes** in pregnancy, birth, and postpartum, especially for **communities of color and Medicaid enrollees**.[59,60,61,62] **Home visiting** can improve perinatal **health outcomes,** identify early postpartum complications, and reduce barriers to **substance use disorder treatment**.[63,64]

Research also connects strategies to **meet basic needs** in pregnancy and postpartum with reducing drivers of maternal mortality. **Food assistance** reduces risks of **pregnancy complications** linked to food insecurity[65] and of suicide.[66] Safe, affordable **housing** is associated with **better maternal health and birth outcomes**.[17,67] And meeting basic needs earlier in the life course may also be protective in pregnancy and postpartum; stress from factors such as suboptimal housing early in life has been linked to worsened birth outcomes later on.[68]

The MMRP recommends **broad actions to strengthen community support services available throughout pregnancy, birth, and postpartum** through solutions that protect mental health and help people navigate social and environmental stressors in the perinatal period. The following recommendations, in addition to the legislative recommendations shared previously, strengthen community support systems to help meet basic needs, address behavioral health challenges, and provide wrap-around support to families.

RECOMMENDATIONS FOR HEALTH SYSTEMS, PROVIDERS, AGENCIES, INSTITUTIONS, AND ORGANIZATIONS

Increasing Trauma-Informed Care

2.5 Health systems should **develop required protocols for hospitals and birth centers to follow in the case of infant relinquishment.** These protocols should include providing support and referrals to social workers for birth parents.

2.6 DCYF should expand partnerships and provide funding for **local social support systems that offer trauma-informed care and support** for **children and young adults** who are or have been part of **foster care systems or experienced involvement with CPS**.

Expanding Home Visiting

2.7 DCYF should collaborate with the Department of Health (DOH) to inform the Home Visiting Advisory Committee (HVAC) and seek its advisement on strategies to prioritize high-quality **prenatal and postpartum home visiting**, as well as **other home-based services**, for people experiencing mental health conditions, substance use disorder (SUD) or opioid use disorder (OUD), or other high-risk circumstances. Home visitors should receive specialized training to effectively support families affected by mental health and substance use challenges.

2.8 DCYF should work in coordination with the Department of Health (DOH) to explore opportunities for **expanding access to home-based services that support chronic disease and medication management**—particularly for conditions such as hypertension, diabetes, and opioid use disorder. As part of this effort, DCYF and DOH should inform the Home Visiting Advisory Committee (HVAC) and seek its advisement on how best to align future funding opportunities, model selection, and service delivery approaches. This work should consider the scope and limitations of existing evidence-based home visiting models.

2.9 HCA should strengthen access to **First Steps or Maternity Support Services (MSS) and ensure that services and tools are comprehensive, high-quality, culturally relevant, and trauma-informed. The programs should be adapted to better meet the needs** of people during pregnancy and postpartum, especially those experiencing mental health conditions, SUD, OUD, or intimate partner violence.

Connecting to Perinatal Support Providers

2.10 HCA and DOH should increase awareness of eligibility for a full spectrum of services from trusted perinatal support providers, including **doulas, case workers, counselors, and community health workers**.

2.11 Health care providers should connect pregnant patients experiencing mental health conditions, substance use disorder, opioid use disorder, or other complicating factors with a **harm reduction doula** trained to coordinate health and social services.

2.12 DOH should develop a **training module** for doulas, community health workers, and other peer support workers to specialize in **behavioral health**.

2.13 DOH should increase investments in sustaining **community outreach or navigator programs**, such as support from community health workers, to **connect people with services** for treatment of SUD, OUD, and mental health conditions.

2.14 Health care facilities and providers should offer **meaningful support and resources** to patients and families who have **experienced pregnancy loss**. This may include:

- Connecting people with doulas, social workers, or peer counselors who specialize in perinatal bereavement for timely and culturally relevant grief counseling.
- Developing programs that help reduce stigma around pregnancy loss.
- Training obstetric and non-obstetric staff, including ED staff, to deliver pregnancy-loss counseling.
- Offering information packets through printed materials or electronic health records (EHR).

2.15 Health systems and facilities should **integrate peer support into care teams** to make it available across the perinatal continuum. This is particularly important for people with co-occurring physical and behavioral health conditions, including histories of SUD or OUD and mental health support needs.

2.16 Funders and state and local agencies should **increase funding and capacity for community-based organizations to support people during pregnancy and postpartum**. Services may include culturally relevant parenting classes, community-led support groups, family reconciliation services, and trauma-informed therapy.

Addressing Social Determinants of Health

2.17 Health systems and facilities should provide **universal access to social workers, nurses, and caseworkers** to screen patients for **social determinants of health. The case workers should also help coordinate** direct handoffs to specialists in obstetrics, intimate partner violence support, mental health care, SUD and OUD treatment, and services that help meet basic needs.

2.18 DOH and other agencies should raise community awareness about **resources people may be eligible to receive in pregnancy and postpartum**. Awareness efforts should focus on services such as MSS, After-Pregnancy Coverage, and short-term child care that provide temporary respite to parents.

2.19 State agencies should work together to expand access to and raise awareness of **safe, affordable, and inclusive housing** for pregnant and postpartum people and their newborns. This includes harm reduction approaches such as Housing First, transitional housing for people experiencing homelessness immediately postpartum, and temporary housing for families who have hospitalized children and face housing or transportation insecurity.

2.20 Substance use and mental health outpatient treatment facilities and providers should expand access to services by offering **child care, transportation, lactation support, or other resources that reduce barriers to attending appointments**.

Creating Safe and Supportive Communities

2.21 DOH and local health departments should invest in **building healthy and safe communities**. This includes working towards systems-level changes that address social, relational, and service gaps, and supporting communities in developing more robust early learning, education, child care, parenting support, health care, and economic opportunities.

2.22 Educational service districts, school districts, and other educational institutions should integrate **upstream strategies** into education to **improve mental health**, **prevent violence**, and promote **healthy relationships**. Some strategies may include:

- Expanding statewide school-based mental health services and providing easier, more equitable, confidential, and supportive care.
- Providing comprehensive, age-appropriate health education to help students understand and manage their emotions and build healthy relationships.

Priority Recommendation #3: Provide Equitable, Culturally Responsive Care

Why Equitable, Culturally Responsive Care?

The MMRP recommends taking action to reduce inequities, bias, and structural racism, as well as violence—including intimate partner violence and gender-based violence. These factors contribute to maternal deaths.[69] Research shows that without addressing inequities and biases, other efforts to reduce maternal mortality have a limited impact.[39]

The MMRP identified **discrimination, bias, interpersonal racism, or structural racism** in **76% of Washington's preventable, pregnancy-related deaths** in 2021–2022, including bias against people with substance use disorder. The maternal mortality rate was over 7 times higher in American Indian and Alaska Native communities than in non-Hispanic white communities—a disparity found in all Washington MMRP reports to date. Rates among Non-Hispanic Black, Native Hawaiian, Pacific Islander, multiracial, and rural communities, as well as people covered by Medicaid, were also disproportionately high.

Inequities don't happen in isolation. They often compound and exacerbate each other. Living in a rural area increases maternal mortality risk for American Indian and Alaska Native communities.[70] Racism increases overdose risk; a study found emergency rooms were less likely to offer Black patients surviving an overdose a referral for outpatient treatment compared to white patients.[71] External factors may worsen inequities and increase maternal mortality, such as pending cuts to Medicaid.[72] Exposure to racism and inequities in the perinatal period—as well as earlier in life—can worsen perinatal health outcomes.[73]

However, research suggests inequities that impact perinatal health can be reversed[74] through opportunities to reimagine[75] health systems to improve health equity, build a larger and more culturally aligned perinatal workforce to reduce provider shortages, prioritize health over profit, expand access to substance use disorder treatment, and support solutions from communities directly affected by inequities.

These strategies can ensure **perinatal care and support services are equitable and culturally responsive**, meaning they reflect people's cultural needs and counter bias. Research shows such care, including culturally aligned Indigenous midwifery and doula care or interpreters who speak patients' languages, can prevent discrimination, build trust, deepen cultural connections, save lives, and improve people's experiences of pregnancy, birth, and postpartum.[76,77]

Research also shows violence prevention strategies can help counteract the higher rates of intimate partner violence and homicide that pregnant and postpartum people face—strategies that include access to safe, affordable, low-barrier housing, or enforcing Extreme Risk Protection Orders (ERPOs) and Domestic Violence Protection Orders (DVPOs).[20,78,79]

The recommendations that follow, in addition to legislative recommendations presented previously, help create culturally responsive, trauma-informed solutions to remove barriers, address maternal mortality inequities, and promote more equitable and culturally responsive care. Please also reference the American Indian Health Commission's Addendum at the end of this report for Tribal and Urban Indian leadership recommendations, as well as the Blueprint for a Just & Equitable Future: The 10-Year Plan to Dismantle Poverty in Appendix 7 on page 70 for aligned recommendations.

RECOMMENDATIONS FOR HEALTH SYSTEMS, PROVIDERS, AGENCIES, INSTITUTIONS, AND ORGANIZATIONS

Provide Culturally Competent Care to Address Long-Standing Disparities

3.3 Health care systems, state agencies, and academic institutions should work together to **build and sustain a diverse maternal health workforce** that **reflects the communities it serves**. This means promoting, recruiting, integrating, and supporting people across all health and allied professions, including doulas, patient navigators, and community health workers (CHWs). Efforts should begin **upstream** through intentional **outreach, education, training, mentorship, and career** pipeline programs for **Black, Indigenous, and people of color (BIPOC) communities, people with disabilities, and 2SLGBTQIA+ students and professionals**.

3.4 Health care systems and providers should ensure staff, including emergency department staff, receive training on and follow practices of **active listening, cultural safety, building trust, and perinatal behavioral health.** Patients should be offered culturally aligned care matches with a provider when possible and desired.

3.5 Health care systems and state agencies should conduct **regular data-driven quality assessments** to identify and address disparities in care, with a specific focus on the impact of bias in care for BIPOC, 2SLGTBQIA+, and disabled pregnant and postpartum patients.

3.6 **Health care systems and providers should revise existing policies** and scheduling to support flexibility in office hours, including weekends and evenings, and to recognize diverse family and caregiving structures.

3.7 Health care systems, state agencies, and others should **learn from BIPOC and other communities** most impacted by inequitable perinatal outcomes to improve cultural relevance in care, communication, and collaboration. This includes building partnerships with CHWs and community-based organizations such as doula organizations to address racism and its effects on maternal health.

3.8 State and local agencies, health care facilities, and health systems should expand and strengthen **certified medical interpretation services** across Washington. This includes investing in interpreter training, especially for **rare and underserved language communities**; simplifying

certification processes; increasing access through on-demand platforms; and providing sustained public funding to support interpretation as a core part of culturally responsive care.

3.9 Providers should communicate clearly and respectfully with patients, using culturally appropriate words and plain language to describe medical information. This approach helps ensure patients understand their medical situations, and it aligns with national CLAS (Culturally and Linguistically Appropriate Services) standards.

3.10 DOH should **expand language access standards** and other **accessibility** standards for filing complaints against DOH-credentialed providers and facilities.

3.11 State and local agencies, along with community-based organizations, should deliver ongoing, culturally relevant messaging about **how to safely access perinatal care**, including for **immigrant and refugee communities**. This includes language-specific messages about **health insurance access, privacy protections, and opportunities to receive perinatal care and support regardless of insurance or immigration status**.

Tribal-Led Solutions

3.12 The Department of Health, Health Care Authority, and local health jurisdictions should work together with and fund **Tribal- and Indigenous-led provider training programs** that emphasize **culturally relevant health care and communication**.

3.13 Health care systems, providers, and state agencies should ensure that **Tribal and Urban Indian health leaders and communities** guide the **provision of culturally responsive care for American Indian and Alaska Native communities**. This means providing access to culturally responsive care through patient navigators, Tribal liaisons, CHWs, doulas, and social support networks. It also means integrating Tribal-led and other Indigenous-led nutrition planning and health practices into perinatal care.

3.14 DOH and other state agencies should fund community-based organizations to increase access to cultural and traditional healing practices and foods. These efforts can help reduce historical and systemic barriers that disproportionately affect Indigenous birthing people and their families.

3.15 DOH and health care systems should **fund Tribal-led, Indigenous-led, and community-led efforts** to expand access to **prenatal and birthing care in American Indian and Alaska Native communities**, including in **rural** areas. This could include investments in mobile prenatal clinics, birth centers, doula training and support programs, and other cultural birthing services.

Providing Trauma-Informed, Anti-Biased Care

3.16 Health care systems should implement **anti-bias practices** to ensure pregnant and postpartum patients receive equitable, judgment-free, and coordinated care, particularly for patients disproportionately affected by perinatal mental health conditions and substance use

disorder. This includes using validated, culturally appropriate **screening tools** and addressing **stigma** through quality improvement efforts.

3.17 Health care facilities and providers, including primary care and support providers, should routinely **screen for trauma history** and **tailor care to respond to the impact of trauma on mental health and well-being**. This may include screening pregnant patients for both **adverse and positive childhood experiences (ACEs and PCEs)** and offering **enhanced wraparound care**.

3.18 All clinical providers, including those working in emergency departments, should be trained to **recognize stigma and bias**, and to **provide trauma-informed care**. This includes understanding **historical and systemic factors that contribute to disparities and biased care provision, particularly in areas of pain management for BIPOC patients.**

3.19 Health care systems and providers should offer **compassionate, respectful care for people with SUD or OUD**. This means supporting stable, nurturing parenting rather than relying on punitive measures and ensuring treatment options and referrals are based on need and not influenced by bias.

3.20 DCYF and partners should provide proactive, community-based resources to help families **stay safely together** and to **strengthen relationships** between children and their fathers or other non-birth parents. This includes offering culturally relevant parenting support and addressing barriers such as incarceration, poverty, or CPS involvement, as well as expanding access to early, voluntary services to support families during pregnancy and postpartum.

Care and Support for Survivors of Violence

3.21 Health care facilities should implement systems that support and deliver **patient-centered, trauma-informed care** for pregnant and postpartum people experiencing intimate partner violence (IPV), domestic violence (DV), or gender-based violence (GBV). This may include:

- Offering multiple confidential disclosure options, including non-verbal options.
- Routinely screening with validated tools at all clinical visits.
- Offering warm hand-off referrals to comprehensive support services. Referrals should include free legal support services, mental health care and counseling, social work, specialized case management, advocacy services, and services to address social determinants of health issues such as safe housing and food insecurity.
- Establishing a health record alert indicating that a patient may require help with safety planning.
- Providing ongoing safety-sensitive follow-up.
- Educating patients about autonomy in their care decisions and when and where to seek help.

3.22 The Department of Health should support systems change to prevent and address IPV, DV, and GBV by requiring **trauma-informed care training and certification** for providers and

facilities. This also includes funding community programs that offer education, advocacy, counseling, and training for health systems to support people experiencing violence.

