



Strengthening Supports for Maternal Health



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hot topics
in practice

www.nwchpr.org/hot-topics

Northwest Center
FOR PUBLIC HEALTH PRACTICE

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The Northwest Center for Public Health Practice acknowledges the land we occupy today as the traditional home of the Tulalip, Muckleshoot, Duwamish and Suquamish tribal nations.

Without them we would not have access to this working, teaching and learning environment. We humbly take the opportunity to thank the original caretakers of this land who are still here.

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Question for the Viewers

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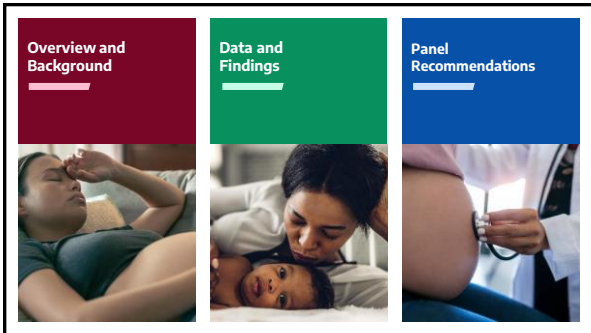
Describe your level of knowledge or experience with maternal mortality data in your state or region:

- A. A lot
- B. Some
- C. Little
- D. None

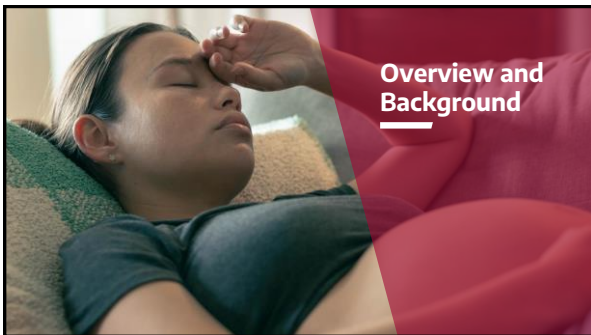
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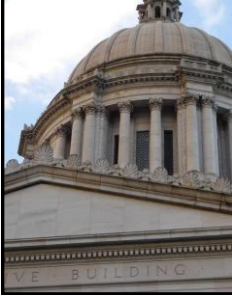


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Maternal Mortality Review Panel: Legislative Mandate



The Panel is directed by the maternal mortality review panel law (RCW 70.54.450) to conduct comprehensive reviews of maternal deaths in Washington.

- The Washington State Legislature established the **Maternal Mortality Review Panel in 2016**, following enactment of Senate Bill 6534.
- **In 2019, the law was amended to permanently establish the Panel** and the maternal mortality review process.

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Maternal Mortality Review Panel: Legislative Mandate



The law 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

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Who is on the Panel?



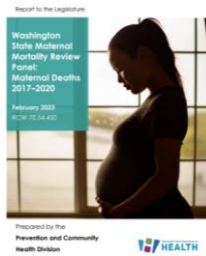
The 2023 - 2025 MMRP has an incredible wealth of experience

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2023 Maternal Mortality Review Report

Aims of the report:

- Prevent maternal deaths
- Raise awareness about contributing factors
- Promote change
- Increase health equity
- Improve perinatal care



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Maternal Mortality: The Tip of the Iceberg

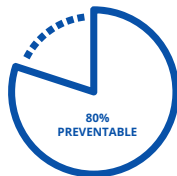


At least **60,000 people** each year in the United States experience severe complications related to pregnancy and childbirth.

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Key Message: Preventability

The Panel found **80 percent of pregnancy-related deaths were preventable**, meaning there was at least some chance of the death being averted if a factor that contributed to the death had been different.

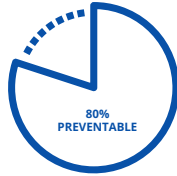


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Key Message: Preventability

This high percentage reflects:

- **A broader understanding of preventability**
 - From a clinical perspective
 - From an equity and social determinants of health perspective
- **An opportunity to take action** because we better understand what's behind maternal deaths



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Overview of Data

- Trend data show that overall pregnancy-associated mortality in Washington state has remained relatively stable in recent years and did not increase in the period 2014 – 2020. But disparities persist.
- Leading underlying causes of pregnancy-related deaths were behavioral health conditions (predominantly by suicide and overdose), hemorrhage, and infection
- We are **not able to draw conclusions about the impact of COVID-19** pandemic on maternal mortality in Washington state because of the very small number of maternal deaths in 2020 associated with COVID-19

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Key Message: Racism, Discrimination, and Bias

- **Critical disparities persist by race and ethnicity, socioeconomic status, and urban vs. rural status**
- We understand these better due to changes in how the Panel reviews cases and how we review data on communities with smaller populations
- The Panel identified **discrimination, bias, interpersonal racism, or structural racism** in **49 percent** of preventable pregnancy-related deaths from 2017 - 2020



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Key Message: Racism, Discrimination, and Bias

