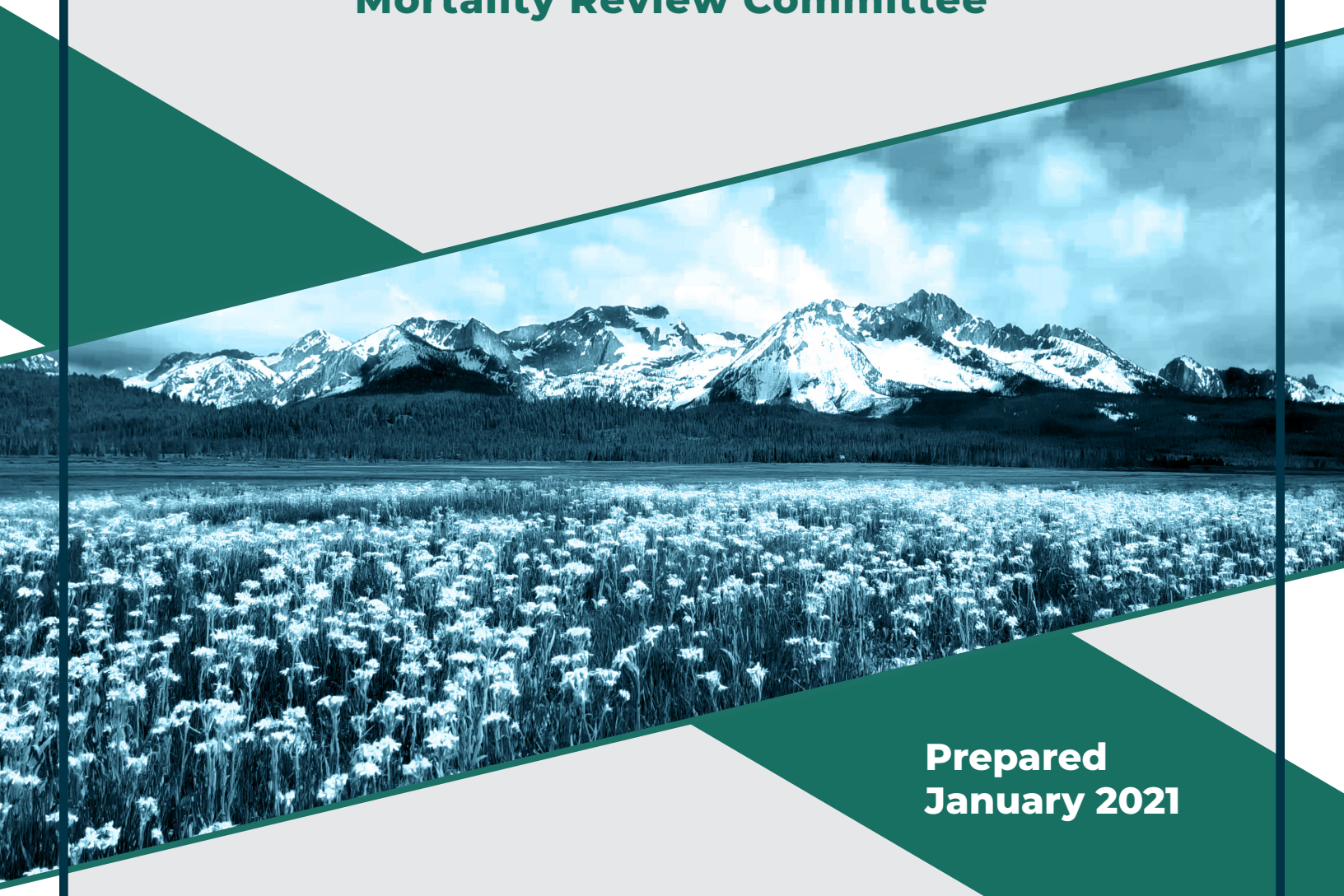
2018
MATERNAL DEATHS IN IDAHO

A report of findings by the Maternal Mortality Review Committee



Prepared January 2021

Idaho maternal & child health

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

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We would like to acknowledge the members of the Idaho Maternal Mortality Review Committee for donating their time and expertise to reduce the morbidity and mortality of women in Idaho.