3.23 To reduce the risk of firearm homicide and suicide, DOH should create a campaign to help **raise awareness of existing Extreme Risk Protection Orders (ERPOs) and Domestic Violence Protection Orders (DVPOs).**

Care for Incarcerated People

3.24 The Department of Corrections (DOC), other state agencies, and county governments should ensure **comprehensive, high-quality prenatal, birth, and postpartum care for pregnant and postpartum incarcerated people**. This includes regularly assessing care quality, accessibility, and transition coordination between correctional and community health services throughout pregnancy, birth, postpartum, and re-entry.

3.25 The DOC should work with the Health Care Authority to create tailored **re-entry plans** for **pregnant and postpartum people while they are incarcerated**, including connections to community-based providers and continued perinatal support after their release.

APPENDICES

Appendix 1: RCW 70.54.450

Maternal mortality review panel—Duties—Confidentiality, testimonial privilege, and liability—Identification of maternal deaths—Reports—Data-sharing agreements.

(1) For the purposes of this section, "maternal mortality" or "maternal death" means a death of a woman while pregnant or within one year of the end of a pregnancy, from any cause.

(2) A maternal mortality review panel is established to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington to identify factors associated with the deaths and make recommendations for system changes to improve health care services for women in this state. The members of the panel must be appointed by the secretary of the department of health, must include at least one tribal representative, must serve without compensation, and may include at the discretion of the department:

(a) Women's medical, nursing, and service providers;

(b) Perinatal medical, nursing, and service providers;

(c) Obstetric medical, nursing, and service providers;

(d) Newborn or pediatric medical, nursing, and service providers;

(e) Birthing hospital or licensed birth center representative;

(f) Coroners, medical examiners, or pathologists;

(g) Behavioral health and service providers;

(h) State agency representatives;

(i) People or organizations that represent the populations most affected by pregnancy-related deaths or pregnancy-associated deaths and lack of access to maternal health care services;

(j) A representative from the department of health who works in the field of maternal and child health; and

(k) A department of health epidemiologist with experience analyzing perinatal data.

(3) The maternal mortality review panel must conduct comprehensive, multidisciplinary reviews of maternal mortality in Washington. The panel may not call witnesses or take testimony from any individual involved in the investigation of a maternal death or enforce any public health standard or criminal law or otherwise participate in any legal proceeding relating to a maternal death.

(4)(a) Information, documents, proceedings, records, and opinions created, collected, or maintained by the maternity mortality review panel or the department of health in support of the maternal mortality review panel are confidential and are not subject to public inspection or copying under chapter 42.56 RCW and are not subject to discovery or introduction into evidence in any civil or criminal action.

(b) Any person who was in attendance at a meeting of the maternal mortality review panel or who participated in the creation, collection, or maintenance of the panel's information,

documents, proceedings, records, or opinions may not be permitted or required to testify in any civil or criminal action as to the content of such proceedings, or the panel's information, documents, records, or opinions. This subsection does not prevent a member of the panel from testifying in a civil or criminal action concerning facts which form the basis for the panel's proceedings of which the panel member had personal knowledge acquired independently of the panel or which is public information.

(c) Any person who, in substantial good faith, participates as a member of the maternal mortality review panel or provides information to further the purposes of the maternal mortality review panel may not be subject to an action for civil damages or other relief as a result of the activity or its consequences.

(d) All meetings, proceedings, and deliberations of the maternal mortality review panel may, at the discretion of the maternal mortality review panel, be confidential and may be conducted in executive session.

(e) The maternal mortality review panel and the department of health may retain identifiable information regarding facilities where maternal deaths occur, or facilities from which a patient whose record is or will be examined by the maternal mortality review panel was transferred, and geographic information on each case for the purposes of determining trends, performing analysis over time, and for quality improvement efforts. All individually identifiable information must be removed before any case review by the panel.

(5) The department of health shall review department available data to identify maternal deaths. To aid in determining whether a maternal death was related to or aggravated by the pregnancy, whether it was preventable, and to coordinate quality improvement efforts, the department of health has the authority to:

(a) Request and receive data for specific maternal deaths including, but not limited to, all medical records, autopsy reports, medical examiner reports, coroner reports, and social service records; and

(b) Request and receive data as described in (a) of this subsection from health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, professions and facilities licensed by the department of health, local health jurisdictions, the health care authority and its licensees and providers, the department of social and health services and its licensees and providers, and the department of children, youth, and families and its licensees and providers.

(6) Upon request by the department of health, health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, professions and facilities licensed by the department of health, local health jurisdictions, the health care authority and its licensees and providers, the department of social and health services and its licensees and providers, and the department of children, youth, and families and its licensees and providers must provide all medical records, autopsy reports, medical examiner reports, coroner reports, social services records, information and records related to sexually transmitted diseases, and other data requested for specific maternal deaths as provided for in subsection (5) of this section to the department.

(7) By October 1, 2019, and every three years thereafter, the maternal mortality review panel must submit a report to the secretary of the department of health and the health care committees of the senate and house of representatives. The report must protect the confidentiality of all decedents and other participants involved in any incident. The report must be distributed to relevant stakeholder groups for performance improvement. Interim results may be shared with the Washington state hospital association coordinated quality improvement program. The report must include the following:

(a) A description of the maternal deaths reviewed by the panel, including statistics and causes of maternal deaths presented in the aggregate, but the report must not disclose any identifying information of patients, decedents, providers, and organizations involved; and

(b) Evidence-based system changes and possible legislation to improve maternal outcomes and reduce preventable maternal deaths in Washington.

(8) Upon the approval of the department of health and with a signed written data-sharing agreement, the department of health may release either data or findings with indirect identifiers, or both, to the centers for disease control and prevention, regional maternal mortality review efforts, local health jurisdictions of Washington state, or tribes at the discretion of the department.

(a) A written data-sharing agreement under this section must, at a minimum:

(i) Include a description of the proposed purpose of the request, the scientific justification for the proposal, the type of data needed, and the purpose for which the data will be used;

(ii) Include the methods to be used to protect the confidentiality and security of the data;

(iii) Prohibit redisclosure of any identifiers without express written permission from the department of health;

(iv) Prohibit the recipient of the data from attempting to determine the identity of persons or parties whose information is included in the data set or use the data in any manner that identifies individuals or their family members, or health care providers and facilities;

(v) State that ownership of data provided under this section remains with the department of health, and is not transferred to those authorized to receive and use the data under the agreement; and

(vi) Require the recipient of the data to include appropriate citations when the data is used in research reports or publications of research findings.

(b) The department of health may deny a request to share either data or findings, or both, that does not meet the requirements.

(c) For the purposes of this subsection:

(i) "Direct identifier" means a single data element that identifies an individual person.

(ii) "Indirect identifier" means a single data element that on its own might not identify an individual person, but when combined with other indirect identifiers is likely to identify an individual person.

(9) For the purposes of the maternal mortality review, hospitals and licensed birth centers must make a reasonable and good faith effort to report all deaths that occur during pregnancy or within forty-two days of the end of pregnancy to the local coroner or medical examiner:

(a) These deaths must be reported within thirty-six hours after death.

(b) Local coroners or medical examiners to whom the death was reported must conduct a death investigation, with autopsy strongly recommended.

(c) Autopsies must follow the guidelines for performance of an autopsy published by the department of health.

(d) Reimbursement of these autopsies must be at one hundred percent to the counties for autopsy services.

[**2019 c 317 § 1**; **2016 c 238 § 1**.]

History of RCW 70.54.450

In 2016, the Washington State Legislature passed Engrossed Second Substitute Senate Bill 6534 to establish an official Maternal Mortality Review Panel.[80] In 2019, the law was amended to permanently establish the Panel and the maternal mortality review process. The law (RCW 70.54.450) directs the Panel to:

- Review maternal deaths in the state and determine if deaths are related to pregnancy;
- Identify factors contributing to those deaths;
- Make recommendations for system changes to improve perinatal health care services;
- Submit a report of findings to the health care committees of the House of Representatives and Senate every three years.

The 2019 amendment to the law made changes, including:

- Requiring the Panel to include Tribal health representatives.
- Expanding representation to include a wider variety of care providers and individuals or organizations that represent populations most affected by maternal mortality and lack of access to maternal care.
- Requiring hospitals and birthing centers to make good-faith efforts to report deaths that occur during pregnancy or within 42 days of pregnancy to the local coroner or medical examiner, who will then conduct a death investigation with autopsy strongly advised.

The law gives the Department of Health the authority to obtain pertinent vital records, medical records, and autopsy reports related to maternal deaths. The law also provides protections for those records and for the Panel members who participate in the review. This authority and protection allow the Department of Health and the Panel to determine which deaths are preventable and identify the issues that lead to preventable deaths. For deaths involving Tribal members, DOH follows processes established in the Centennial Accord and in alliance with Tribal data sovereignty.

Appendix 2: MMRP Members 2023–2025 and Additional Report Contributors

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Appendix 3: MMRP Review Process

The Department of Health and Panel conduct maternal mortality reviews through a multi-level process grounded in a review framework originally developed by the *Building U.S. Capacity to Review and Prevent Maternal Deaths* initiative[81] and updated over time. The process includes four levels of review.

Multi-level Review Process, Washington State

During Level 1, the Department of Health's Center for Health Statistics first identifies deaths of Washington residents who were pregnant at the time of death or within a year of death.

In **Level 2**, Department of Health staff identify which deaths may have been pregnancy-related, gather information that includes, but is not limited to, medical and death records, social services involvement, case management, law enforcement investigation, maternity support services, etc., and produce an anonymized summary of key information for the Panel to review.

Level 3 is the Panel's review. The Panel, with great care and respect for the lives lost, reviews each anonymized death to determine whether it was pregnancy-related. If it was not pregnancy-related, the Panel review stops there. If it was pregnancy-related, the Panel determines whether there was a chance the death could have been prevented—from a clinical, equity, or social determinants of health perspective. If the death might have been preventable, the Panel identifies factors that may have contributed to the death and makes recommendations to prevent such deaths in the future.

Level 4 is an analysis of the Panel's findings to identify trends and priority recommendations for this report. Every three years, the Department of Health completes quantitative and qualitative analysis of the review findings and recommendations. Quantitative analysis includes cumulative data from past reports and recent years. Qualitative analysis focuses only on the recommendations from the reviews since the last report. The Panel and Department of Health prioritize among the recommendations to distill a set of priorities they select based on criteria such as being systems-level, feasible, timely, equity-focused, supported by evidence or best practice, and aligned with our partners' goals. DOH submits a report informed by maternal mortality data and the work of the Panel to the legislature every three years.

This report arrives less than three years since the 2023 MMRP Report because the period of that report was expanded to four years instead of three (2017–2020) to provide a glimpse into the COVID era, with this report subsequently covering two years instead of three (2021–2022).

Appendix 4: Qualitative & Quantitative Methods

After each MMRP Level 3 meeting, case details—including committee decisions and recommendations—are entered into the Maternal Mortality Review Information Application (MMRIA), a secure online system maintained by the Centers for Disease Control and Prevention (CDC). MMRIA provides a standardized platform for documenting maternal mortality data and supports analyses that inform public health strategies aimed at improving maternal outcomes.

Qualitative Methods

Once the Level 3 meetings for deaths in 2021 and 2022 were completed, the recommendations were imported into Atlas.ti for qualitative analysis by two epidemiologists. Each recommendation was coded using a combination of deductive, inductive, and axial coding methods. The resulting codes were then reviewed to identify potential groupings and hierarchical relationships, enabling the identification of emerging connections, patterns, and overarching themes.

The Department of Health worked alongside a small subset of the MMRP to develop prioritization criteria for the recommendation themes identified through the qualitative analysis. The criteria were feasibility, systems change, urgency, addressing health equity, and magnitude of death prevention. A prioritization tool was created to help narrow the top 10 recommendation themes into three key priority areas. These areas were used to organize the final set of recommendations for presentation to the legislature and other stakeholders.

As part of Level 4, three meetings were held to collectively review and discuss the recommendations within each of the three priority areas. Prior to these meetings, DOH sent the recommendations to MMRP subject matter experts for pre-review. During the meetings, Panel members were asked to provide contextual updates, identify any recommendations they believe should be removed or elevated as top priorities, and offer general feedback. These discussions allowed for broad participation and consensus-building among Panel members. Following each meeting, panelists completed a ranking survey, in which they ranked each recommendation from most to least important based on the established prioritization criteria. All feedback gathered through this process was used to edit, combine, remove, or adjust the recommendations in preparation for final review by external partners and internal leadership.

Quantitative Methods

Maternal mortality rates are calculated as the number of deaths per 100,000 live births within a specified time frame and geographic area. Rates are reported with 95% confidence intervals using the Gamma distribution method, which provides a statistically reliable range for the

estimated rates. Due to the relatively small number of maternal deaths, findings are sometimes presented descriptively, and caution is advised when interpreting rates with a high relative standard error (≥25%), as these are considered statistically unstable.

Data on maternal characteristics are primarily obtained from birth certificates; when unavailable, supplemental sources such as medical or death records are used. Maternal deaths are categorized as: (1) **pregnancy-related** (directly caused by pregnancy, a pregnancy complication, a chain of events initiated by pregnancy, or an unrelated condition aggravated by pregnancy), (2) **pregnancy-associated but not related** (the cause had no relationship to pregnancy), or (3) **unable to be determined** in terms of pregnancy-relatedness (the Panel doesn't have enough information to determine whether the death was pregnancy-related).

Rates are stratified by key demographic variables, including age, race/ethnicity, insurance type, and urban/rural residence. Trend analyses spanning 2014–2022 are conducted to assess changes over time. These methods provide a rigorous approach to identifying patterns and disparities in maternal mortality and informing targeted public health interventions.

Appendix 5: Additional Data and Findings

Definitions for pregnancy-associated, pregnancy-related, pregnancy-associated but not related, and pregnancy-associated but unable to determine if related can be found on page 8.

