



WASHINGTON STATE MATERNAL MORTALITY REVIEW PANEL FINDINGS AND RECOMMENDATIONS FROM THE 2025 REPORT



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OVERVIEW AND BACKGROUND: Washington State's MMRP

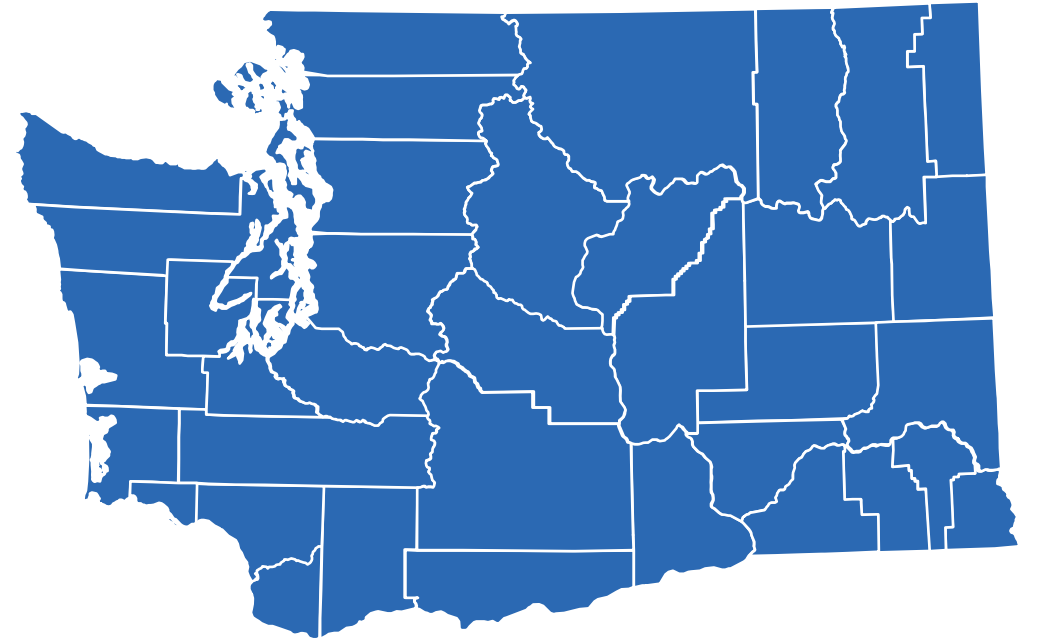
WA's Legislative Mandate for Maternal Mortality Review

- The Washington State Legislature established the **Maternal Mortality Review Panel in 2016**, following enactment of Senate Bill 6534.
 - State maternal mortality review law: **RCW 70.54.450**.
 - **In 2019, the law was amended to permanently establish the Panel** and the maternal mortality review process.
- Directs the MMRP to conduct comprehensive reviews of deaths of Washington state residents during pregnancy or up to one year after the end of pregnancy.
- Requires a legislative report every 3 years.
- Enables DOH to access records to prepare cases for review.



Washington State Maternal Mortality Review Panel

- At **Washington State Department of Health (DOH)**
- **80+ members** last term; 100+ this new term
- About **35–50 members per review meeting**
- **Breadth** of expertise and backgrounds, including priority focus on **American Indian / Alaska Native** communities



Washington's MMRP: A Wealth of Expertise

indigenous lactation counseling
medicaid and other insurance
rural health professional organizations
fqhcs reproductive justice emergency care
parenthood
lactation counseling urban indian health intimate partner violence
patient advocacy midwifery lived experience
home visiting social work antiracism nursing autopsy
academia birth justice wic maternal-fetal medicine ems/medical transport
nicu care
global health doula care health equity family medicine
substance use disorder obstetrics psychology health policy
food justice social justice tribal health local health jurisdictions
health advocacy state agencies community voice nutrition food access
genetics community organizations community experience
therapy/counseling mental/behavioral health
perinatal quality improvement

Washington's Maternal Mortality Review Process



1. DOH **identifies and confirms** deaths.



2. DOH requests medical and other records, then **writes a de-identified summary**.



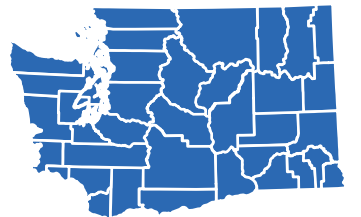
3. MMRP **meets to review** the death and make recommendations for prevention.