Idaho maternal & child health

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Executive Summary

Idaho Code Title 39, Chapter 96 (passed by the legislature in 2019), gives the Department of Health and Welfare the authority to establish the Idaho Maternal Mortality Review Committee (MMRC). This interdisciplinary group from across the state reviews every pregnancy-associated death and makes recommendations to improve the care for women and to reduce or eliminate preventable maternal deaths. The committee began by reviewing the deaths from 2018, the most recent year of complete data. This report describes the development and establishment of the MMRC, committee processes, and committee structure. The report also covers demographics, causes of death, and contributing factors to the deaths that occurred in 2018. Below are the key findings and recommendations from the 2018 review.

Key Findings:

- Ten women in Idaho died while pregnant or within one year of pregnancy.
- All 10 (100%) of the deaths could have been prevented.
- Five (50%) of the deaths occurred while the women were pregnant.

Ten women in Idaho died while pregnant or within one year of pregnancy

- Four (40%) of the women who died were between the ages of 20 to 24; four (40%) were between 35 to 39, and two (20%) were between 30 to 34 years of age.
- Five (50%) of the women who died entered prenatal care during the first trimester of pregnancy (between 1 and 12 weeks gestation) and three (30%) entered prenatal care during the second trimester (between 13 and 26 weeks gestation).
- Four (40%) of the deaths were classified as pregnancy-related. The pregnancy-related mortality ratio (PRMR), or number of pregnancy-related deaths per 100,000 live births, was 18.7.
- Substance use disorder was a contributing factor in four (40%) of the deaths.

18.7

18.7 pregnancy-related deaths per 100,000 live births

Key Recommendations:

- Providers should implement the American College of Obstetricians and Gynecologists standard of care for postpartum visits occurring 2-3 weeks after delivery.
- Communication between prenatal providers and substance use disorder providers should take place when the patient is or has been seen by both. This communication should occur during the prenatal and postpartum periods.
- Facilities* should use validated/Edinburgh Postnatal Depression Scale screening tools at first prenatal visits, labor and delivery hospitalization, and first postpartum follow-up visit for depression, anxiety, and intimate partner violence. Screening should always be done privately with the patient.
- Facilities that provide prenatal, labor and delivery, and postnatal care to women should provide or have access to social work or case management services.
- Facilities should have a sepsis protocol in place that addresses pregnant and postpartum women.
- Medicaid should expand coverage for pregnant women to 12 months postpartum, regardless of pregnancy outcome.
- The State of Idaho should address legislation regarding autopsies for pregnant and postpartum women.
- Communities and faith-based organizations should work to destigmatize intimate partner violence, especially for pregnant and postpartum women.

*A facility may include, but is not limited to: hospitals, birthing centers, and/or women's clinics.

Definitions

The following definitions will be used throughout this report.

Maternal death (mortality): is the death of a woman from any cause during pregnancy or within one (1) year following the end of the pregnancy.[1]

Maternal morbidity: unexpected outcomes of labor and delivery that result in short- or long-term consequences to a woman's health.

Pregnancy-associated death: the death of a woman while pregnant or within one year of the end of pregnancy, regardless of the cause.

Pregnancy-related death: the death of a woman 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.

Pregnancy-related mortality ratio: an estimate of the number of pregnancy-related deaths for every 100,000 live births. This ratio is often used as an indicator to measure the nation's health.[2]

Background

Maternal Mortality

Maternal Mortality Review Committees (MMRCs) have been in existence since the early 1900s and initially consisted of obstetricians. Today, these committees are comprised of a variety of professionals that care for women during and after pregnancy. Although MMRCs have been around for over a century, more recently states and territories have recognized the importance of MMRCs when looking at maternal deaths. There are two main sources of maternal death estimates in the United States, the National Center for Health Statistics (NCHS) and the Pregnancy Mortality Surveillance System