Table 1: Number of Maternal Deaths, Washington State, 2014–2022

Year	Livebirths	Total Pregnancy-Associated Deaths (PA)	Pregnancy-Related Deaths (PR)	Pregnancy-Associated, Not Related (PANR)	Pregnancy-Associated, Unable to Determine if Related (PA-UTD)
2014	88,561	38	14	24	0
2015	89,000	32	8	23	1
2016	90,489	32	10	18	2
2017	87,508	29	13	12	3
2018	86,047	35	15	15	5
2019	84,918	37	21	12	4
2020	83,101	21	16	2	3
2021	83,899	59	28	24	7
2022	83,314	48	23	22	3

Table 2: Maternal Mortality Rates (deaths per 100,000 live births) and 95% Confidence Intervals, 2014–2022

Year	PA Mortality Rate	PR Mortality Rate	PANR Mortality Rate
2014	42.9 (30.6, 59.1)	15.8 (11.5, 26.5)	27.1 (17.4, 40.3)
2015	36.0 (24.5, 50.9)	9.0 (3.9, 17.7)	27.0 (17.3, 40.1)
2016	35.4 (24.1, 50.1)	11.1 (5.3, 20.3)	24.3 (15.2, 36.8)
2017	33.1 (22.2, 48.0)	14.9 (7.9, 25.4)	18.3 (10.5, 29.7)
2018	40.7 (28.4, 56.5)	17.4 (9.8, 28.8)	23.2 (14.2, 35.9)
2019	43.6 (30.8, 60.1)	24.7 (15.3, 37.8)	18.8 (10.8, 30.6)
2020	25.3 (15.6, 39.2)	19.3 (11.0, 31.3)	6.0 (2.0, 14.0)
2021	70.3 (52.7, 92.5)	33.4 (22.2, 48.2)	36.9 (25.1, 52.4)
2022	57.6 (42.0, 77.3)	27.6 (17.5, 41.4)	30.0 (19.4, 44.3)

Table 3: Pregnancy-Related Mortality and Pregnancy-Associated but not Related Mortality by Demographics, 2014–2022

Demographics	PR Mortality Counts	PR Mortality Rates	PANR Mortality Counts	PANR Mortality Rates
Total	148	20.2 (17.1, 23.6)	332	42.9 (38.4, 47.7)
Age				
<25	30	19.2 (12.9, 26.6)	71	45.4 (35.4, 56.5)
25-29	28	12.7 (8.5, 17.9)	75	34.1 (26.9, 42.3)
30-34	44	18.2 (13.2, 23.9)	100	41.3 (33.6, 49.7)
35-39	34	25.7 (17.8, 35.1)	64	48.5 (37.3, 61.0)
40+*	12	46.0 (23.7, 75.4)	22	84.2 (52.8, 122.9)
Race/Ethnicity				
Hispanic	33	21.7 (15.0, 29.7)	69	45.4 (35.3, 56.8)
Non-Hispanic Black*	11	31.0 (15.5, 51.9)	24	67.7 (43.4, 97.4)
Non-Hispanic White	66	14.8 (11.5, 18.6)	160	35.9 (30.6, 41.7)
Non-Hispanic American Indian Alaska Native*	11	108.7 (54.2, 181.7)	32	316.1 (216.2, 434.7)
Non-Hispanic Asian American	11	14.0 (7.0, 23.5)	20	25.5 (15.6, 37.8)
Non-Hispanic NHPI*	4	37.4 (10.2, 82.0)	8	74.9 (32.3, 135.0)
Non-Hispanic Multi-Racial*	12	35.9 (18.6, 58.9)	18	53.9 (31.9, 81.5)
Insurance				
Medicaid	104	35.5 (29.0, 42.7)	207	70.7 (61.4, 80.7)
Private Ins	34	8.3 (5.7, 11.3)	60	14.6 (11.2, 18.6)
Other Ins	6	11.5 (4.2, 22.4)	8	15.3 (19.0, 72.8)
No insurance/Unknown Insurance*	4	18.5 (5.0, 40.5)	9	41.5 (19.0, 72.8)
Residence				
Urban	122	18.1 (15.0, 21.4)	271	40.1 (35.5, 45.0)
Rural	26	26.2 (17.1, 37.2)	61	61.5 (47.0, 77.8)

*Rates marked with asterisks have a standard error that is greater than 25% of the rate itself, it indicates that the estimate is statistically unstable. This level of variability suggests that the rate may not accurately represent the underlying population due to small sample sizes and maternal mortality being a rare event. As a result, the rate should be interpreted with caution, as it may fluctuate widely with small changes in the data and may not be reliable for making definitive conclusions or comparisons.

The manner of death indicates how a death occurred and is either natural, in which death is caused by disease only, or unnatural, in which injury of any type caused or contributed to death. Any death which may be unnatural in manner is to be reported to the applicable medicolegal system, either the coroner or medical examiner. Only the coroner or medical examiner can certify a death as unnatural in manner.

Table 4: Maternal Deaths by Manner of Deaths, 2014–2022

Death Classification	Natural	Accident	Suicide	Homicide	Unknown
PA (Overall)	45%	37%	7%	8%	3%
PANR	35%	48%	2%	12%	3%
PA-UTD	39%	50%	7%	0%	4%
PR	57%	23%	13%	5%	2%

Table 5: Manner of Death and Underlying Causes of Death for Pregnancy-Related Deaths, 2014–2022

Manner & Cause	n	%
Accident	34	100%
SUD	30	88%
Other	4	12%
Natural	85	100%
Embolism	14	16%
Hemorrhage	10	12%
Infection	16	19%
Cardiovascular Conditions	15	18%
Hypertensive or Pulmonary Disorders	7	8%
Other	23	27%
Homicide	7	100%
All causes	7	100%
Suicide	19	100%
Firearms	8	42%
Other	11	58%

Table 6: Average Time from Pregnancy to Death by Manner of Death, Pregnancy-Related Deaths, 2014–2022

Manner of Death	Pregnant at the Time of Death	Died the Day of Delivery	Died Within 42 days of Delivery	Died Between 43 Days to One Year After Delivery
All Types	20%	5%	38%	37%
Accident	12%	0%	20%	68%
Natural	22%	8%	52%	18%
Suicide	21%	0%	21%	58%
Homicide	3%	0%	0%	97%

Table 7: Preventability of Pregnancy-related Deaths as Determined by the Maternal Mortality Review Panel by Year

Preventability of Pregnancy-Related Deaths	Count (n)	Percent (%)
Yes - Preventable	120	81%
No - Not Preventable	23	16%
Unable to Determine Preventability	5	3%

Appendix 6: Updates from 2023 MMRP Report Recommendations

Background

This appendix highlights a selection of systems-level initiatives developed or expanded on since the release of the Washington State Maternal Mortality Review Panel: Maternal Deaths 2017 – 2020 report published in February 2023. These initiatives reflect how state agencies and partners are acting on the Panel's recommendations to improve maternal health outcomes across Washington. For more examples of and stories about successful implementation of MMRP recommendations, see pages 28–29.

MMRP report recommendations are not owned by any single entity. They are intended to guide action across a wide network of contributors—including health care practitioners, hospitals, community-based organizations, advocacy groups, and academic institutions. Each plays a vital role in reducing disparities and preventing severe maternal injury and death.

The examples included here primarily reflect activities led or supported by state agencies and partners, including the Washington State Perinatal Collaborative (WSPC), Washington State Department of Health, Washington State Health Care Authority, and Department of Children, Youth, and Families. However, true progress depends on collective and sustained commitment across sectors and systems. We recognize and appreciate the many people and organizations who continue to implement and adapt MMRP recommendations in their communities.

2023 Priority Recommendations 1: Undo Racism and Bias

Birth Doula Medicaid Reimbursement

In January 2025, Washington state implemented Medicaid reimbursement for certified birth doulas, marking a major milestone in expanding access to culturally appropriate, evidence-based non-clinical perinatal support. This benefit allows Apple Health (Medicaid) clients to receive prenatal, labor, birth, and postpartum services from state-certified doulas at no cost to them.

The doula benefit is designed to improve pregnancy and perinatal health outcomes, reduce birth disparities, and enhance the birth experience, particularly for communities disproportionately impacted by maternal mortality and morbidity, including Black, Indigenous, and People of Color (BIPOC), as well as rural and low-income populations. DOH and HCA are working with community-based organizations to grow and sustain a diverse doula with a potential path for workforce and create a "doula hub" to maintain a centralized referral system and provide support functions for doulas including navigating Medicaid.

Birth Equity

DOH has expanded the Parenting and Birth Support Program (formerly Birth Equity Project), a community-led initiative aimed at reducing maternal mortality and addressing disparities in birth outcomes. The project focuses on supporting organizations led by and serving communities of color.

With increased funding, the program has broadened its reach, providing grants to additional community-based organizations that offer culturally relevant care, including doula services, midwifery, lactation support, and perinatal education. These efforts empower birthing people by ensuring they have access to care that respects traditional practices.

The Parenting and Birth Support Program was developed by a community advisory board comprising doulas, midwives, childbirth educators, parents, caregivers, and other community birth workers from priority communities. This collaborative approach ensures that decisions are made using community-partnered participatory practices, fostering trust and effectiveness in addressing the needs of birthing people.

Perinatal Data Dashboard

In May 2024, DOH launched an interactive Perinatal Dashboard on its Perinatal Data webpage to enhance understanding of pregnancy, birth, and parenting experiences across the state. This tool provides data on health conditions during pregnancy, birth outcomes, substance use, postpartum experiences, and overall pregnancy experiences. Information is disaggregated by age, race/ethnicity, Medicaid status, and geography to highlight disparities and inform research, programming, and policy development. The dashboard draws from birth certificates and the Pregnancy Risk Assessment Monitoring System (PRAMS).

2023 Priority Recommendation 2: Address Mental Health and Substance Use Disorder

Centers of Excellence for Perinatal Substance Use

As of 2025, 6 hospitals in Washington have received certification as Centers of Excellence for Perinatal Substance Use. This represents a major achievement in creating comprehensive, evidence-based care and system-level change across hospital departments and disciplines.

Certified hospitals are recognized for providing high-quality, family-centered care, including routine substance use screening, medication-assisted treatment, and support for both parent and infant during the perinatal period. This work was nationally recognized by the Association of Maternal & Child Health Programs (AMCHP) as a cutting-edge practice in maternal health.

Legislation to Improve Maternal Health Outcomes – SB 5580

Passed in 2024, Senate Bill 5580 strengthened Apple Health's (Medicaid) role in supporting maternal mental health by expanding access and enhancing services for perinatal people. Key components include raising the income eligibility threshold for pregnancy and 12-month postpartum coverage from 193% to 210% of the Federal Poverty Level, allowing more Washington residents to maintain vital coverage during and after pregnancy.

The legislation also established a hospital post-delivery and transitional care program specifically for people with a substance use disorder at the time of delivery—ensuring comprehensive support during a critical period.

Additionally, it invests in the First Steps Maternity Support Services (MSS) program by modernizing screening tools, increasing benefit limits and reimbursement rates, and requiring systemic collection of client screening outcomes to improve care coordination and quality.

Plan of Safe Care Enhancements

Washington has strengthened its Plan of Safe Care (POSC) to better support infants prenatally exposed to substances while also supporting their families. As of 2022, infants with certain substance exposures and no safety concerns are now referred to Help Me Grow Washington for wraparound support, rather than routed to Child Protective Services, or left without services. Birthing hospitals can make referrals directly through an online portal.

To align with this approach, the Center of Excellence for Perinatal Substance Use criteria include alignment with POSC practices. DCYF, DOH, HCA, and the Washington State Hospital Association issued a joint letter asking hospitals to update their relevant policies and procedures by January 1, 2025. DCYF, in partnership with Help Me Grow Washington affiliate WithinReach, offers technical assistance and hosts monthly Community of Practice sessions to support hospitals and providers in implementing POSC practices.

In early 2024, a pregnancy pathway was added to the POSC initiative through which Help Me Grow Washington connects pregnant people with substance use to voluntary prevention services like substance use disorder treatment, home visiting, and basic needs supports.

2023 Priority Recommendation 3: Enhance Health Care Quality and Access

Smooth Transitions

DOH is supporting the expansion of the Smooth Transitions Program, which aims to improve the transfer of care for perinatal patients between health care facilities. Since 2023, the program has seen growth in the number of participating facilities and the implementation of EMS simulations and training to enhance the effectiveness of patient transfers. Additionally, protected case reviews are being conducted to identify areas for improvement and strengthen the transfer process. This work helps ensure that perinatal patients receive timely, coordinated,

and high-quality care during transitions, ultimately contributing to better health outcomes and improved collaboration across the health care system.

TeamBirth in Washington Hospitals

WSHA implemented TeamBirth across 51 birthing hospitals. This initiative aims to enhance obstetric outcomes and reduce disparities, particularly for birthing people experiencing structural racism and discrimination.

TeamBirth fosters shared decision-making by ensuring that birthing people and their care teams have aligned input throughout labor, delivery, and postpartum care. Key components include team huddles at critical decision points, with discussions documented on shared planning boards in patient rooms. These huddles happen upon admission, when there are changes in the care plan, and whenever requested by the patient or a team member.

The program is being implemented over 3 years, from 2023–2026, with hospitals participating in 1 of 5 cohorts. Each cohort participated in training and received support to integrate TeamBirth practices, aiming for full adoption across the state by 2026.

2023 Priority Recommendation 4: Strengthen Clinical Care

Improving Rural Access to Obstetric Care

To strengthen obstetric and newborn care in rural areas, Washington is investing in training and equipment for Rural and Critical Access Hospitals. In partnership between DOH and WSHA, this initiative supports tailored perinatal education and simulation-based training for staff, helping them maintain critical skills to safely care for pregnant and postpartum patients. A key focus is preparing obstetric and neonatal teams to respond to low-frequency, high-risk events, ensuring effective stabilization and transfer when needed. This work also supports Rural and Critical Access hospitals in making necessary equipment purchases and providing perinatal training services for obstetric and newborn staff.

Technical assistance and OB hemorrhage training are being offered to both hospitals with obstetric services and those without, including rural emergency departments. These efforts aim to improve safety and access to quality perinatal care across Washington's rural communities.

Blue Band Initiative

Launched in September 2023, the Blue Band Initiative is a state-wide effort to improve early detection and management of preeclampsia and postpartum hypertension. At-risk patients receive blue wristbands during and after pregnancy to serve as visual alerts for health care providers, prompting timely monitoring and intervention. The initiative has been widely adopted across hospitals, doula organizations, outpatient services, and home visiting programs. To strengthen its impact, clinical guidelines were introduced to enhance emergency department awareness and education about postpartum hypertension and the significance of

the blue bands. The initiative has contributed to more timely care for people with hypertension during and after pregnancy and is raising statewide awareness about this serious condition.

2023 Priority Recommendation 5: Meet Basic Human Needs

Expanding Access to Child Care and Early Learning Programs HB 2124

Passed in 2024, HB 2124 expands access to the Working Connections Child Care (WCCC) program by making participation in certain early learning programs—such as ECEAP, Head Start, and Early Head Start—an approved activity for WCCC eligibility. Families enrolled in these programs who meet the income threshold of 85% of the State Median Income (SMI) or lower may be eligible for subsidized childcare at no cost.

2023 Priority Recommendation 6: Address and Prevent Violence

"Nothing About Us Without Us" Act

This legislation, effective January 1, 2025, ensures that survivors of domestic violence have a mandated role in shaping policies that directly affect them. By requiring survivor representation in policy development, the act aims to create more informed and effective interventions.

Washington Safe Haven Law Awareness

Washington's Safe Haven Law (RCW 13.34.360) allows parents to safely and anonymously surrender an unharmed newborn within 72 hours of birth at designated locations—such as hospitals, staffed fire stations, and rural health clinics—without fear of criminal liability.

To enhance public awareness and accessibility, DOH has supported the development and funding of signage for these Safe Haven locations. The signs, available in both English and Spanish, provide clear information about the law and include a 24-hour Safe Haven Hotline.