4. MMRP and DOH **consolidates and narrows down recommendations** after 3 years.



5. MMRP and DOH compile **data and recommendations** into a report.



Maternal Mortality Review Definitions



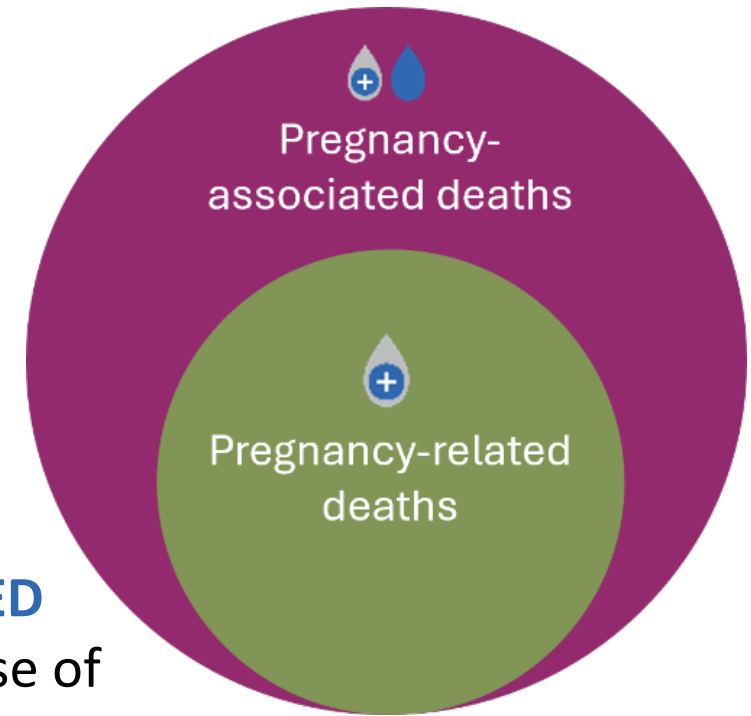
PREGNANCY-ASSOCIATED DEATHS: *all maternal deaths from any cause during pregnancy or up to 1 year after—regardless of whether the death was related to pregnancy.*




Some pregnancy-associated deaths are **PREGNANCY-RELATED (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.

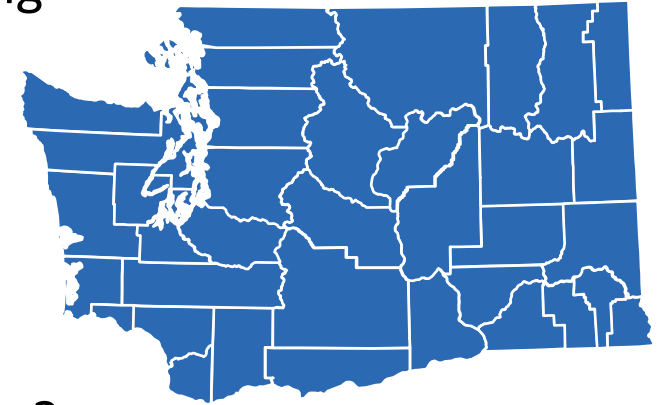


Some pregnancy-associated deaths are NOT pregnancy-related—the cause had no connection to pregnancy. For some deaths, the Panel doesn't have enough information to determine if the death was related to pregnancy.



How MMRP Cases are Reviewed

- A respectful review of each potentially pregnancy related death, using an anonymized, de-identified case narrative summary:
 - Was the death **pregnancy-related**? 
 - If it was pregnancy-related, was it **preventable**?
 - From a **clinical** perspective?
 - From an **equity and social determinants of health** perspective?
 - Did **racism, discrimination, and bias** play a role?
 - What **factors contributed** to pregnancy-related, preventable deaths?
 - **Making recommendations:** What interventions or systems changes might help prevent such a death, at the time or even years before?
 - These are the basis for our legislative report every three years.



2025 Maternal Mortality Review Panel Report



Report to the Legislature

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

RCW 70.54.450

- Submitted to the Washington State Legislature December 2025 (fourth MMRP report in WA)
- **Data** from **2021–2022** maternal deaths, and cumulative findings 2014–2022
- **Recommendations: legislature and other audiences**
- **Addendum: American Indian Health Commission**



Prepared by the
Prevention and Community
Health Division



Maternal Mortality Review Panel: Maternal Deaths 2021–2022

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Changes and New Components

- **Shorter**, more **focused** report
- Stronger focus on **legislative audience**—
legislative recommendations first
- **Voices from Washington:**
Storytelling about pregnancy, birth, or
postpartum experiences and challenges in
Washington
- **Success stories** about implementing
recommendations from the 2023 MMRP report



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Voices from Washington



“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.”