1. https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title39/T39CH96.pdf
2. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#:~:text=The%20pregnancy%2Drelated%20mortality%20ratio%20is%20an%20estimate%20of%20the,among%20pregnant%20and%20postpartum%20women

(PMSS). Both sources are valuable and provide data about maternal deaths; however, neither can point to specific factors that contribute to a mother's death. Therefore, MMRCs are seen as vital to the prevention of maternal deaths. MMRCs can comprehensively review every maternal death at the state level. They identify, review, and analyze these deaths and then make recommendations. Recommendations must be actionable changes that patients, providers, facilities, the community, and the system can make in their respective areas. The recommendations support health and wellness during a woman's pregnancy, birth, and postpartum period to reduce future maternal mortality and morbidity.[3]

As seen in Figure 1, maternal deaths are just the tip of the iceberg when improving the health of women. By eliminating preventable maternal deaths and determining what is needed to reduce maternal mortality, we are able to decrease the number of women who experience a near miss and reduce the impact of maternal morbidity in Idaho.

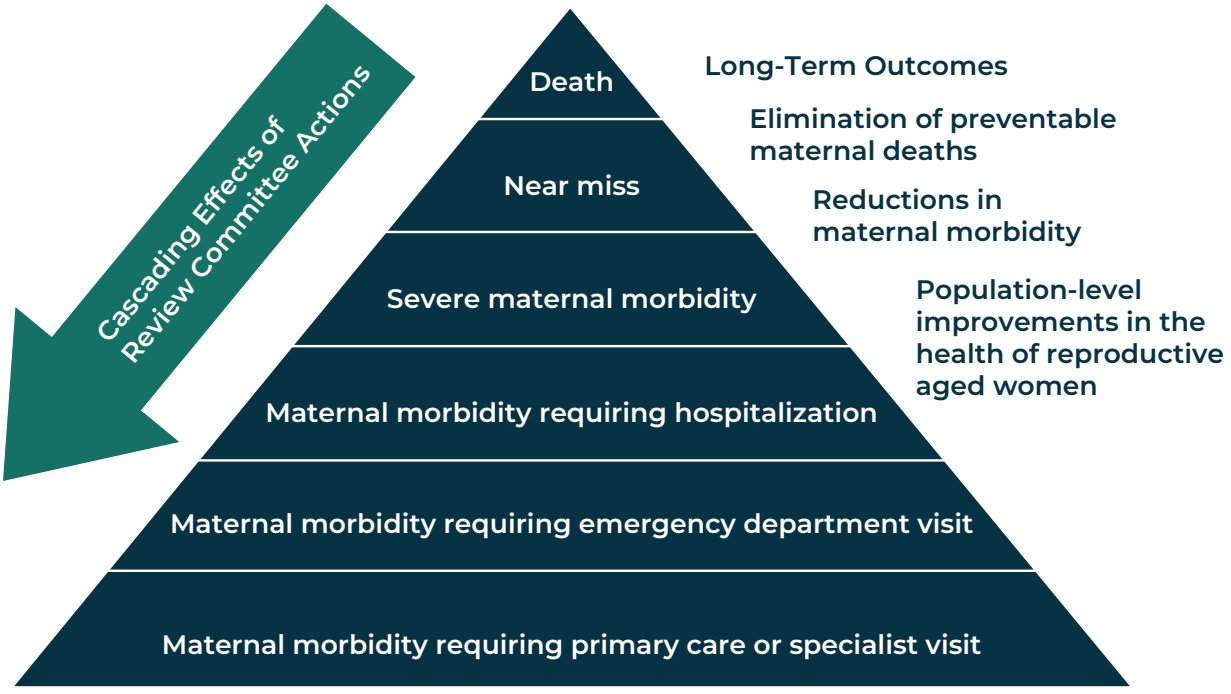

Figure 1 - Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Sourced from http://reviewtoaction.org/Report_from_nine_MMRCs