In addition, DOH has created printable posters, also in English and Spanish, which are distributed at no cost to qualifying facilities. These posters mirror the signage content and are available for download directly from the DOH website.

Appendix 7: Alignment with 10-Year Plan to Dismantle Poverty

Background

The MMRP recommendations in this report align with several components of Washington's Blueprint for a Just and Equitable Future: the 10-Year Plan to Dismantle Poverty (the 10-Year Plan). Both aim to improve the well-being of Washingtonians, drawing on a shared understanding of the systemic causes of hardship. The Washington Economic Justice Alliance, which is a collaboration between experts with lived experience, community organizations, state and Tribal governments, and legislators, is responsible for implementing and iterating on the plan. The mission is to ensure every Washingtonian can meet their basic needs, fully contribute their talents, and pass well-being on to future generations.

Below is a table outlining the intersections and alignment between recommendations from the MMRP and the 10-Year Plan.

Conceptual Theme	MMRP Report Strategies	10- Year Plan Strategies	Alignment
Addressing root causes and systemic injustices	Strategies include upstream interventions at the systems level to address root causes that contribute to maternal mortality and poor health outcomes.	Strategies include addressing upstream investments and actions to prevent the crises from transpiring.	**Both champion systemic changes to eradicate structural barriers that cost lives and perpetuate poverty and poor health outcomes.**
Centering communities disproportionately affected by the issue	Report recommends strategies to ensure care is "culturally responsive, free from bias, and grounded in trauma-informed practices" because Black, Indigenous, and People of Color communities carry a disproportionate burden of maternal mortality.	Plan centers solutions around those disproportionately affected by poverty such as Indigenous, Black, Brown, women, families with young children, seniors, LGBTQIA+, people with disabilities, rural residents, immigrants, and refugees.	**Both recognize the disproportionate impact of systemic injustices on communities furthest away from decision-making tables, and the importance of following the lead of these communities in prioritizing solutions.**
Elevating lived experience	Integrates storytelling through "Voices from Washington" to	Foundational principle is co-creating solutions with those who stand to	**Both underscore the importance and value of direct**

	illuminate the real-life challenges and impacts of maternal health issues. Includes lived experience expertise on the MMRP.	benefit the most from state policy, programs, and budgets, and using their stories to complement the data.	**experiences and insights from those affected to design more effective solutions.**
Addressing behavioral health and substance use disorders	Recommends increased funding and access for treatment and unbiased support for pregnant and postpartum patients. Emphasizes the enormous impact of behavioral health and substance use disorder, with accidental overdose as the leading cause of maternal mortality.	Improved access to behavioral health prevention, treatment, and recovery services including integration in other settings such as business, health care and education. (Strategy 5)	**Both acknowledge the critical link between poverty, well-being, and behavioral health by supporting expanded access to integrated mental health and substance use disorder treatment and support services.**
Importance of housing and basic needs	Highlights housing and food instability as crucial social determinants of health and root causes of maternal deaths. Recommendations include funding housing solutions such as "housing first," supporting cash programs such as a guaranteed basic income, and maintaining food assistance program benefits.	Highlights affordable housing and tax system changes that benefit low-income households and also recommends increasing unconditional cash. (Strategy 3 and 7)	**Both recognize the foundational role of essential needs (stable housing, adequate food, sufficient income) in improving overall well-being.**
Focusing on birthing people, children, and families	Recommendations all focus on the health and well-being of birthing people and families. Emphasizes that investments in parents, families, and infants can reap significant	Has recommendations tailored for women, families with young children, and youth, such as increasing affordable childcare, providing housing for student parents, and	**Both prioritize the well-being of families and the intergenerational impacts of both poverty and health outcomes, with a clear focus on**

	returns in the form of improved health, equity, education, and economic well-being across the lifespan.	strengthening health supports across the lifespan for families.	**supporting birthing people, families, and children.**
Addressing rural disparities	Specific recommendations address the shortage of maternity care and emergency obstetric care in rural areas and include increased support for hospitals, increased rural perinatal care providers, and improved responses to obstetric emergencies.	Has strategies to promote equitable education, training, jobs, and health access in rural areas.	**Both acknowledge and propose strategies to mitigate geographic disparities, particularly concerning access to essential services and economic opportunities in rural communities.**
Leveraging home visiting and doula services	Recommends strengthening home visiting and doula support as key community services to improve health, save lives, and address inequities and disparities.	Recommends expanding home visiting programs to optimize early childhood development.	**Both understand the importance of strengthening and expanding these services as vital components of community support for families.**

Investments to address maternal mortality can also make progress towards dismantling poverty in Washington—and vice versa. The MMRP report and the 10-Year Plan to Dismantle Poverty both fundamentally align on the need to address systemic issues, prioritize the experiences of those affected by these issues, tackle behavioral health challenges, address the need for health and community supports, and ensure basic needs are met for overall well-being. Both sets of work can track the policies, programs, and budgets for much-needed short- and long-term solutions to improve lives of those who call Washington home.

Endnotes

1. Slaughter-Acey J, Behrens K, Claussen AM, et al. *Social and Structural Determinants of Maternal Morbidity and Mortality: An Evidence Map*. Agency for Healthcare Research and Quality (AHRQ); 2023. doi:10.23970/AHRQEPCCER264

2. Gunja MZ, Gumas ED, Masitha R, Zephyrin LC. *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*. The Commonwealth Fund; 2024. Accessed May 18, 2025. https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison

3. CDC. *Data from the Pregnancy Mortality Surveillance System*.; 2025. Accessed May 21, 2025. https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/

4. Simpson KR. Effect of the COVID-19 Pandemic on Maternal Health in the United STates. *MCN Am J Matern Nurs*. 2023;48(2):61.

5. U.S. Government Accountability Office. *Maternal Health: Outcomes Worsened and Disparities Persisted During the Pandemic*. GAO; 2022. Accessed May 22, 2025. https://www.gao.gov/products/gao-23-105871

6. Hailu EM, Maddali SR, Snowden JM, Carmichael SL, Mujahid MS. Structural Racism and Adverse Maternal Health Outcomes: A Systematic Review. *Health Place*. 2022;78:102923. doi:10.1016/j.healthplace.2022.102923

7. Cannon JS, Kilburn RM, Karoly LA, Mattox T, Muchow AN, Buenaventura M. Investing Early: Taking Stock of Outcomes and Economic Returns from Early Childhood Programs. *Rand Health Q*. 2018;30(7):4.

8. Gurung B, Jackson LJ, Monahan M, Butterworth R, Roberts TE. Identifying and assessing the benefits of interventions for postnatal depression: a systematic review of economic evaluations. *BMC Pregnancy Childbirth*. 2018;18(179). doi:https://doi.org/10.1186/s12884-018-1738-9

9. Ashton K, Schroder-Back P, Clemens T, Dyakova M, Stielke A, Bellis MA. The social value of investing in public health across the life course: a systematic scoping review. *BMC Public Health*. 2020;20(597). doi:https://doi.org/10.1186/s12889-020-08685-7

10. Vedam S, Stoll K, Taiwo TK, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health*. 2019;16(1):77. doi:10.1186/s12978-019-0729-2

11. Leitao S, Manning E, Greene RA, Corcoran P, Maternal Morbidity Advisory Group*. Maternal morbidity and mortality: an iceberg phenomenon. *BJOG Int J Obstet Gynaecol*. 2022;129(3):402-411. doi:10.1111/1471-0528.16880

12. Declercq E, Zephyrin LC. *Severe Maternal Morbidity in the United States: A Primer*. The Commonwealth Fund; 2021. Accessed May 15, 2025. https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer

13. Byrd TE, Ingram LA, Okpara N. Examination of maternal near-miss experiences in the hospital setting among Black women in the United States. *Womens Health*. 2022;18:17455057221133830. doi:10.1177/17455057221133830

14. Washington Economic Justice Alliance. Blueprint for a Just & Equitable Future: The 10-Year Plan to Dismantle Poverty in Washington. Published online December 2020. https://dismantlepovertyinwa.com/wp-content/uploads/2020/12/Final10yearPlan.pdf

15. Singh GK. Trends and Social Inequalities in Maternal Mortality in the United States, 1969-2018. *Int J Matern Child Health AIDS*. 2021;10(1):29-42. doi:10.21106/ijma.444

16. Laraia BA, Gamba R, Saraiva C, Dove MS, Marchi K, Braveman P. Severe maternal hardships are associated with food insecurity among low-income/lower-income women during pregnancy: results from the 2012–2014 California maternal infant health assessment. *BMC Pregnancy Childbirth*. 2022;22:138. doi:10.1186/s12884-022-04464-x

17. Muchomba FM, Teitler J, Reichman NE. Association Between Housing Affordability and Severe Maternal Morbidity. *JAMA Netw Open*. 2022;5(11):e2243225. doi:10.1001/jamanetworkopen.2022.43225

18. Hill L, Rao A, Artiga S, Published UR. Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. KFF. October 25, 2024. Accessed June 23, 2025. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/

19. Campbell J, Matoff-Stepp S, Velez ML, Cox HH, Laughon K. Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence. *J Womens Health*. 2021;30(2):236-244. doi:10.1089/jwh.2020.8875

20. Jones BW, Quick-Graham L, Martin SL. Perinatal Homicide in the United States: A Systematic Literature Review. *Trauma Violence Abuse*. 2024;25(3):2452-2467. doi:10.1177/15248380231217044

21. Khalili R, Liu Y, Xu Y, et al. Adverse Birth Outcomes Associated with Heat Stress and Wildfire Smoke Exposure During Preconception and Pregnancy. *Environ Sci Technol*. Published online June 18, 2025. doi:10.1021/acs.est.4c10194

22. Gaynes B, Meltzer-Brody S, Lohr K. Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes: Summary. *AHRQ Evid Rep Summ*. 2005;119. https://www.ncbi.nlm.nih.gov/books/NBK11838/

23. Orsolini L, Valchera A, Vecchiotti R, et al. Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates. *Front Psychiatry*. 2016;12(7):138. doi:10.3389/fpsyt.2016.00138

24. Gavin N, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. *Obstet Gynecol*. 2005;106(5 Pt 1):1071-1083. doi:10.1097/01.AOG.0000183597.31630.db

25. Washington State Department of Health. Unintentional Drug Overdose Data (SUDORS).

26. Washington State Economic and Revenue Forecast Council. June Revenue Review. Published online June 24, 2025. https://erfc.wa.gov/sites/default/files/2025-06/rev20250624.pdf

27. Commercial determinants of health. Accessed July 14, 2025. https://www.thelancet.com/series-do/commercial-determinants-health

28. Girardi G, Longo M, Bremer AA. Social determinants of health in pregnant individuals from underrepresented, understudied, and underreported populations in the United States. *Int J Equity Health*. 2023;22(1):186. doi:10.1186/s12939-023-01963-x

29. Nasir N. Why do so many Black women die in pregnancy? One reason: Doctors don't take them seriously. AP NEWS. Accessed July 21, 2025. https://projects.apnews.com/features/2023/from-birth-to-death/black-women-maternal-mortality-rate.html

30. Girardi G, Longo M, Bremer AA. Social determinants of health in pregnant individuals from underrepresented, understudied, and underreported populations in the United States. *Int J Equity Health*. 2023;22:186. doi:10.1186/s12939-023-01963-x

31. Johnson A. For some Black women, the fear of death shadows the joy of birth. *Washington Post*. https://www.washingtonpost.com/health/interactive/2023/black-women-pregnancy-mortality-fear/. December 14, 2023. Accessed July 10, 2025.

32. Huang K, Waken RJ, Luke AA, Carter EB, Lindley KJ, Joynt Maddox KE. Risk of delivery complications among pregnant people experiencing housing insecurity. *Am J Obstet Gynecol MFM*. 2023;5(2):100819. doi:10.1016/j.ajogmf.2022.100819

33. Thompson D. Food Assistance Ensures Healthy Pregnancies. January 27, 2025. Accessed July 14, 2025. https://www.healthday.com/health-news/pregnancy/food-assistance-ensures-healthy-pregnancies

34. Marçal K. Housing hardship and maternal mental health among renter households with young children. *Psychiatry Res*. 2024;331:115677. doi:10.1016/j.psychres.2023.115677

35. Reece J. More Than Shelter: Housing for Urban Maternal and Infant Health. *Int J Environ Res Public Health*. 2021;18(7):3331. doi:10.3390/ijerph18073331

36. Wilson C, Boehnke, Braun, et al. *SB 6109 - 2023-24*.

37. *Safety of Newborn Children Law*. https://app.leg.wa.gov/RCW/default.aspx?cite=13.34.360

38. Fleszar LG, Bryant AS, Johnson CO, et al. Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States. *JAMA*. 2023;330(1):52-61. doi:10.1001/jama.2023.9043

39. Davidson KW, Terry MB, Braveman P, Reis PJ, Timmermans S, Epling JWJ. Maternal Mortality: A National Institutes of Health Pathways to Prevention Panel Report. *Obstet Gynecol*. 2024;143(3):e78. doi:10.1097/AOG.0000000000005488

40. Nowhere to Go: Maternity Care Deserts Across the US. Accessed September 8, 2025. https://www.marchofdimes.org/maternity-care-deserts-report

41. Sonenberg A, Mason DJ. Maternity Care Deserts in the US. *JAMA Health Forum*. 2023;4(1):e225541. doi:10.1001/jamahealthforum.2022.5541

42. Ala AS. Why Maternity Care Is Underpaid. TIME. May 7, 2024. Accessed September 8, 2025. https://time.com/6972880/maternity-ward-closures-us/

43. Kozhimannil KB, Interrante JD, Carroll C, et al. Obstetric Care Access at Rural and Urban Hospitals in the United States. *JAMA*. 2025;333(2):166-169. doi:10.1001/jama.2024.23010

44. Gleeson D, Busch S, Ickovics JR. State-level Prevalence of Maternity Care Deserts: Association with Healthcare Access, Utilization, and Outcomes among Medicaid Recipients. *AJPM Focus*. Published online May 3, 2025:100362. doi:10.1016/j.focus.2025.100362

45. Herald-Republic SOY. "There are going to be deaths:" Toppenish residents raise concerns about maternity center closure. Yakima Herald-Republic. January 4, 2023. Accessed June 20, 2025.

https://www.yakimaherald.com/news/local/there-are-going-to-be-deaths-toppenish-residents-raise-concerns-about-maternity-center-closure/article_11e509be-8d42-11ed-ad4e-535c51b3b05f.html

46. Magazine HPH, Chandra N. To break cycles of trauma, we need family-friendly addiction treatment. Harvard Public Health Magazine. November 20, 2024. Accessed September 8, 2025. https://live-harvard-public-health-magazine.pantheonsite.io/policy-practice/children-of-addicts-with-opioid-use-disorder-need-more-support/

47. Hogue A, Becker SJ, Wenzel K, et al. Family involvement in treatment and recovery for substance use disorders among transition-age youth: Research bedrocks and opportunities. *J Subst Abuse Treat*. 2021;129:108402. doi:10.1016/j.jsat.2021.108402