*“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.**”*

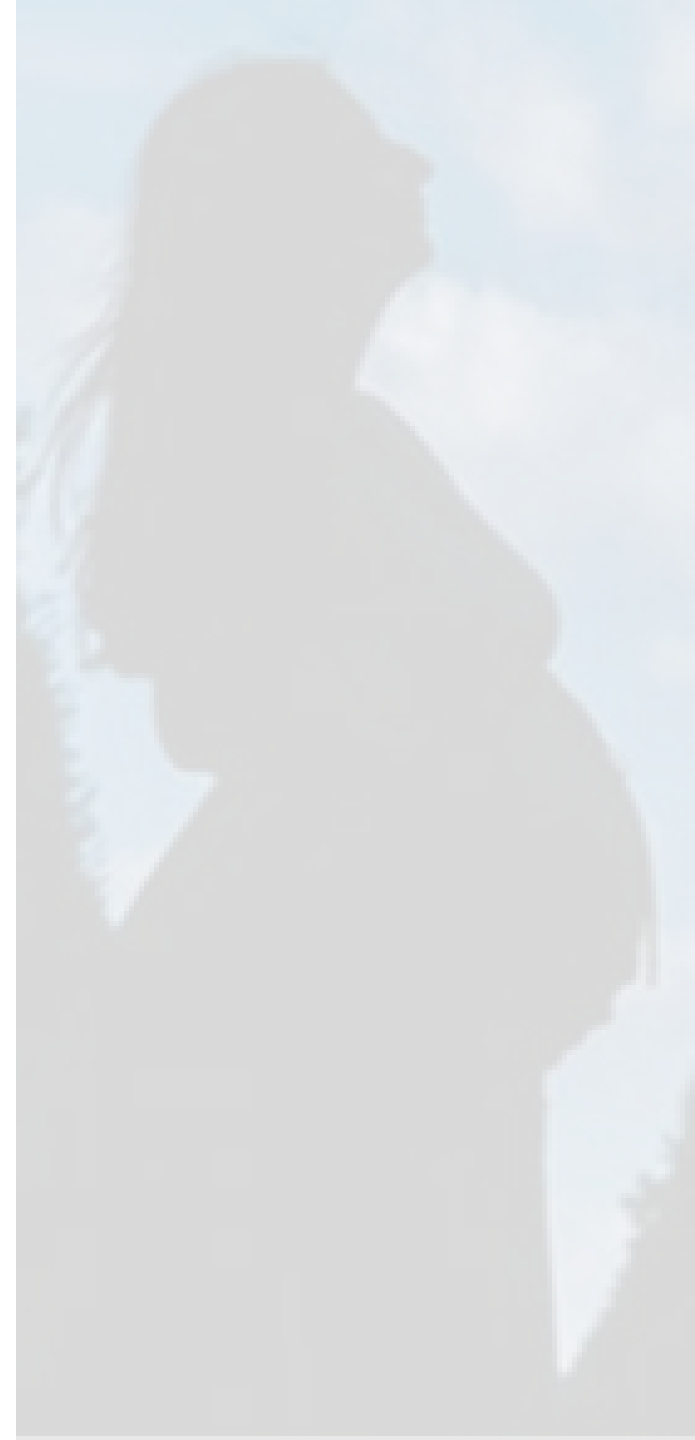
*“I'm of African descent and it's **really hard to find a provider of color in Washington.** It is also hard to find any practitioner that even inquired about LGBTQ patients or that was **knowledgeable about the queer community.** The understanding and language was not there.”*



MMRP REPORT: DATA and FINDINGS

Considerations

- **Maternal mortality is a rare event.**
 - That makes it difficult to discern true change or compare demographic differences on a year-to-year basis.
 - We can **still make meaningful recommendations and interventions.**
- **We can't accurately compare rates in WA vs. the US.**
 - US rates don't include accidental deaths (including **overdose**) or injury deaths (homicide, suicide).
- **We don't have county-level data.**
 - *Extremely* small or non-existent numbers for each county.
 - State MMRP law requires confidentiality.
 - Counties can still **find relevant information** and **recommendations** based on needs and demographics.