3. https://reviewtoaction.org/learn/what-makes-maternal-mortality-review-unique

Idaho's MMRC

During the 2019 Idaho Legislative session, House Bill 109 was passed and signed into statute (Title 39, Chapter 96) authorizing the Department of Health and Welfare (DHW) to create an MMRC and request records with the strict expectation that records are kept confidential. The statute also specifies positions that must be represented on the committee based on the state's geographic diversity. Below are the required positions:

- Five (5) licensed physicians:
  - ▹ Family medicine with practice that includes maternity care and delivery
  - ▹ Obstetrics and gynecology
  - ▹ Maternal fetal medicine
  - ▹ Family medicine, obstetrics and gynecology, or emergency medicine that includes maternity care and delivery in a rural setting
  - ▹ Medical examiner, pathologist, or other physician who conducts autopsies
- One advanced practice professional nurse midwife
- One registered nurse
- One midwife
- One coroner
- One master social worker
- One emergency medical services provider
- One public health representative with an expertise in maternal and child health

Figure 2 shows the number of MMRC members from each public health district.

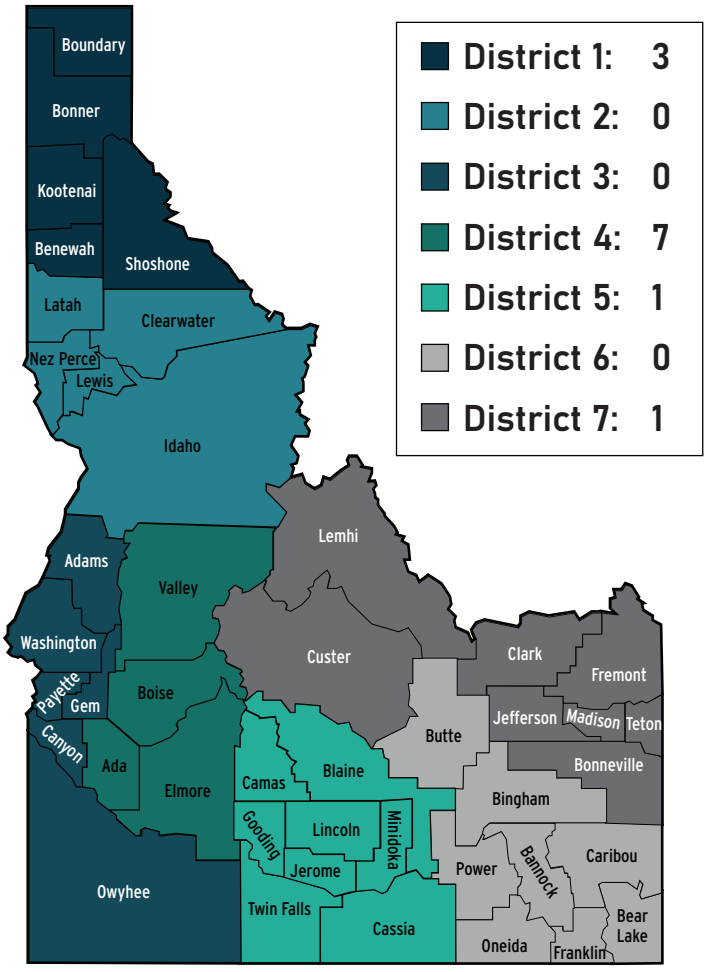

Figure 2 - Members per Idaho Health Districts, 2018

Idaho Maternal Mortality Review Initiative: Methods

Development of the Maternal Mortality Review Committee

The Idaho Division of Public Health, Bureau of Clinical and Preventive Services (BOCAPS), Maternal & Child Health (MCH) Section began the work of developing Idaho's first MMRC in July 2019. The MCH Section partnered with a graduate student from the Colorado School of Public Health to assist with development and implementation until a full-time staff position, MMR Program Manager, was allocated to the program in October 2019.