48. Britt R. Why Reimbursement Policies Alone Won't Fix Postpartum Mental Health Care. Policy Center for Maternal Mental Health. July 10, 2025. Accessed September 8, 2025. https://policycentermmh.org/why-reimbursement-policies-alone-wont-fix-postpartum-mental-health-care/

49. Morgan MH, Coe JL, Kranzler EC, et al. Implementation of family centered substance use treatment for pregnant and postpartum people to prevent the intergenerational transmission of adverse childhood experiences. *Child Abuse Negl*. 2024;157:107066. doi:10.1016/j.chiabu.2024.107066

50. Maternal Deaths From Cardiovascular Causes On the Rise in U.S. American College of Cardiology. Accessed September 8, 2025. https://www.acc.org/About-ACC/Press-Releases/2025/03/25/10/19/http%3a%2f%2fwww.acc.org%2fAbout-ACC%2fPress-Releases%2f2025%2f03%2f25%2f10%2f19%2fMaternal-Deaths-From-CV-Causes-On-the-Rise-in-US

51. The Role of State Health Leaders in Addressing Substance Use Disorders Among Women, Infants, and Families. ASTHO. Wayback Machine archive from September 14, 2024. Accessed September 8, 2025. https://web.archive.org/web/20240914173823/https://www.astho.org/globalassets/report/role-leaders-addressing-substance-use-disorders-women-infants-families.pdf

52. Montalmant KE, Ettinger AK. The Racial Disparities in Maternal Mortality and Impact of Structural Racism and Implicit Racial Bias on Pregnant Black Women: A Review of the Literature. *J Racial Ethn Health Disparities*. 2024;11(6):3658-3677. doi:10.1007/s40615-023-01816-x

53. Lateef MA, Pillay JD. Evidence mapping on barriers in accessing prenatal healthcare services among homeless women: a scoping review. *BMC Health Serv Res*. 2025;25:87. doi:10.1186/s12913-024-12147-w

54. Daw JR, MacCallum-Bridges CL, Admon LK. Trends and Disparities in Maternal Self-Reported Mental and Physical Health. *JAMA Intern Med*. 2025;185(7):857-865. doi:10.1001/jamainternmed.2025.1260

55. Pacho M, Aymerich C, Pedruzo B, et al. Substance use during pregnancy and risk of postpartum depression: a systematic review and meta-analysis. *Front Psychiatry*. 2023;14:1264998. doi:10.3389/fpsyt.2023.1264998

56. Belluck P. Women With Depression During or After Pregnancy Face Greater Suicide Risk, Even Years Later. *The New York Times*. https://www.nytimes.com/2024/01/10/health/perinatal-depression-suicide.html. January 10, 2024. Accessed July 14, 2025.

57. read ZA 8 min. How insurance woes are impacting mental health care. https://www.apa.org. Accessed July 15, 2025. https://www.apa.org/topics/psychotherapy/insurance-mental-health-care

58. Chatterjee R. Mental health care is hard to find, especially for people with Medicare or Medicaid. *NPR*. https://www.npr.org/sections/health-shots/2024/04/03/1242383051/mental-health-care-shortage-medicare-medicaid-hhs-inspector-general. April 3, 2024. Accessed July 14, 2025.

59. Knocke K, Chappel A, Sugar S, Lew ND, Sommers BD. Doula Care and Maternal Health: An Evidence Review.

60. Ramey-Collier K, Jackson M, Malloy A, McMillan C, Scraders-Pyatt A, Wheeler SM. Doula Care: A Review of Outcomes and Impact on Birth Experience. *Obstet Gynecol Surv*. 2023;78(2):124. doi:10.1097/OGX.0000000000001103

61. Falconi AM, Bromfield SG, Tang T, et al. Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. *eClinicalMedicine*. 2022;50:101531. doi:10.1016/j.eclinm.2022.101531

62. Utilizing Doula Care to Support Substance Use Disorder in the Postpartum Period. Accessed July 15, 2025. https://www.astho.org/topic/brief/utilizing-doula-care-to-support-sud-in-the-postpartum-period/

63. Lowell AF, Suchman NE, Byatt N, Feinberg E, Friedmann PD, Peacock-Chambers E. Parental substance use and home visiting programs: Implementation considerations for relationship-based treatment. *Infant Ment Health J*. 2023;44(2):166-183. doi:10.1002/imhj.22041

64. Maternal Mental Health in Home Visiting: Addressing Depression, Anxiety, and Stress. Published online 2025.

65. Thompson D. Food Assistance Ensures Healthy Pregnancies. January 27, 2025. Accessed July 15, 2025. https://www.healthday.com/health-news/pregnancy/food-assistance-ensures-healthy-pregnancies

66. Thompson D. The Public Policies That Really Help Prevent Suicide. January 9, 2025. Accessed July 15, 2025. https://www.healthday.com/health-news/public-health/the-public-policies-that-really-help-prevent-suicide

67. Health CB. PAID POST: Housing insecurity influences birth outcomes and maternal health. The Texas Tribune. January 11, 2024. Accessed July 15, 2025. https://www.texastribune.org/paid-post/housing-insecurity-influences-birth-outcomes-and-maternal-health/

68. Hipwell AE, Fu H, Tung I, Stiller A, Keenan K. Preconception stress exposure from childhood to adolescence and birth outcomes: The impact of stress type, severity and consistency. *Front Reprod Health*. 2023;4:1007788. doi:10.3389/frph.2022.1007788

69. Fleszar LG, Bryant AS, Johnson CO, et al. Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States. *JAMA*. 2023;330(1):52-61. doi:10.1001/jama.2023.9043

70. Celaya M, Zahlan AI, Rock C, et al. Individual- and community-level risk factors for maternal morbidity and mortality among Native American women in the USA: a systematic review. *BMJ Open*. 2024;14(11):e088380. doi:10.1136/bmjopen-2024-088380

71. Shastry S, Carpenter J, Krotulski A, et al. Disparities in Treatment and Referral After an Opioid Overdose Among Emergency Department Patients. *JAMA Netw Open*. 2025;8(7):e2518569. doi:10.1001/jamanetworkopen.2025.18569

72. Medicaid Cuts Could Increase Maternal Mortality and Jeopardize Women's Health. doi:10.26099/65T4-9J76

73. Liu SR, Glynn LM. The contribution of racism-related stress and adversity to disparities in birth outcomes: evidence and research recommendations. *FS Rep*. 2022;3(2, Supplement):5-13. doi:10.1016/j.xfre.2021.10.003

74. Tobón AL, Berry OO, Gorelik S, et al. A Call To Address The Political Determinants Of Perinatal Mental Health. doi:10.1377/forefront.20240822.518945

75. McLemore MR. Using Retrofit, Reform, and Reimagine to Advance Toward Health Equity. *J Perinat Neonatal Nurs*. 2022;36(2):99-102. doi:10.1097/JPN.0000000000000639

76. The Rise of Indigenous Doulas. ELLE. September 21, 2023. Accessed July 10, 2025. https://www.elle.com/culture/a45191818/indigenous-doulas-native-women-childbirth-2023/

77. Durham A. Crisis to Care: 5 Charts on Black Maternal Health Progress. Word In Black. April 15, 2025. Accessed July 21, 2025. https://wordinblack.com/2025/04/crisis-to-care-5-charts-on-black-maternal-health-progress/

78. Winters B. Policy Recommendations to Increase Safe Housing for Survivors.

79. Frattaroli S, Zeoli AM, Webster DW. Armed, Prohibited and Violent at Home: Implementation and Enforcement of Restrictions on Gun Possession by Domestic Violence Offenders in Four U.S. Localities. *J Fam Violence*. 2021;36(5):573-586. doi:10.1007/s10896-020-00241-6

80. 6534-S2.SL.pdf. Accessed June 20, 2025. https://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/Senate/6534-S2.SL.pdf#page=1

81. Zaharatos J, St Pierre A, Cornell A, Pasalic E, Goodman D. Building U.S. Capacity to Review and Prevent Maternal Deaths. *J Womens Health 2002*. 2018;27(1):1-5. doi:10.1089/jwh.2017.6800

Addendum from the American Indian Health Commission

Please see the addendum, *American Indian Health Commission (AIHC) Addendum to the Washington State Department of Health Maternal Mortality Review Panel Report to the Legislature: Tribal and Urban Leadership Recommendations July 2025*, at the end of this document. This addendum was prepared by our partners at the AIHC. It builds on the work of the AIHC addendum at the end of the 2023 MMRP Panel Report.

American Indian Health Commission Addendum to the Washington State Department of Health Maternal Mortality Review Panel Report to the Legislature

Tribal and Urban Indian Leadership Recommendations

July 2025

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THE AMERICAN INDIAN HEALTH COMMISSION

PULLING TOGETHER FOR WELLNESS

July 31, 2025

Secretary Dennis Worsham
Department of Health
Washington State

Re: Maternal, Infant, Child, and Adolescent Health of American Indians and Alaska Natives in Washington State

Dear Secretary Worsham,

The American Indian Health Commission (AIHC) is a non-profit organization founded by Tribal and Urban Indian Health Organization leaders over 30 years ago to improve the health status of American Indian and Alaska Natives (AI/AN) in Washington State. Maternal and Infant Health (MIH) is one of the foundational priorities for AIHC, which in 2010 published "Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan." In the report, eight causes of infant mortality were identified, and eight policy and program recommendations were made, resulting in seventy recommended actions. The work to implement these recommendations and actions made MIH effort a priority for AIHC and part of our biennial planning process with our delegates. Until recent years, AIHC mostly utilized limited funding through a DOH Women Infant Children (WIC) and Home Visiting grants to carry out this work. The Tribes and Urban Indian Health Programs received no additional funding for MIH work.

In the 2019 State of Washington Maternal Mortality Review Panel Report to the Legislature found that AI/AN people have the highest Maternal Mortality of any other race or ethnicity in WA State. The 2023 Report confirmed this finding again, and it is also true for the 2025 report. This persistent trend is of great concern to Indian Country — Tribal and Urban Indian Health leaders, elders, people of childbearing age, students, families, and the community at large.

Projects such as the Community Conversations About the Health of Native Pregnant, Birthing and Postpartum Women and People are essential to let communities know that their concerns about birthing people are valid and shared, that their insights and solutions are appreciated and that we want to work together to ensure that positive change will occur.

We appreciate the support of DOH for this important project and support for Tribal developed and led work. We hope that together we will continue to find creative solutions that will resonate and work to reduce AI/AN and overall maternal mortality and morbidity in our state.

Thank you for the opportunity to share these recommendations and express the need for support to implement these Tribal and community driven solutions. If you have any questions, please contact Vicki Lowe, AIHC Executive Director at vicki.lowe@aihc-wa.com or 360-460-3580.

Sincerely,

Stephen Kutz, BNS, MPH
Chair, American Indian Health Commission

July 2025 - Report and Recommendations from Listening Sessions Held with American Indian and Alaska Native Communities and Tribal and Urban Indian Leaders

Table of Contents

American Indian Health Commission

The American Indian Health Commission (AIHC) a Tribally driven non-profit that focuses on American Indian and Alaska Native (AI/AN) health in Washington state. Our membership includes 29 federally recognized Indian Tribes whose traditional lands and territories included parts of Washington, and two Urban Indian Health Organizations (UIHOs). Our goal is to bring wellness to our communities and honor the sovereignty of our ways. We work with Washington State government agencies to develop policies that reflect and support our resilience. Our ways are resilient.

Web site: https://aihc-wa.com/

Facebook: https://www.facebook.com/AIHCWA/

Facebook: https://www.facebook.com/pullingtogetherforwellness/

Acknowledgements

AIHC acknowledges the Tribal and American Indian and Alaska Native (AI/AN) community members, AIHC Delegates, Tribal Leaders, staff from Tribes, Urban Indian health programs, and Tribal organizations for generously sharing about their experiences, wisdom, and love for working to improve the health and experience of Pregnant, Birthing and Postpartum Women and People and improve the health status of AI/AN people in Washington for our current and future generations.

AIHC would like to thank the state agency staff from the Department of Health for their dedication to public service, improving the health of the state, and their response to AIHC's request to develop a strategy for identifying issues related to AI/AN maternal mortality and morbidity and recommendations to address that to be for included in the 2025 Maternal Mortality Review Panel Report to the Legislature.

Prepared by: JanMarie Ward, MPA and Cindy Gamble, MPH

Report and Recommendations from Listening Sessions Held with American Indian and Alaska Native Leaders and Community Members

EXECUTIVE SUMMARY

It was a grave concern when DOH staff presented the 2019 Maternal Mortality Review Panel (MMRP) Report to the Legislature at the AIHC Annual Delegates meeting which showed that American Indian and Alaska Native (AI/AN) people in Washington State had the highest rates of maternal mortality (MM) compared to any other race and ethnicity. This concerning trend continued in the 2023 MMRP Report,[i] and now the 2025 Report indicates AI/AN maternal mortality and morbidity is a crisis in our state.

The MMRP determines whether maternal deaths were pregnancy-related and preventable. From these cases, the panel makes recommendations to prevent similar situations from happening again. Every three years, the MMRP and DOH prioritize recommendations for a report that is submitted to the Washington State legislature. Several of the MMRP's findings for maternal deaths from 2014-2022 are particularly relevant to the 2025 AIHC report and recommendations (unless otherwise noted all data is from 2014-2022):

Relevant Findings from 2014-2022 data:

- Total Maternal Deaths: A total of 331 pregnancy-associated deaths were identified from 2014–2022. These are defined as deaths from any cause during pregnancy or within one year of the end of pregnancy. They include deaths related to (or exacerbated by) pregnancy, those not related to (or exacerbated by) pregnancy, and those that cannot be determined if they are related to pregnancy. Of these 331 deaths, the Panel identified 148 pregnancy-related deaths, defined as deaths in this timeframe due to a pregnancy complication, a chain of events initiated by pregnancy, or aggravation of unrelated condition(s) by the physiological effects of pregnancy.
- Persistent Racial Disparities: Maternal mortality rates in Washington have historically been lower than national rates.[ii] However, disaggregated data shows AI/AN people face higher maternal mortality rates than other racial and ethnic groups in Washington state. It is also important to underscore that pregnancy-related ratio from 2014-2022 was 7.3 times higher for AI/AN maternal deaths than for non-Hispanic white individuals. This disparity has been persistent throughout all reporting periods.
- While the panel only reviews pregnancy-related maternal deaths, not the total of pregnancy-associated (all) deaths, it should be noted that the rate of pregnancy-associated (all) death of AI/AN individuals was 8.8 times higher than for non-Hispanic white individuals for the same time period.
- Preventability: The MMRP found 80% of all pregnancy-related deaths were preventable. The panel identified contributing factors that, if altered, might have prevented those pregnancy-related deaths, meaning there was at least some chance of the death being averted if a factor that contributed to the death had been different.
- Leading Causes: The primary causes of pregnancy-related deaths were behavioral health conditions (suicide and overdose), hemorrhage, and infection.
- When: Sixty-two percent (62%) of all pregnancy related deaths took place after the birth of the baby. (maternal deaths 2017-2020).