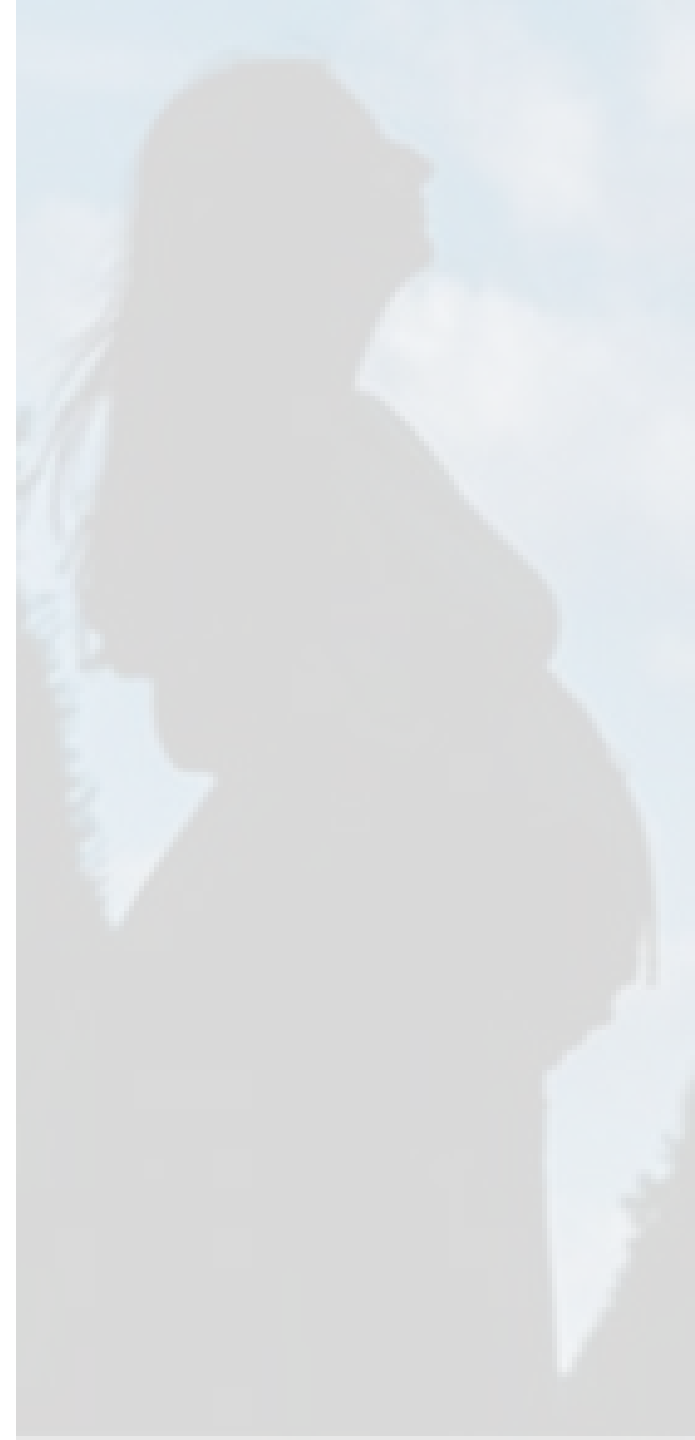
Pregnancy-Related Maternal Mortality Rate

Maternal mortality increased in 2021–2022.

- This is the **first increase to date** in WA MMRP reports.

The pregnancy-related maternal mortality rate was **30.5 per 100,000 live births.**

- This is **statistically significantly** higher than the state's rate in 2017–2020, of 19.0 per 100,000 live births.



Causes of Pregnancy-Related Deaths

- **Behavioral health**-related deaths accounted for **nearly half** (45%) of all pregnancy-related deaths in 2021–2022.
 - The majority of these were **accidental overdose** deaths, most of which involved fentanyl.
- Other leading causes included **COVID-19** and **cardiovascular** conditions.





Preventability of Pregnancy-Related Deaths

The Panel found **82% 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.

This reflects:

- **A broader understanding of preventability:** Clinical, equity, and social-determinants-of-health factors, including upstream factors earlier in life.
- **An opportunity to take action:** Better understanding of what's behind maternal deaths.

**82% of
pregnancy-
related deaths
were
PREVENTABLE**



Disparities by Race/Ethnicity

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

- Risk of pregnancy-related mortality was **7.3 times higher** than non-Hispanic white people.
- The report contains an **addendum** from the **American Indian Health Commission** with recommendations from Tribal and Urban Indian leaders and communities.

Black, Multiracial, and Native Hawaiian or Pacific Islander communities also experienced **disproportionately high rates**.



**Disparities
and
INEQUITIES
persist**



Disparities by Urban/Rural Residency, Insurance Status, and Age

Despite more pregnancy-related deaths among people living in urban areas, the **mortality rate was highest among people in RURAL areas.**

- *Importance of **access to quality rural maternal health services.***

People with **Medicaid** as primary insurance had the **highest frequency AND highest rate of pregnancy-related deaths.**

- *Importance of **access to care and support for people with Medicaid in pregnancy and postpartum.***

Pregnancy-related mortality was most common among people 30–34, but the **rate was highest among people age 40 and older.**

- *Risk increases with age, especially for those over 40.*



**Disparities
and
inequities
persist**

Identifying Racism, Discrimination, and Bias

The panel identified **discrimination, bias, interpersonal racism, or structural racism in 76%** of preventable pregnancy-related deaths from 2021–2022.

