Report to the Legislature

Washington State Maternal Mortality Review Panel: Interim Executive Summary, Maternal Deaths 2017–2020

October 2022
RCW 70.54.450

Prepared by the
Prevention and Community Health Division

Washington State Department of Health

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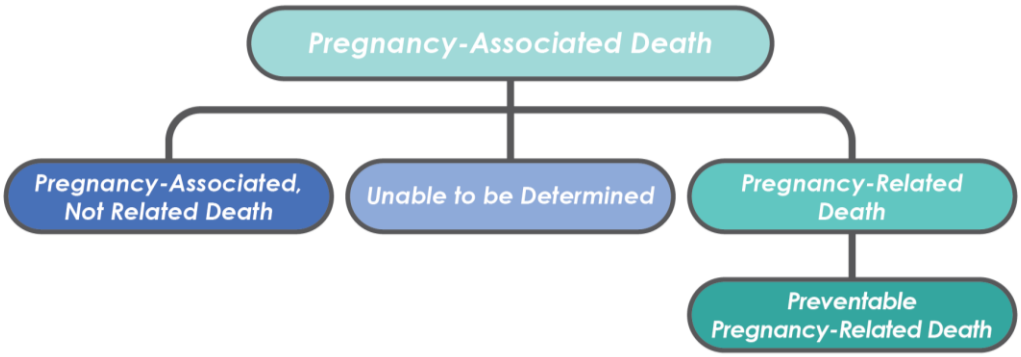
Interim Executive Summary

The Washington State Maternal Mortality Review Panel (Panel) reviews anonymized maternal deaths and makes recommendations based on pregnancy-related, preventable deaths to prevent similar losses in the future. RCW 70.54.450 requires the Panel to submit a report with data and recommendations to the Legislature every three years. This briefing contains a preview of policy and funding recommendations from 2017–2020 maternal deaths, and a review of findings based on cumulative data from 2014–2020 deaths. A full report will be released in February 2023.

Figure 1: Key Definitions - Washington State Maternal Mortality Review Panel



Pregnancy-Associated Death
The death of a person during pregnancy or within one year of the end of pregnancy from any cause*
(*This term is synonymous with maternal death in this report and as outlined in RCW 70.54.450.)

Pregnancy-Associated, Not Related Death
The death of a person during pregnancy or within one year of the end of pregnancy from a cause that is not pregnancy related.

Unable to be Determined
Pregnancy-relatedness could not be determined.

Pregnancy-Related Death
The death of a 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.

Preventable Pregnancy-Related Death
A death is considered preventable if the Panel determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

Review Findings: 2014–2020 Maternal Deaths

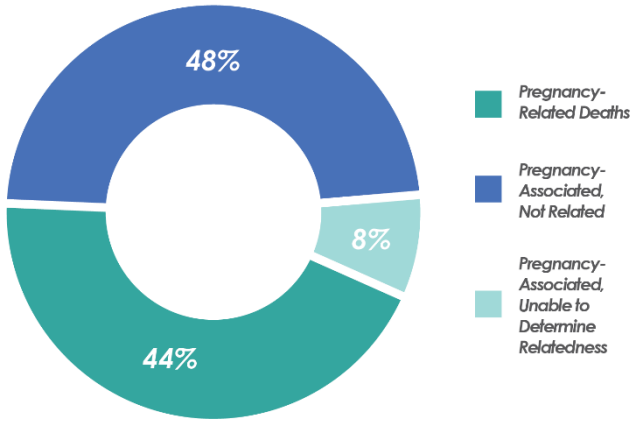
(Note: These numbers, while each representing a tragic loss, are statistically small and should be interpreted with caution.)

The *overall* maternal mortality rate decreased slightly in 2017 and increased in 2018 and 2019. Unlike in much of the United States, the maternal mortality rate in Washington decreased in 2020. However, this decrease is expected to be temporary, as preliminary 2021[1] data suggest a rate more consistent with 2018–2019 trends.

[1] 2021 deaths will be reviewed by the Panel in 2023 and will be included in the subsequent report expected in 2025.

There were **224 *pregnancy-associated* deaths,** defined as deaths from any cause during pregnancy or within one year of the end of pregnancy. Of these 224, the Panel identified **97 *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 physiologic effects of pregnancy.

Figure 2: 2014-2020 Pregnancy Relatedness



Pregnancy-related deaths

- There were **15.9 *pregnancy-related* deaths per 100,000 live births** in Washington from 2014–2020, lower than the U.S. rate of 18.6 pregnancy-related deaths per 100,000 live births in this timeframe.

- Most ***pregnancy-related*** deaths **occurred after the end of pregnancy**, with 31 percent occurring 2–42 days after pregnancy and 31 percent occurring 43 days to one year after pregnancy. Most people have only one visit with their pregnancy care provider in the first 42 days after birth and then care transitions back to a person's primary care provider.