- Communities most burdened by perinatal health inequities have the **expertise** and **cultural knowledge** to lead solutions to reduce maternal mortality
- Black, indigenous, and communities of people of color must be **centered as leaders** for the successful implementation of many of the recommendations in this report



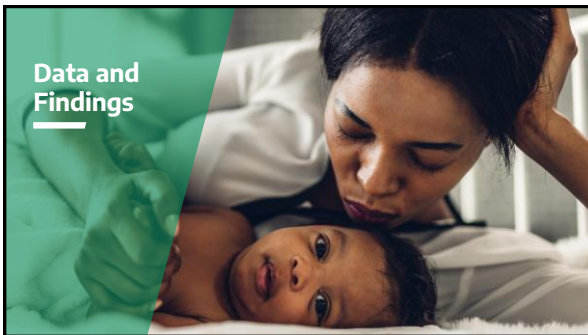
CONSIDER:
How do we operationalize this locally? What is your role? What is already being done?

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How Cases Are Reviewed

- **A respectful review of each potentially pregnancy related death**
- **Try to reach consensus**
 - Was the death pregnancy related?
 - What was the underlying cause of death?
 - If it was pregnancy related, was it **preventable**?*
 - **Did racism, discrimination, and bias play a role?**
 - If it was pregnancy related and preventable, what factors contributed to the death?
- **Make recommendations (provided in report every three years)**
 - What were the opportunities for intervention – who needs to do what and when?

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Considerations



Maternal mortality is a rare event.

- Observations from maternal mortalities in Washington are not generalizable outside the state
- Small numbers often make rates unstable, making it difficult to discern true change on a year-to-year basis
- We can still make meaningful recommendations and interventions

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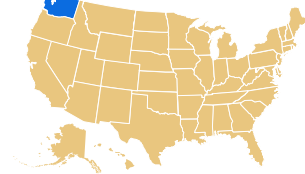
Maternal Mortality, WA and US, 2014 – 2020

Washington

- 15.9 pregnancy-related deaths / 100,000 live births*

United States

- 18.6 pregnancy-related deaths / 100,000 live births**
- 861 pregnancy-related deaths per year (PMSS - CDC 2020)
- Rates increasing since 1980s
- Higher than rates in Canada, Europe, and other wealthy nations

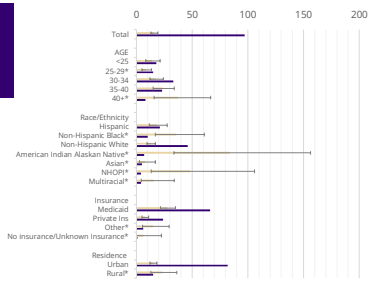


* This rate (WA) includes deaths from substance use overdose and suicide
 ** This rate (US) does NOT include deaths from accidental or incidental causes

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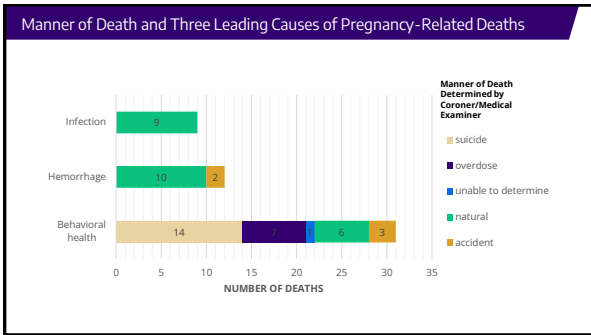
Pregnancy-Related Deaths, 2014 – 2020 (n = 97)

- Rate per 100,000 Births
- Frequency



*RSE is above 25%; rates are unstable.

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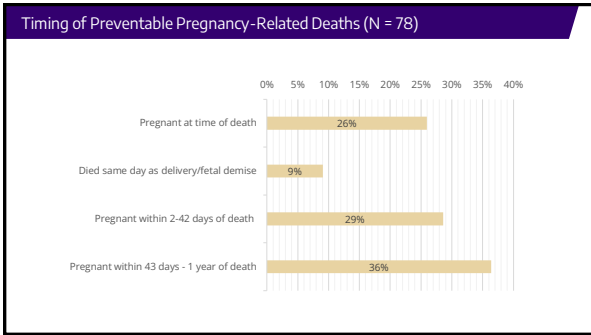


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Preventability of Pregnancy-Related Deaths as Determined By MMRP

Preventability of Pregnancy Related Deaths	Count	Percent (%)
YES - Preventable	78	80.4
NO - Not preventable	16	16.5
Unable to determine preventability	3	3.1

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Societal Levels of Contributing Factors

Contributing Factors to Death

Event(s) or issue(s) identified by the Panel during the review of each death that **if changed or averted**, may have **prevented the death** from occurring

- ▶ **Community Level**
- ▶ **Systems of Care Level**
- ▶ **Facility Level**
- ▶ **Provider Level**
- ▶ **Patient/Family Level**

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Question for the Viewers

In your own work to support maternal health, which of the following areas is currently your highest priority?