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



Racism, discrimination, and bias play a role in 76% of preventable, pregnancy-related deaths



Timing of Pregnancy-Related Deaths, 2021–2022



Most pregnancy-related deaths occurred between 43 days to 1 year postpartum, followed by deaths within 42 days of pregnancy.

- **82% of pregnancy-related deaths due to unintentional overdose** occurred between 43 days and 1 year after the end of pregnancy.

These findings underscore the **importance of care, support, and health insurance coverage through 1 year postpartum.**



MMRP REPORT RECOMMENDATIONS

MMRP Report Recommendations

3 priority recommendations, which include:

- **12 recommendations** for the Washington State **Legislature** (page #s 16–23)
- **75 recommendations** for **other audiences** (page #s 32–49), including:
 - Health systems and facilities
 - Health care and support providers
 - State and local agencies/departments
 - Academic institutions
 - Organizations
 - Communities
 - WA State Perinatal Collaborative
 - And others



www.doh.wa.gov/maternalmortality

Report to the Legislature

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Prepared by the
Prevention and Community
Health Division



MMRP Priority Recommendations



Improve health care quality and access



Strengthen community support services



Provide equitable, culturally responsive care



Recommendation 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.



Sample Recommendations: Health Care Quality and Access

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

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.

1.23 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.

Sample Recommendations: Health Care Quality and Access

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: (...)

- 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.

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.

Recommendation 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**.



Sample Recommendations: Community Support Services

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**.

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.

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.

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.

Sample Recommendations: Community Support Services

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.

Recommendation 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.**



Sample Recommendations: Equitable, Culturally Responsive Care

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.**

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.**

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.**

Sample Recommendations: Equitable, Culturally Responsive Care

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.

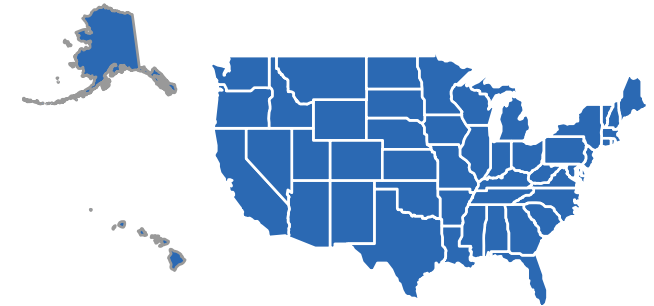
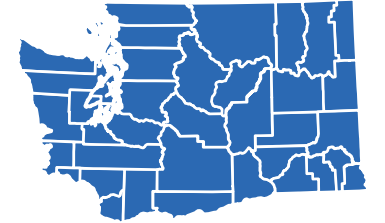
3.15 DOH and health care systems should **fund Tribal-led, Indigenous-led, and community-led efforts** to expand access to **prenatal and birthing care in American Indian and Alaska Native communities**, including in **rural** areas.

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.

Current Context and Emerging Challenges

Current and emerging issues may make recommendations more **challenging** and **important**:

- **Medicaid changes** (Medicaid covers 45% of WA births; 70% in rural areas)
- **Rural** maternity care shortages
- **Perinatal** and **reproductive care** access challenges and fears
- **Mental health care** access
- State and local **budget** limitations and current **funding** landscape
- **Misinformation** and **disinformation**
- Threats to **immigrant**, **BIPOC**, and **LGBTQ+** communities
- **Uncertainty** about health, environment, and society in the future



The report includes recommendations to both **protect existing services** and **take new steps**. Some recommendations require legislative support or funding, and some do not.



IMPLEMENTATION AND SUCCESS STORIES

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

2023 MMRP Recommendation: 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.”

Implementation

Centralized implementation:

- Legislative change
- Statewide efforts
- DOH-led work
- Washington State Perinatal Collaborative

De-Centralized Implementation:

- Local and regional efforts
- Led by any organization, institution, coalition, board, or individual, etc.
- From practice-level to regional level
- Regional perinatal collaboratives
- Regional/county Boards of Health
- Many other examples



Connecting 2025 MMRP Report Recommendations to Your Priorities

- Which recommendations are **most relevant in King County?**
- How do the report's findings and recommendations **align with your work and priorities?**
- How can these findings and recommendations be **useful in your work?**
- What might your **next steps** be?



Clarifying Questions?

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