- **Leading underlying causes** of *pregnancy-related* deaths were **behavioral health conditions** (32 percent), predominantly by **suicide** and **overdose**. Other common causes included **hemorrhage** (12 percent) and **infection** (10 percent). **Accidental overdose** was the cause of death in seven percent of *pregnancy-related* deaths and 10 percent of *all* maternal deaths. **Substance use** was associated with 20 percent of *all* maternal deaths.

Preventable pregnancy-related deaths

- The Panel found **80% of *pregnancy-related* deaths were *preventable*.**
- **Contributing factors** that, if altered, might have prevented a *pregnancy-related* death included: gaps in **clinical skill** and **quality** of care, particularly recognizing and responding to obstetric emergencies; lack of **screening** or appropriate **follow-up for** risk factors such as behavioral health, substance use, violence, and lack of social support; lack of **care coordination** or **continuity of care**, lack of access to health care and behavioral health treatment, and issues of **bias and discrimination** affecting referrals and use of clinical standard procedures. Contributing factors were exacerbated by social and structural determinants of health such as **housing instability** and **systemic racism**.

Overview of Priority Recommendations

These are the Panel's six priority areas for recommendations, with a condensed preview of recommended policy and funding actions.

1. **Address racism, discrimination, bias, and stigma in perinatal care by cultivating a health care workforce that reflects the communities they serve.**
   - Increase the number, variety, and cultural congruence of perinatal health care providers.
   - Increase access to care in patients' preferred languages.
   - Fund training and education for providers and staff on addressing implicit bias, providing culturally and linguistically appropriate care, and strategies to ensure people giving birth are heard and seen as decision makers in their own care.

2. **Increase access for pregnant and parenting people to equitable, high-quality, trauma-informed mental health and substance use disorder prevention, screening, and treatment.**
   - Fund services for pregnant, birthing, and postpartum people with mental health and substance use disorders, including home visiting (both immediately after delivery and later in postpartum); residential treatment; increased availability of outpatient treatment; culturally appropriate mental health care and screening; peer recovery support; and longer birth hospital stays for patients in need of medications for opioid use disorder (MOUD).
   - Increase mental health and substance use disorder services so pregnant and parenting people can access inpatient and outpatient services in their community, accompanied by their dependent children, without barriers or long wait times.
   - Expand and support addiction specialist consultation for providers.

3. **Expand coverage of equitable and high-quality health care by increasing care integration, expanding telehealth services, and increasing reimbursement.**
   - Support rural hospitals and tribal clinics to expand access to obstetric care through funding and obstetrical training.
   - Fund home visiting services for pregnant and postpartum families across Washington state. Within 2–3 days after discharge, have a licensed provider assess parent and newborn for safety, medical, psychosocial, and economic needs. After initial visit, focus long-term home visiting on those with complex needs.
   - Improve and expand telehealth access.
   - Increase Medicaid reimbursement and number of visits for high-quality prenatal and postpartum care.
   - Make pregnancy a qualifying life event for individuals purchasing a health plan on the state's health insurance exchange.

4. **Strengthen the quality and availability of perinatal clinical and emergency care that's comprehensive, coordinated, culturally appropriate, and adequately staffed.**
    - Fund and support easily accessible reproductive and contraceptive health care, including abortion.
    - Fund perinatal clinical quality improvement efforts such as those being implemented by the Obstetrical Care Outcome Assessment Program (OBCOAP), Alliance for Innovation on Maternal Health (AIM), Perinatal Substance Use Disorder Learning Collaborative, and the perinatal regional coordinators' quality improvement projects.
    - Fund improved electronic health record (EHR) data sharing across health systems and EHR vendors.
    - Provide training and drills for coordination between obstetricians and emergency departments to respond to obstetric emergencies.

5. **Meet urgent needs of pregnant and parenting people by prioritizing access to housing, income, nutrition, transportation, child care, care navigation, and culturally relevant support services.**
    - Support and fund basic needs services that remove inequities in social and structural determinants of health, including housing, nutrition, transportation, child care, and education throughout the life course.
    - Streamline access to, approval of, and re-enrollment in programs that support health care, housing, transportation, child care, nutrition, and education.
    - Fund a pilot project to explore universal basic income for pregnant people.

6. **Improve the prevention of domestic, intimate partner, and firearm violence in the perinatal period through survivor centered and culturally appropriate coordinated services.**
    - Fund survivor-centered support resources.
    - Fund tribally based domestic violence prevention programs.
    - Incentivize patient screening, education, and support for survivors of intimate partner and gender-based violence.
    - Incentivize health care providers to receive training about intimate partner violence in pregnancy and postpartum.
    - Strengthen legal supports, representation, and advocacy for survivors of violence, and ensure appropriate implementation of existing firearm protections for survivors.

Maternal mortality reviews identify critical points of intervention that can prevent maternal deaths. A better understanding of these issues is foundational to undoing inequities that make communities of color especially vulnerable to poor maternal health outcomes. The full report will be released in February 2023.