- A. Addressing racism and promoting health equity
- B. Increasing access to mental health and substance use disorder prevention
- C. Strengthening care integration
- D. Improving quality of care
- E. Other (type in chat)

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Panel Recommendations

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Recommendations: Key Audiences

The Panel's recommendations fall under six broad categories, each with detailed recommended actions for four key audiences:

1. Policy and Budget Actions (**Legislature**)
2. Perinatal Systems of Care (**Providers and Facilities**)
3. Governmental, Academic, Community, and Professional Agencies and Organizations
4. The **Department of Health**

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Action Item



1. Address racism, discrimination, bias, and stigma in perinatal care.

- Expanding and diversifying the perinatal workforce to reflect cultures and languages of communities
- Prioritizing access to perinatal care in communities experiencing inequities

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Action Item



2. Increase access to mental health and substance use disorder prevention, screening, and treatment for pregnant and parenting people.

- Enhance reimbursement for mental health and substance use disorder screening
- Increasing the number of residential treatment facilities that allow parents and children to be together

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Action Item



3. Expand equitable and high-quality health care by improving care integration, expanding telehealth services, and increasing reimbursement

- Expanding home visiting services for pregnant and postpartum families
- Supporting legislation to increase doula and midwives through one year postpartum

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Action Item



4. Strengthen the quality and availability of perinatal clinical and emergency care that is comprehensive, coordinated, culturally appropriate, and adequately staffed

- Supporting legislation that creates perinatal quality improvement incentive programs for outpatient perinatal services
- Ensuring pregnant patients of all body sizes and weights get appropriate and respectful care

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Action Item



5. Meet basic needs of pregnant and parenting people by prioritizing access to housing, nutrition, income, transportation, childcare, care navigation, and culturally relevant support services

- Increasing access to safe, affordable, stable housing
- Increasing funding for education, employment, childcare, transportation, and other services

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Action Item



6. Prevent violence in the perinatal period through survivor-centered and culturally appropriate coordinated services

- Funding safe housing for pregnant and postpartum people
- Funding free legal services for families

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American Indian Health Commission

“The number one priority is to reduce Native Maternal Mortality until the disparity is eliminated.”

“It is essential to American Indian/Alaska Native healing to rely on Tribally developed and implemented solutions. What the Tribes and Urban Indian Health Organizations need is partnership with the state in funding and collaboration. It has been 500+ years of trauma and discrimination; it will take time to heal”



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Implementation: Washington State Perinatal Collaborative (WSPC)

Vision

Washington state is a safe and equitable place to experience pregnancy, give birth, be born, and parent

Mission

End preventable morbidity, mortality, and disparities in pregnancy, postpartum, and infant care through quality improvement initiatives and fostering a network of statewide perinatal leaders



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Current and Past Projects

- Center of Excellence for Perinatal Substance Use
- Postpartum Coverage Expansion to 1 year under Medicaid
- Hemorrhage care bundle
- Maternal autopsy guidelines
- Perinatal Substance Use Disorder Learning Collaborative
- Smooth Transitions - safe hospital transfers
- MMRP ECHO Case Conference Series

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To get involved...

Reach out to our team:

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A Chat with Katie Eilers

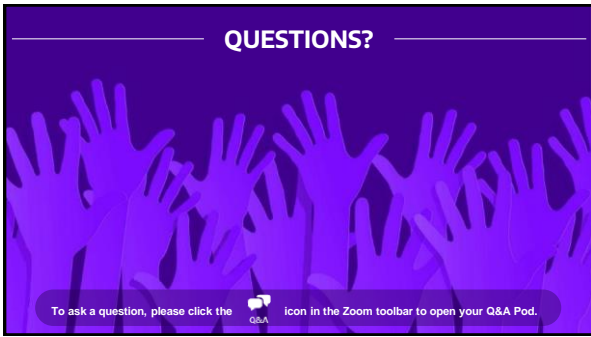


Sue Grinnell



Katie Eilers

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Resources

Maternal Mortality Review Panel
Washington State Department of Health
<https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/maternal-mortality-review-panel>

Maternal Morality Review Panel Report with Addendum from the American Indian Health Commission
<https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf>

Maternal Deaths 2014 - 2020 | Factsheet
<https://doh.wa.gov/sites/default/files/2023-03/141-081-MaternalDeathsFactSheet-2023.pdf?uid=646e887a79593>

Prevention Recommendations and Activities for Agencies, Organizations & Institutions
<https://doh.wa.gov/sites/default/files/2023-04/141-086-MMR-RecommendationsforAgenciesOrganizations-FactSheet2023.pdf?uid=64d66c51429f7>

Washington State Perinatal Regional Collaborative (WSPC)
<https://doh.wa.gov/you-and-your-family/womens-health/washington-state-perinatal-collaborative-wspc#:~:text=The%20Washington%20State%20Perinatal%20collaborative.pregnant%20mothers%2C%20newborns%20and%20infants>

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