From July 2019 through December 2019, the MMR Program completed committee development tasks including an application for committee members, provider notification, the creation of MMRC policies and procedures, and determination and documentation of committee processes. From November 2019 through March 2020, the MMR Program requested records and began record abstraction for 10 deaths that occurred in 2018. Abstraction is the process of reviewing records, entering information into the appropriate data system, and writing a narrative of the events that occurred before, during, and after the woman's death. All case narratives are written without personally identifiable information. Record abstraction was completed by the MMR program manager and registered nurse.

During development, letters and emails regarding the MMRC were sent to hospitals, obstetricians and gynecologists, midwives, police and sheriff departments, emergency medical services agencies, and other providers. This notification included information about why the committee was being formed, the department's authorization to request records for review, and the confidentiality of the records and committee meeting. Membership applications were also sent out to these stakeholders to recruit applicants to serve voluntarily on the committee.

The process used for preparation for each MMRC meeting was adopted from Review to Action, a resource developed by the Association of Maternal and Child Health Programs (AMCHP) along with the Centers for Disease Control and Prevention (CDC) Foundation and the CDC Division of Reproductive Health. The examination process is shown in Figure 3. Each step in the process is explained on the following pages.

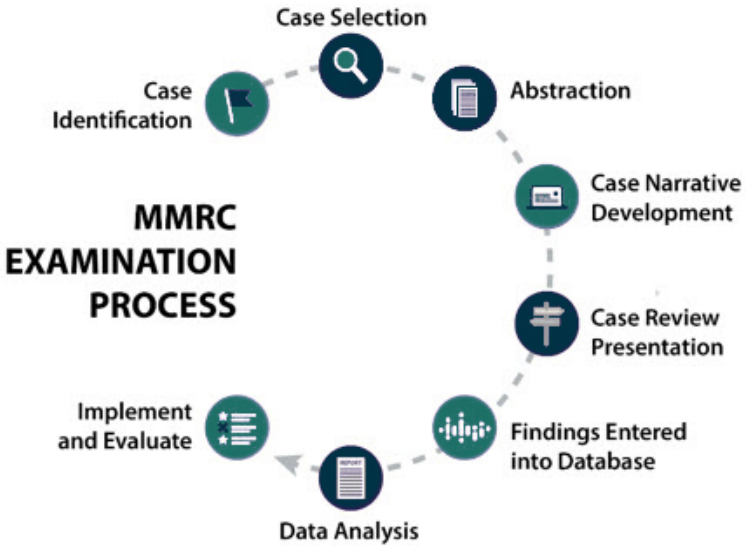

Figure 3 - CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality Orientation PowerPoint. (2019).

Identification of Cases for Review

The MMR Program works with the Bureau of Vital Records and Health Statistics (BVRHS) to identify deaths for review and to gather this information. The Maternal and Child Health Research Analyst, in BVRHS, notifies the MMR Program Manager when a death record is received and a check box on the death certificate is marked indicating pregnancy (see Figure 4). The research analyst also notifies the MMR Program if the cause of death listed on the death certificate includes a code that is related to pregnancy. These codes include, but are not limited to, conditions such as eclampsia, postpartum hemorrhage, or amniotic fluid embolism.

30. IF FEMALE (Aged 10-54):

- ☐ Not pregnant within a year
- ☐ Pregnant at time of death
- ☐ Not pregnant, but pregnant within 42 days of death
- ☐ Not pregnant, but pregnant 43 days to 1 year before death
- ☐ Unknown if pregnant within the past year

Figure 4 - Example Pregnancy Check box on Idaho Death Certificate

After collecting a list of deaths that occurred within the review timeframe, the research analyst matches the death certificates with birth certificates or stillbirth certificates and provides them to the MMR program.

These records are kept strictly confidential between the BVRHS and the MMR Program. Members of the committee do not have access to personally identifiable information.

Abstraction, Case Narrative Development, and Review Process

Once death certificates have been received, the MMR Program Manager reviews them and contacts a variety of stakeholders for records. Records are collected for each death and are then abstracted into case narratives. Case narratives are summaries of the events that occurred leading up to a woman's death with all personally identifiable information, locations, and names redacted. These case narratives are provided to the committee members so they can review each death with an objective, unbiased perspective on the facts of the death.