- Recommendations: The MMRP made several recommendations to address these issues, including addressing racism and bias, improving access to mental health and substance use disorder services, enhancing healthcare quality and access, strengthening clinical care, and meeting basic human needs.

DOH's disaggregated data and responsive action to the concerns expressed during an initial meeting with AIHC delegates in 2019, so that the true state of AI/AN maternal health could be revealed is appreciated. Knowing the true rates of AI/AN maternal mortality is critical to strategizing a response. This is the importance of the Community Conversations About the Health of AI/AN Pregnant, Birthing, and Postpartum Women and People (PBPWP) Project.

Although the Community Conversation Project was intended to be onsite in Tribal and Urban Indian communities, the first iteration of the project turned out to be all virtual gatherings due to COVID-19 restrictions. There were 5 statewide community gatherings and 5 leadership gatherings. These gatherings informed the Leadership Recommendations in the 2023 AI/AN Addendum. With additional funding provided by DOH to extend the project, AIHC was able to hold in-person community gatherings during the last two years consisting of 6 additional Tribal and Urban Indian communities. The results of these gatherings have informed the 2025 AI/AN Addendum and confirm the importance of AI/AN Tribal and community led work.

The dramatic and persistent AI/AN maternal mortality disparity in our state strongly indicates that continued funding of the AIHC Community Conversations Project is a vital priority.

BACKGROUND

American Indian and Alaska Native people once populated and occupied the entirety of what is now the United States. In the pre-contact days, the sovereign Tribal Nations and Tribal Citizens lived an active and sophisticated lifestyle, attuned to the nuances of their homelands and the changes of the seasons. Every Tribe in every environment knew that the land – Mother Earth – provided everything they needed for a rich and balanced life. In those days, the role of birthing people was respected and there were many cultural ceremonies, practices, and beliefs to ensure that the mother and baby were welcomed, healthy, cared for, and loved so the people could go on. That simple fact was understood.

The change began with the arrival of the European visitors and the diseases they carried. The depopulation was traumatic and dramatic, with scientists estimating an 80-90% depopulation of the people who were Indigenous to what the Europeans called the New World. There was little concern that the lands had been fully occupied for thousands of years with hundreds of Tribal Nations and hundreds of thousands of Tribal citizens. This depopulation was followed by other traumatic and incomprehensible acts: warfare, attempted genocide, land grabs, occupation, forced removal, reservations, boarding schools, and termination policies which included literal extermination, termination of Tribal Nation status, and termination of the ability to have children through forced sterilization. The ongoing systemic and interpersonal racism, and the lack of respect of Tribal culture, beliefs, and life ways is resultant to where we are today — AI/AN people live with profound disparities in many measurements: physical health, behavioral health, social determinants of health, and maternal mortality. For more information about the effects of Historical Trauma see Walters KL, et.al, 2011[iii].

WASHINGTON STATE MATERNAL MORTALITY REVIEW

The MMRP is under the auspices of the Secretary of Health as established in RCW 70.54.450: Maternal Mortality Review Panel. The MMRP members are appointed by the Secretary of Health. The makeup of the MMRP includes perinatal health professionals and health equity experts across Washington State from diverse disciplines and backgrounds. The MMRP engages in a multi-level maternal mortality review process and serves as expert clinical or subject advisors.

The MMRP reviews deaths of people who died during pregnancy or within a year after pregnancy. For each case, MMRP examines a variety of deidentified records, including information about hospitalizations, vital statistics, medical records, and autopsy reports. Documents and data collected for the maternal mortality review process are confidential; the MMRP members are prohibited from releasing any information that could identify individuals.

Additionally, there are two definitions that are significant in interpreting the categories used by the MMRP in their determination process that are important to understand.

Pregnancy-associated death: This is inclusive of all maternal deaths. The death of a woman or birthing person from any cause during pregnancy or within one year of the end of pregnancy. This includes motor vehicle accidents (MVA), cancer, homicide, suicide, overdose, other accidents, and some seizures.

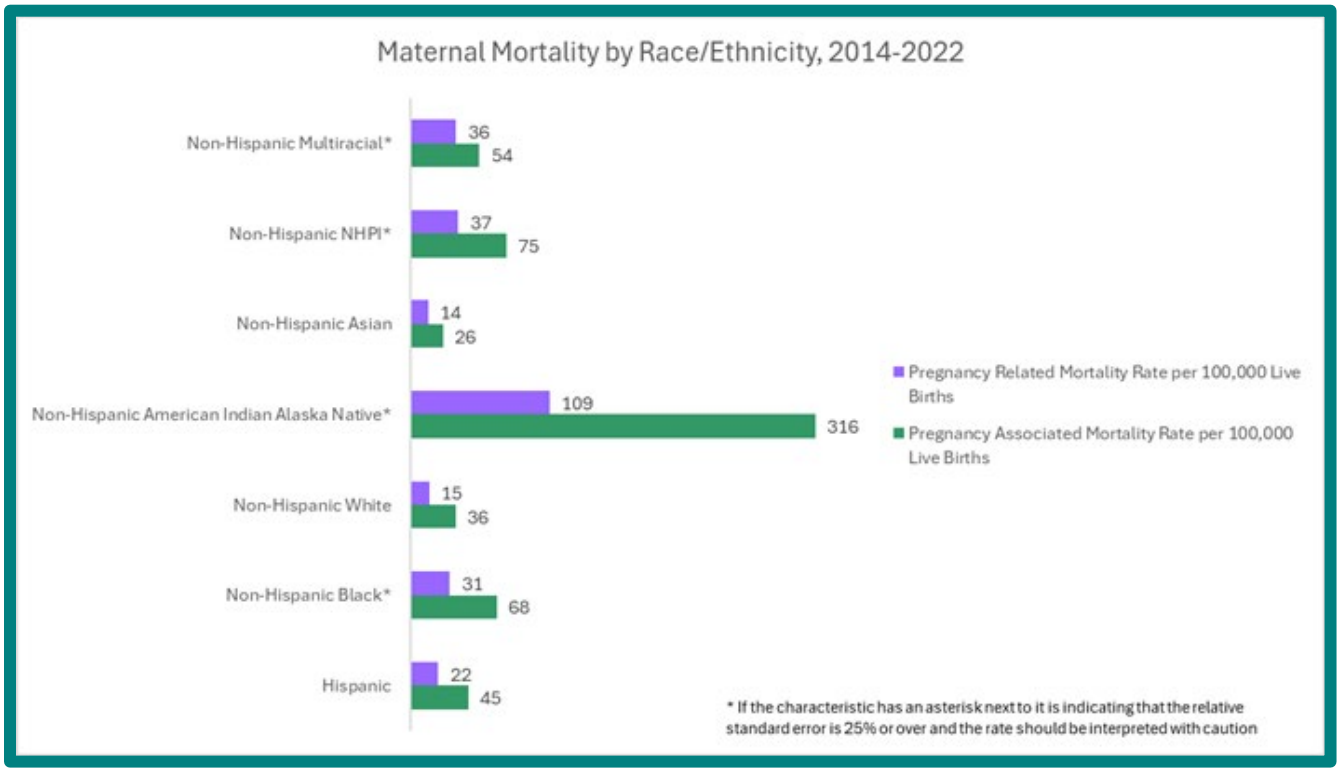
Pregnancy-related death: This is a subset of maternal deaths of a woman or birthing person during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. **These are the deaths that are reviewed by the Maternal Mortality Review Panel.**

The 2025 MMRP report examines maternal deaths between 2014 and 2022 and includes data from previously published reports. A growing understanding of the complex role that behavioral health issues play in pregnancy led the panel to examine maternal deaths from suicide and substance overdose for this report.

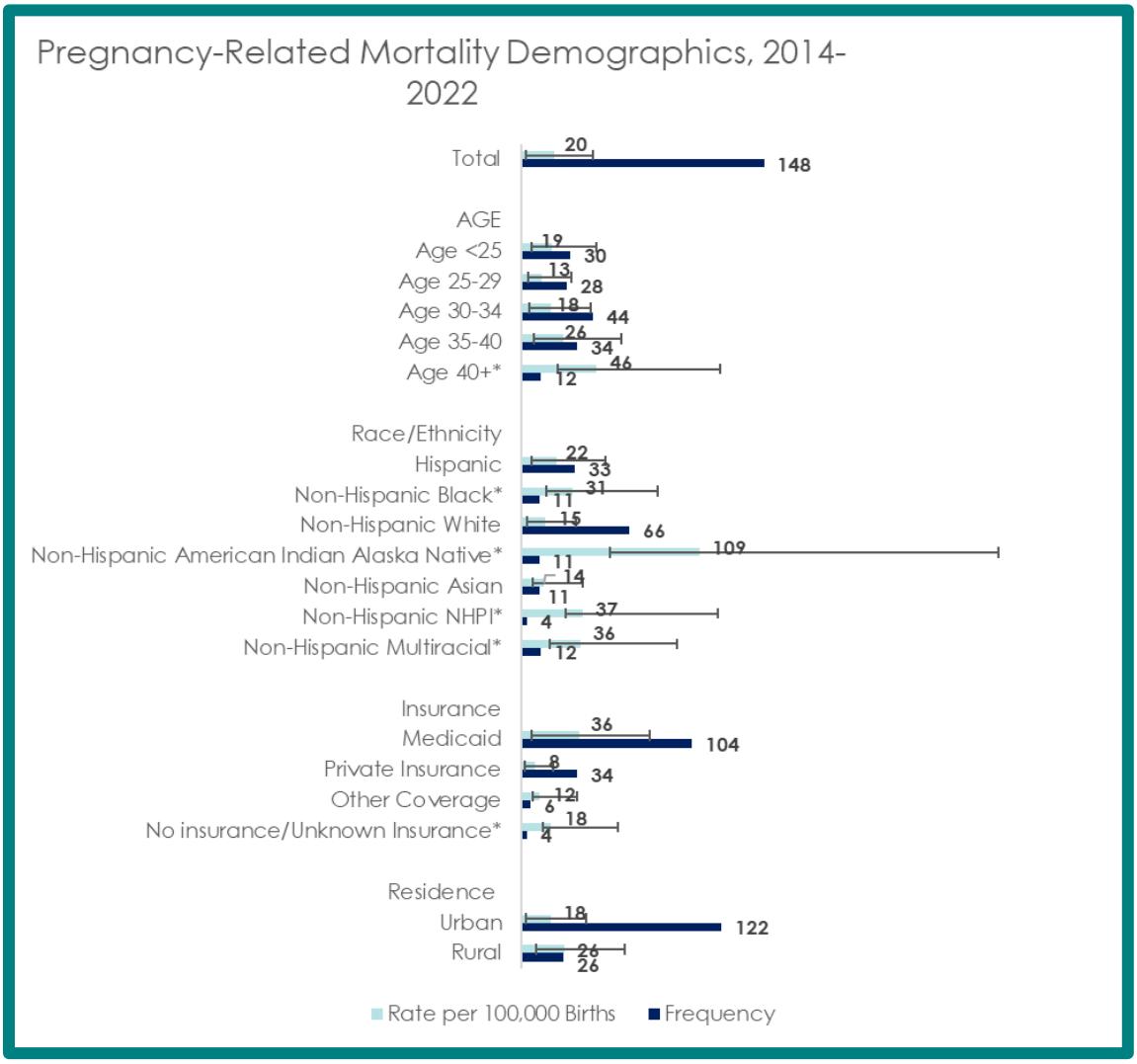
MMRP Data Reports

The following graphs ranging from 2014 to 2022 are intended to raise the awareness of the magnitude of the Maternal Mortality disparities experiences by AI/AN PBPWP in Washington State, where otherwise statewide Maternal Mortality rates are decreasing.

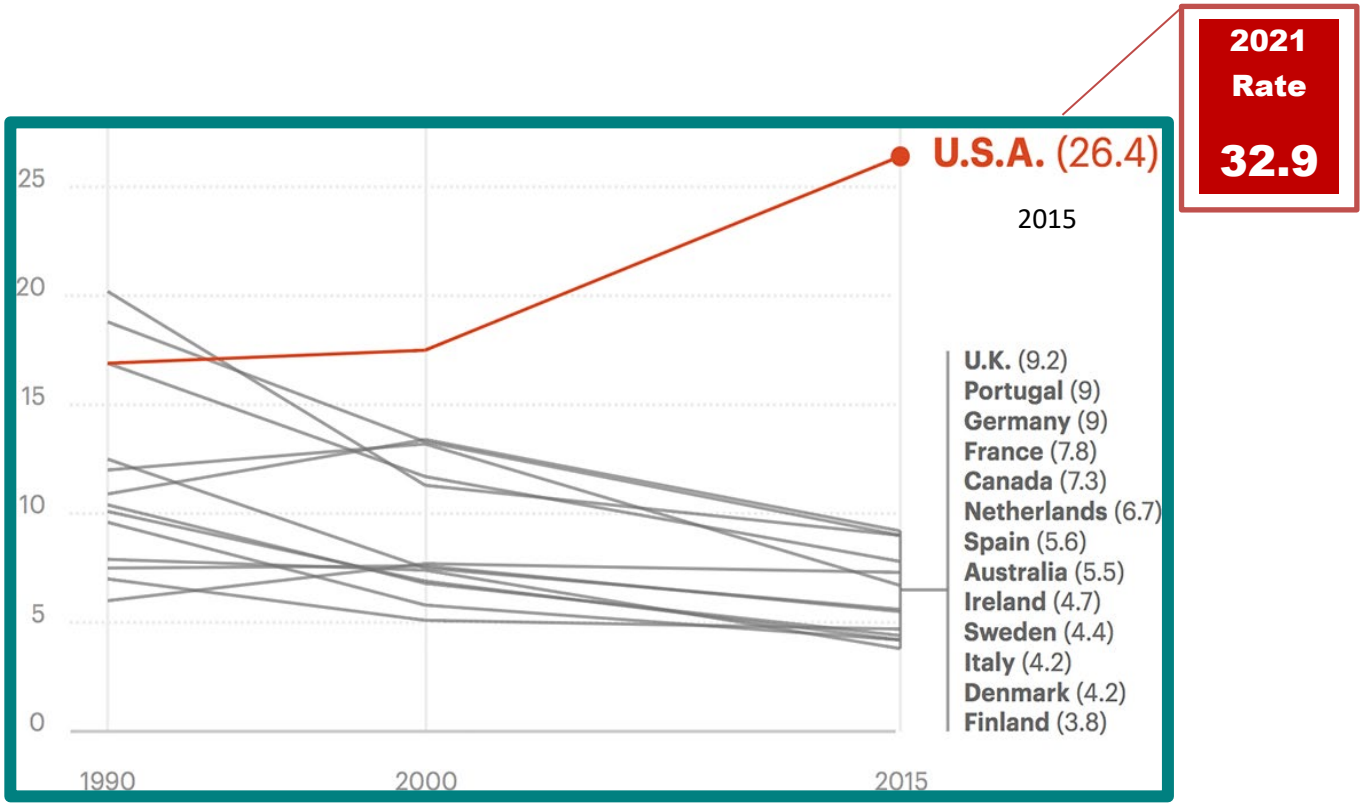
GRAPH 1: 2025 DEMOGRAPHIC MATERNAL MORTALITY RATIOS AND COUNTS FOR PREGNANCY-ASSOCIATED AND PREGNANCY-RELATED DEATHS, WASHINGTON STATE 2014-2022, WASHINGTON STATE DOH



GRAPH 2: 2025 PREGNANCY RELATED MATERNAL DEMOGRAPHICS 2014 – 2022, WASHINGTON STATE DOH



GRAPH 3: MATERNAL MORTALITY IS RISING IN THE U.S. AS IT DECLINES ELSEWHERE



Source: Chart originally published online: https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world. Data for this chart: GBD 2015 Maternal Mortality Collaboration. (2016) "Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015," *The Lancet*. Volume 388, pp.1775-812. Accessed online: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31470-2.pdf.

Kim S, Lee H, Park J, Son Y, López Sánchez GF, Pizzol D, Lee J, Lee YJ, Lee H, Kim HJ, Smith L, Woo S, Yon DK. Global, Regional, and National Trends in Maternal Mortality Ratio Across 37 High Income Countries From 1990 to 2021, With Projections up to 2050: A Comprehensive Analysis from the WHO Mortality Database. J Korean Med Sci. 2025 Feb;40(21):e85. https://doi.org/10.3346/jkms.2025.40.e85

Community Conversations (Listening Sessions)

Maternal Mortality Community Conversations - 2nd Round: Special Funded Project

In 2022, AIHC convened a series of listening sessions to address AI/AN maternal mortality disparities in the State of Washington. DOH provided $30,000 to fund a one-year contract for one or more listening session(s) focused on maternal mortality with the AI/AN community and Tribal health partners.

In 2024, DOH extended the opportunity for AIHC to continue this work by providing $30,000 for the second round of the project to convene 2 or more listening sessions focused on the health of AI/AN PBPWP with AI/AN Community members and Tribal Health partners.

Findings from the sessions are presented to AIHC leadership for recommendations and are finalized to be included in this addendum to the DOH 2025 MMRP legislative report.

This 2025 Addendum to the Washington State MMRP Report to the Legislature includes:

1. Findings from the 2024 – 2025 Community Conversations
2. Updates on findings and recommendations from the 2023 Report
3. Community comments and leadership recommendations for the 2025 Addendum

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Engagement Plan

AIHC Community Conversations were planned to be in-person convenings. The activities focused on bringing community members together to discuss and gather input about the health of AI/AN PBPWP community members.

This work continued to build on the previous work completed to support the 2023 American Indian Health Commission Maternal Mortality Report Addendum to the Washington State DOH Maternal Mortality Review Panel Report to the Legislature.

PULLING TOGETHER FOR WELLNESS FRAMEWORK

The Pulling Together for Wellness (PTW) framework is a culturally grounded policy, systems, or environmental change approach. PTW serves as guidance to AIHC strategic development to ensure both community and leadership engagement. Central to the PTW approach is the concept of holistic health, symbolized by the medicine wheel. This powerful symbol serves as a reminder that our physical, mental, emotional, and spiritual health are all interwoven in culture as central to all parts of personal, community, and environmental wellness. It's a visual representation of the framework's commitment to nurturing and healing the whole person: heart, mind, body, and soul.

The framework guides us to apply our values and balance Native and Western science in our processes. It raises the significance of Native epistemology "ways of knowing" and practice-based knowledge. It guides us to embrace the *Seven Generation Principle* as defined by our ancestors, which is defined as standing in the present, while looking back three generations to the wisdom and experiences of our ancestors to address issues in their current context while we embracing the strength of our ancestors in our planning for three generations forward to protect our children, grandchildren, great-grandchildren and the generations to come.

PTW reminds us of the importance of having partners that understand and honor Tribal Sovereignty and self-determination as a foundation in establishing effective relationships as well as valuing the history of the Tribe(s) and Indian Communities in their regions.

COMMUNITY CONVERSATIONS RESULTS

As reported above, in the first funding cycle of the Community Conversations about the Health of Native PBPWP Project with AI/AN community members and Tribal Health partners, all conversations with AI/AN community members were virtual due to the sequelae of COVID-19 restrictions. The 5 statewide virtual AI/AN community gatherings and the 5 Tribal and Urban Indian leadership gatherings resulted in the 7 strong leadership recommendations presented in the 2023 Maternal Mortality Review Panel Report to the Legislature AI/AN Addendum.

During the past two years, Tribal and Urban Indian communities were reopened to onsite visits, and AIHC was finally able to schedule Community Conversations in person, resulting in 6 Tribal and Urban Indian gatherings. Although the virtual gatherings were informative, the in-community gatherings are a culmination of a long-standing goal. The act of facilitating conversations in a participant's community is not only about gathering information, but also about building relationships and trust and demonstrates and affirms the importance of community wisdom and values.

The table below reflects comments shared by Community Conversation participants. Most of the comments are in participant's own words, in hope of keeping the spirit of their comments.

2024-25	Community Conversations Results
QUESTION 1	*How do you define maternal health, or the health of pregnant, birthing, and postpartum people (PBP)? What is important to know and understand?*
	There were many wonderful definitions of maternal health shared with us. Most of them referenced the importance of the holistic health of the mother and baby, including the importance of mental, emotional, spiritual, physical, and cultural health. The needs mentioned to support the health of PBP people in their community included support for a postpartum mom to heal mentally and physically. It was emphasized that parents need support for time to strongly bond with their new child. Additional support mentioned: • Access to health care and Indigenous providers in or near Tribal communities • Community Services Available to all 24/7 • Work policies to support parenting and breastfeeding • For postpartum depression and anxiety • Preventative education for both parents • More resources and education for both moms, parents and the community to understand what PBP people go through and what support parents of newborns need As one participant noted: "A happy momma is a happy baby!"
QUESTION 2	*What pregnancy and birth experiences do PBP people in your community have?*
	There were more participants who answered that they or PBP people in their community had negative (horrible, sad, traumatic, or hard) pregnancy and birth experiences, than participants who answered they or people in their community had positive experiences. As one participant noted: "(My birth experience was….) Traumatic. I never realized this until the conversation about birth stories happened." This participant's experience is something that needs further conversation and investigation – how many women are so acclimated to the lack of quality and trauma-informed care, that they do not realize that their own birth experience is not acceptable. A major concern across all participating communities was transportation issues, especially having to travel outside of community to access prenatal, birthing, and postpartum care. This impacted the quality of pregnancy and birth experiences. Additionally, participants felt that to improve the pregnancy and birth experiences the following services need to be available in their community: • Providers who are in the community, including midwives • Birthing classes • Lactation consultant • Support groups throughout the continuum, but especially for postpartum • Mental health support • Additional childcare options

QUESTION 3	*Do you believe substance misuse support and harm reduction options are needed and available to PBP people and people in your community?*

	The answers to this question were overwhelmingly yes, that resources are needed to support substance misuse prevention and treatment programs for PBP people in their communities. In some communities, participants noted that although there were some services and resources available, they were not meeting the need. More services, and more timely services without a long waiting period, are needed.
	
	Many participants also mentioned their concerns about postpartum depression and that the following services need to be available in their community:
	• More counselors specifically for pregnant and postpartum people and families
	• Mental health support for recovery
	• Detox and inpatient services where they will be comfortable
	• More support groups
	• Parent Child Assistance Program (PCAP) in their own community
	• More educational offerings for all ages:
	  ○ Prenatal classes
	  ○ Parenting classes
	• Prevention services for nicotine, vaping and alcohol

QUESTION 4	*What concerns do you have for PBP people in your community during the postpartum period?*

	The community participants have clear concerns about the postpartum period for the new parents in their community. Many participants remarked on the lack of support and outreach for the postpartum period while recognizing that this is a sensitive time of need for parents with a new family member. There is much concern over postpartum depression and other mental and physical health issues, exacerbating an underlying worry that parents will go back to misusing substances.
	
	Needs expressed for specific services and resources include:
	• Follow up visits at home
	• Help and support for postpartum depression
	• More mental health services
	• Cultural teachings for cultural practices
	• A hotline is needed for new mothers to be connected to services
	• Education/classes/hotline
	  ○ Postpartum depression
	  ○ Finances
	  ○ Lactation support
	  ○ Childbirth education
	  ○ Parenting classes
	• Education for community to understand postpartum needs
	• More childcare options
	• Support groups
	• Mental health and spiritual support

QUESTION 5	*What do new parents need to feel supported to fulfill their child's needs as they grow and develop?*

	The community member participants felt that new parents' greatest needs are family support, community support, and lots of love. They also felt that having someone to talk to, such as family members, elders, and friends is very important.
	
	Structured programs are also mentioned – programs such as:
	• Native Prenatal to 3 programs
	• Home visiting
	• Other cultural resources
	• Programs and classes such as:
	  ○ Childbirth education
	  ○ Lactation support classes
	  ○ Group play groups
	• WIC is also cited as an important resource

QUESTION 6	*What issues are you aware of that cause or contribute to Maternal Morbidity and Maternal Mortality?*
	The issues that participants felt contributed to maternal morbidity and mortality in their communities include a lack of support, lack of knowledge, and isolation. There were multiple remarks about the impacts of racist practitioners and systemic racism on the PBP people and families. Also stress, drug and alcohol misuse, and physical and emotional abuse were recognized as risk factors. Other risk factors cited include health conditions such as generational high blood pressure, obesity, depression and other mental health issues, and diabetes. Lack of prenatal care was also mentioned as a concern. Risk factors listed that contribute to maternal morbidity and mortality: • generational high blood pressure • Obesity • Postpartum depression/depression • Lack of support and isolation • Lack of knowledge • Drug use/substance misuse • Mental health issues • Poor nutrition • Lack of prenatal care • Systemic racism/racist practitioners • Physical and emotional abuse/domestic violence • Gestational diabetes mellitus • Stress • Smoking

QUESTION 7	*How can we get more people invested in community solutions to address maternal morbidity and mortality at all levels of support (family, community, systems, policy, and leadership)?*
	All the participants from all communities were in alignment – we need to get the word out! There are many great suggestions of how to share the news about the importance of healthy parents and healthy babies. These included town halls, fun and interactive community events, and educational events, all with incentives for everyone. Support groups, such as mommy groups, were also a popular suggestion, with one interesting suggestion that they hold discussion groups for different ages. It was a consensus to come together as a Native community to increase resources and services to families and expecting mothers. It is important to involve community leaders and hire staff who understand the parents', families,' and communities' backgrounds. It is important to recognize and utilize family power! The creative ideas to get more community members invested in addressing maternal morbidity and mortality in their communities include: • More support • Community events – make them fun! • Townhall meetings • Family power • Education/workshops with incentives • Support groups • Counseling • Involve community leaders • Parent groups • Come together as a Native community • Hire staff who understand our background • Increase resources and services to families and expecting mothers • Have discussions for different age groups • Personal stories, stories of our relatives

QUESTION 8	*Conversation for the Good of the Circle: What do we want our leadership and communities to know and do?*

	Three powerful statements for what participants want both leadership and community to know are:
	• to understand how important maternal health is
	• to know that mothers struggle
	• to know that pregnancy is very different for everyone
	
	They ask everyone to show more support to new parents and families; to honor our ways and demonstrate how sacred pregnancy is.
	
	There are also specific requests for leadership. They would like leadership to prioritize care, resources, and services for expecting parents and families; to determine what resources are needed and work to get them to their community.
	
	Specific needs requested include:
	• 24/7 access to care
	• Extended maternity and paternity benefits; this supports bonding between parents and child
	• Pregnant moms, families in the community need more classes to prepare and support:
	  ○ Childbirth education
	  ○ Parenting
	  ○ Lactation support
	  ○ Decreasing stigma
	  ○ Dealing with addiction
	  ○ Understanding maternal health, etc.
	• Need prenatal, lactation, mental health, and behavioral health providers in the community
	• Services to deal with racism and stigma
	• Support groups
	• Resources for new parents and families: transportation, gas cards, etc.
	• Find grant monies to aid in the objective of maternal health

QUESTION 8A	*What participants want leadership and communities to know and do?*
	• What resources we have or don't have. If we don't have them, we want our leaders to go after them and bring them to the community • Show more support to new parents and families • Honor our ways • I want leadership and community to know mothers struggle because they literally do everything • Understand how important maternal health is • Understand the benefits of bringing baby to work

In summary, it was a great honor for us to be welcomed and trusted in communities. It was humbling to hear very personal stories from participants about the most concerning obstacles, challenges, and injustices Tribal community members are dealing with. It was uplifting and inspiring to hear their brilliant insights about their home communities, community members, and families, as well as their ideas about ways to make their lives and the lives of people in their communities better. It was a beautiful experience.

There were common answers seen as important and pragmatic solutions for each question and across each community, like the need for education and classes of different subjects. The 3 most mentioned were: childbirth education classes, parenting classes, and lactation support classes.

Whatever need was suggested, the critical component was that the services needed to be available in their own community. Another issue that permeated across all the questions was assertions that both mothers and fathers need to be supported.

In-person gatherings are an important component of Tribal-led work. These visits are a win-win-win strategy – AIHC, community members, and Tribal/Urban Indian Health leaders all gain imperative insights. To achieve meaningful change, these projects do need to be sustainable, which requires long-term support, funding, and commitment.

LEADERSHIP CONSIDERATIONS

> "Sovereignty, the inherent right of self-government and self-determination, is the focal point in all Indian issues."
>
> Senator Daniel K. Inouye, former Chairman of the Senate Select Committee on Indian Affairs.

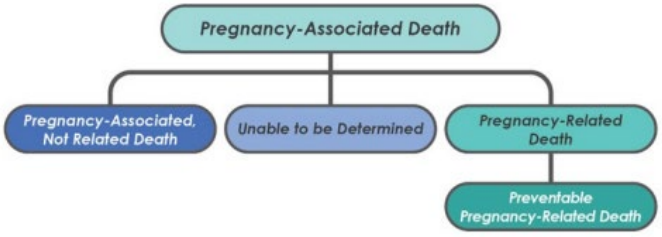
Upholding Tribal Sovereignty is a foundational principle – this is fundamental for all issues related to Tribes, as it is the law of the land in federal law and Washington state law.[iv] The U.S. Constitution, specifically the "Indian Commerce Clause" (Article I, Section 8, Clause 3), acknowledges tribes as separate entities with whom Congress can regulate commerce.[v] Washington State Law requires agencies make a reasonable effort to collaborate with Tribes in the development of policies, agreements, and program implementation that directly affect Indian tribes and develop a consultation process that is used by the agency for issues involving specific Tribes.[vi]

The Washington State death records indicate that AI/AN maternal mortality has not decreased; in fact, AI/AN maternal mortality rates have increased since the 2023 MMRP report in our state. An incident of the loss of the life of a mother is devastating for loved ones and can have rippling effects across the lifespan of a child's experience and have impact on multiple generations of the relatives and tribal community members that care for the infant child. However, the absence of a mother is most stark for the newborn, who will not have the benefit of a lifelong maternal-infant bond that is formative to developing early relationships which increase the infant's ability to thrive;[vii] nor will the infant have the opportunity for the essential breast milk and nutrients that serve as immunological benefits crucial for developing a strong immune system. From a public health perspective, there needs to be a better understanding of the true impact of a loss of a mother due to Maternal

Mortality in the context of the AI/AN experience in the United States, and in Washington State specifically. Although there is literature in the experiences from other countries, studies specific to AI/AN is void.[viii] It is critical to identify AI/AN Maternal Mortality as an urgent priority. This is a crisis for our Native parents, families, and future generations. It must be a priority until the AI/AN maternal mortality disparity is eliminated.

The Washington State MMRP conducts reviews of all maternal deaths; pregnancy associated death is synonymous with maternal death. As part of the review process, the MMRP categorizes each maternal death into one of the following categories: Pregnancy-Associated, Not Related Death; Unable to be Determined; Pregnancy-Related Death; or Preventable Pregnancy-Related Death.

Figure 1a: Key Definitions – Maternal Mortality Review Panel



Considering the high number of AI/AN Pregnancy-Associated Maternal Deaths, there should be an effort to better understand the cause of all AI/AN maternal deaths. All AI/AN maternal deaths may need to undergo the same level of review as Pregnancy-Related Maternal deaths to understand the potential complexities of the root causes of maternal deaths specifically for AI/AN PBPWP. Tribes and UIHOs may raise this issue with DOH and the MMRP to understand the structure and feasibility of changing the review guidelines to include full review of pregnancy associated deaths in a thorough examination process by the State Maternal Mortality Review Committee.

2025 AIHC Maternal Mortality Recommendations to DOH and The Legislature

	2025 AIHC MATERNAL MORTALITY RECOMMENDATIONS
RECOMMENDATION 1:	Uphold Tribal Sovereignty – this is fundamental for all issues related to Tribes, as it is the law of the land.
RECOMMENDATION 2:	Prioritize elimination of Native Maternal Mortality until the disparity is eliminated.
RECOMMENDATION 3:	Acknowledge that the Maternal Mortality of AI/AN birthing people is a crisis.
RECOMMENDATION 4:	Work with DOH to change the review process to include pregnancy associated deaths for full examination in the review process by State MMRP.
RECOMMENDATION 5:	Continue efforts to facilitate discussions regarding MMR in each Tribal community and urban Indian community.
RECOMMENDATION 6:	Align with Opioid/Fentanyl Response Taskforce efforts as they relate to maternal mortality and morbidity.
RECOMMENDATION 7:	Explore development of Maternal Mental Health Behavior Health Aide provider type and a Maternal Health Support hotline.
RECOMMENDATION 8:	Continue investment in the people who experience the highest level of impact of social determinants of health, the highest mortality rates, and are most affected by discrimination.
RECOMMENDATION 9:	Support the implementation of the Pulling Together for Wellness framework at the Tribal/UIHO level.
RECOMMENDATION 10:	Support sustainable long-term implementation of the AI/AN PRAMS-like survey, State PRAMS survey, and ACEs questionnaire.
RECOMMENDATION 11:	Assess provider training and education within state systems to understand gaps in knowledge base in working with Tribes and AI/AN people.
RECOMMENDATION 12:	Utilize AIHC's MCHBG assessment data, Community Conversations data, other Tribally developed and led data sets for planning and policy development, in combination with the addendum recommendations.
RECOMMENDATION 13:	Continuously monitor the implications of recent federal actions and policy changes that impact State and Tribal funding, affecting AI/AN health and wellness systems, structures, and supports.
RECOMMENDATION 14:	Support the Washington State-administered Pregnancy Risk Assessment Monitoring Survey and Surveillance System (PRAMS), as well as the AI/AN Pregnancy Resilience and Risk Assessment and Action Monitoring Surveillance System (AI/AN PRRAAMSS).

These recommendations are strong and important strategies in the work of improving AI/AN maternal, infant, and family health. It is important to note that although most of the Tribal/Urban Indian leader recommendations for the 2025 Addendum are new, the original recommendations still stand as foundational recommendations and strategies, which need to be reviewed and considered when actions and projects are suggested. The 14 new

leadership recommendations reflect the rich detail of working face-to-face in the community, the work that has occurred in the last 2 years and the impacts of the current state and federal environment.

Our #1 priority is consistently to reduce Native Maternal Mortality until the disparity is eliminated.

Ongoing and Current Work of AIHC

Tribal-led, holistic approaches, and continuity of work is critical to Tribal/Urban Indian Health Leaders. When you are continually underfunded and under-resourced, duplicative, and unnecessary rework is not welcome or efficient. In the overview presentation to the Tribal and UIHO leaders, the current and ongoing MIH work and projects were shared. It was agreed that these are a priority and should be integrated into the recommendations.

In the 2023 Maternal Mortality Review Panel Report to the Legislature, the AIHC AI/AN Addendum was informed by 5 statewide AI/AN Tribal and Urban Indian community member virtual sessions and 5 AI/AN Tribal/Urban Indian Leadership virtual sessions. These 10 sessions resulted in the following 7 Tribal/Urban Indian leader recommendations:

1. The number one priority is to reduce Native Maternal Mortality until the disparity is eliminated.
2. Culturally appropriate engagement and building trust at the community level is critical to understanding root causes of Native Maternal Mortality and essential to finding appropriate solutions and strategies.
3. Tribal-led data needs assessments, planning, administration, and analysis, including Tribal PRAMS, to address root causes of AI/AN maternal morbidity and mortality, substance misuse, and harm reduction strategies.
4. Address historical inequities and create trust in health transformation system change through policy, inclusion, and allocation of funds to create and assure culturally relevant services.
5. Improved and expanded access for culturally relevant services and resources, utilizing Seven Generations Principles, throughout the continuum of pregnancy, birth and postpartum for parents.
6. Funding, focus and prioritization to support Tribal-led workforce planning and development to successfully recruit, train, and hire an AI/AN workforce to support the needs of Native PBP people.
7. Support and fund Tribal-led nutrition planning and project development initiatives, such as Food Sovereignty and First Foods (breastfeeding) work.

Updates on Progress

AI/AN Maternal Mortality 2023 Recommendations Updates

The one original recommendation that is consistent in both is the 2023 and the 2025 AI/AN Addendum is "Prioritize reducing Native Maternal Mortality until the disparity is eliminated" with the addition of "as well as maintain this priority until it is achieved" in the 2025 report. (This list is provided to offer a glimpse of some of the activities since the last report; however, it is not complete as we have not officially conducted a comprehensive assessment or scan).

2023-2025 Progress to Address AI/AN Maternal Mortality	
2023 Recommendations	Initiatives
The number one priority is to reduce Native Maternal Mortality until the disparity is eliminated.	• There are several Tribal and Urban Indian grass roots organizations (versus Tribal Nations) who are conducting significant birth justice work in their communities. • AIHC is working on the AI/AN PRAMS Project to administer a unique AI/AN PRRAAMS survey. This is a Tribal-led project to address root causes. • AIHC Maternal Child Health Block Grant (MCHBG) needs assessment; was designed and implemented as a Tribal led project. • AIHC Community Conversations Project is gathering data on the health of Native PBP people. • AIHC MIH workgroup survey is gathering data on the needs/resources gap in Tribal and Urban Indian communities. • AIHC is gathering data about the feasibility of Tribal MMRP/C models and raising awareness of this effort to leadership and elders. • AIHC is conducting a study regarding the needs of AI/AN families utilizing WIC.
Culturally appropriate engagement and building trust at the community level is critical to understanding root causes of Native Maternal Mortality and essential to finding appropriate solutions and strategies.	• AIHC is working on the AI/AN PRAMS Project to administer a unique AI/AN PRRAAMS survey. This is a Tribal-led project to address root causes. • AIHC is applying appropriate comprehensive strategies in engagement and trust building.

Tribal-led data needs assessments, planning, administration, and analysis, including Tribal PRAMS, to address root causes of AI/AN maternal morbidity and mortality, substance misuse, and harm reduction strategies.	• AIHC is working on the AI/AN PRAMS Project to administer a unique AI/AN PRRAAMS survey. This is a Tribal-led project to address root causes. • AIHC MCHBG needs assessment; was designed and implemented as a Tribal led project. • AIHC Community Conversations Project is gathering data on the health of Native PBP people. • AIHC MIH workgroup survey is gathering data on the needs/resources gap in Tribal and Urban Indian communities.
Address historical inequities and create trust in health transformation system change through policy, inclusion, and allocation of funds to create and assure culturally relevant services.	• Tribes, Urban Indian Health leaders, AIHC, and legislative/state agency partners worked together to successfully pass the Traditional Indian Medicine Bill.
Improved and expanded access for culturally relevant services and resources, utilizing Seven Generations Principles, throughout the continuum of pregnancy, birth and postpartum for parents.	• Affiliated Tribes of Northwest Indians (ATNI) adopted the PTW framework and its 21 competencies by resolution as the policy of ATNI Conference in May. • AIHC's PTW framework is a culturally grounded policy, systems, or environmental change approach and introduces the concept of the Seven Generational Principle in Tribal and non-Tribal training. • Generational Clarity training is available through AIHC. The training addresses the impact of historical trauma and adverse childhood experiences on the health and well-being of AI/AN people. It includes the importance of both our authentic stories and the acknowledgment of the strength of our ancestors.
Funding, focus, and prioritization to support Tribal-led workforce planning and development to successfully recruit, train and hire an AI/AN workforce to support the needs of Native PBP people.	• Tribal, Urban Indian, and Indigenous Grass Roots organizations such as the Northwest Portland Area Indian Health Board, Hummingbird Indigenous Family Services, and the Center for Indigenous Midwifery are working on training. • AI/AN Community Health Aides and Behavioral Health Aides, Indigenous Doulas and Lactation Consultants, and Community Midwives and Childbirth Educators respectively.

Support and fund Tribal-led nutrition planning and project development initiatives, such as Food Sovereignty and First Foods (breastfeeding) work.	• AIHC has sponsored a Food Sovereignty Speaker Series for two years based on feedback from Tribal communities. The series has had inspirational and captivating AI/AN experts to address topics like kinship and reciprocity with our environmental and cultural resources, first foods, access to traditional foods and medicines, nutrition, sacred tobacco, addressing hunger in tribal settings, cultivating gardens, harvesting, meal preparation, and more.

In closing, we offer you a wonderful highlight of the work of the Suquamish Tribe in their Changing Tides, Helping Hands Home Vising Program. The program is an incredible example of innovations that are happening in Tribal and UIHO settings through the vision and commitment of strong Native women, like Cori and Shallee, who are changing the world by the impact they have on the lives of those they serve in community.

We also want to acknowledge the importance of fathers, uncles, and grandfathers who attended the Community Conversation convenings and expressed their commitment to maternal, paternal, infant, child, and family health in their communities.

Tribal Program Highlight

Suquamish Tribe Changing Tides, Helping Hands Home Visiting Program

In the Suquamish community, Cori Silvey (Suquamish) and Shallee Moss (Port Gamble S'Klallam) offer Parents as Teachers services to families enrolled in their Changing Tides, Helping Hands Home Visiting program through the lens of Indigenous Home Visitors and birthing people. To be welcomed into someone else's home, family, and pregnancy is sacred work. Since working together, both Cori and Shallee have felt passionate about honoring the experiences of Indigenous birthing and parenting relatives. Although their program is small – one funding source (DCYF) and eighteen slot – much of their recruitment and community engagement is rooted in building connections and making generational impacts.

Over the past year, Cori and Shallee have secured additional grant funding to plan and host an Indigenous Parenting Conference in December (2024), and two Womb Wisdom and Healing Dips this past June (2025). Both events left a legacy of caring deeply for Indigenous families in the Suquamish community. In addition to their own events and celebrations, Cori and Shallee also find creative ways to participate and contribute to other community events, celebrations, and services in an intentional effort to be in good relationship with other programs and services, who also serve their home visiting families. In coming years, Cori and Shallee hope to obtain Indigenous lactation consultant training, host and facilitate more collective healing opportunities, and growing the learning community that they've created.

Closing Summary

There is a lot of incredible work happening in Tribal and Urban Indian communities in Washington State. This work is possible due to the passion and commitment of the AI/AN and Indigenous leaders and the support and funding by partners. This work is critical, but it takes support, resources, understanding, and funding for it to continue to a sustainable level for the time needed to make measurable differences. When it is emphasized that working with the AI/AN population requires a trauma informed approach, sustainability is one of the most powerful messages to demonstrate.

When programs and projects are funded on a limited basis, it only feeds into the true-life experiences and messaging that AI/AN people do not matter. Building trust and healthy committed relationships with individuals and communities is a powerful strategy to ensure healthy moms, healthy dads, healthy babies, and healthy families, now, and for future generations.

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[i] Washington State Department of Health. (2023). Report to the Legislature, Washington State Maternal Mortality Review Panel: Maternal Deaths 2017-2020. https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf, Retrieved July 23, 2025

[ii] Hoyert DL. Maternal mortality rates in the United States, 2020. NCHS Health E-Stats. 2022. DOI: https://dx.doi.org/10.15620/cdc:113967

[iii] Walters KL, Mohammed SA, Evans-Campbell T, Beltrán RE, Chae DH, Duran B. BODIES DON'T JUST TELL STORIES, THEY TELL HISTORIES: Embodiment of Historical Trauma among American Indians and Alaska Natives. Du Bois Rev. 2011 Apr;8(1):179-189. doi: 10.1017/S1742058X1100018X. PMID: 29805469; PMCID: PMC5967849.

[iv] Wilkinson, C. F., Miklas, C. L. (1988). Indian Tribes as Sovereign Governments: A Sourcebook on Federal-Tribal History, Law, and Policy. United States: AIRI Press.

[v] https://constitution.congress.gov/browse/article-1/section-8/clause-3/

[vi] https://app.leg.wa.gov/RCW/default.aspx?cite=43.376.020

[vii] Modak A, Ronghe V, Gomase KP. The Psychological Benefits of Breastfeeding: Fostering Maternal Well-Being and Child Development. Cureus. 2023 Oct 9;15(10):e46730. doi: 10.7759/cureus.46730. PMID: 38021634; PMCID: PMC10631302

[viii] Miller S, Belizán JM. The true cost of maternal death: individual tragedy impacts family, community and nations. Reprod Health. 2015 Jun 17; 12:56. doi: 10.1186/s12978-015-0046-3. PMID: 26081494; PMCID: PMC4470047