The purpose of the Maternal Mortality Review is **not**:

- A mechanism to assign blame or responsibility for any death,
- A research study,
- Peer review,
- An institutional review,
- A substitute for existing mortality and morbidity inquiries or reviews.[4]

Maternal mortality reviews **are**:

- Ongoing anonymous and confidential processes of data collection, analysis, interpretation, and action;
- Systematic processes guided by Idaho Code and policies;
- Intended to move from data collection to prevention activities.[5]

For the review process, committee members convene for an in-person meeting and review the case narratives. Using the multi-disciplinary positions on the committee, they can make recommendations at the patient, provider, facility, system, and community levels. These recommendations are made to address factors the committee identifies as "contributing factors" to a woman's death. Examples of contributing factors can be found in Figure 5.

4. https://reviewtoaction.org/rsc-ra/term/80
5. https://reviewtoaction.org/rsc-ra/term/80

Delay	Tobacco use	Communication
Adherence	Chronic disease	Continuity of care/care coordination
Knowledge	Childhood abuse/ trauma	Clinical skill/quality of care
Cultural/religious	Access/financial	Outreach
Environmental	Unstable housing	Law enforcement
Violence	Social support/ isolation	Referral
Mental health conditions	Equipment/ technology	Assessment
Substance use disorder - alcohol, illicit/prescription drugs	Policies/procedures	Legal
		Other

Figure 5 - Contributing Factors from Maternal Mortality Review Committee Decision Form v18

MMRIA Database and Data Analysis

The MMR Program utilizes the Maternal Mortality Review Information Application system (MMRIA). This data system is designed to assist MMRCs across the country by providing a common data language. This standardized data collection system, developed by the CDC, is the first major step toward fully understanding the causes of maternal mortality in each state and nationally. This system helps Idaho organize state data for comprehensive data analysis. Currently, only the MMR Program Manager has access to Idaho's MMRIA data, and committee members are not able to see personally identifiable information.

Implementation and Evaluation

After recommendations are made by the committee, the actions need to be implemented. The work of implementing these recommendations in many states is done by a perinatal quality collaborative (PQC) or Maternal Health Task Force. Currently, Idaho doesn't have a PQC or Maternal Health Task Force. However, the MMR Program is working toward establishing a statewide PQC that would implement MMRC recommendations to improve health outcomes for mothers and babies.

Findings from the 2018 Death Review

Case Identification

The 2018 deaths were received by the established process of obtaining records from the Bureau of Vital Records and Health Statistics. Eleven deaths for 2018 were identified through the use of the pregnancy checkbox.

After reviewing the records, the MMR Program found that one death was incorrectly identified and the woman was not pregnant when she died or one year prior to her death. This record has been excluded from our analysis.

A total of 10 deaths were identified and brought forward to the committee for review. Five (50%) of those could be linked to a birth or stillbirth certificate.

Demographics

Table 1 describes the demographics of all the pregnancy-associated deaths that occurred in 2018. By age group, the majority of deaths occurred in women between 20 and 24 years (40%), and women between 35 and 39 years (40%). All racial and ethnic minority groups combined comprised 60% of all deaths, yet these groups are only 18% of Idaho's entire population. Non-Hispanic, white women were the leading single racial category with 40% of all deaths.

2018		
Demographics	**Number**	**Percent**
Age (5-year age groups)		
15 to 19 years	0	0%
20 to 24 years	4	40%
25 to 29 years	0	0%
30 to 34 years	2	20%
35 to 39 years	4	40%
40 to 44 years	0	0%
45 to 49 years	0	0%

Race/Ethnicity		
Non-Hispanic, White	4	40%
Non-Hispanic, Black	0	0%
Hispanic	2	20%
American Indian/Alaska Native	1	10%
Pacific Islander	1	10%
Bi-racial	2	20%
Marital Status		
Married	5	50%
Married, but Separated	0	0%
Widowed	0	0%
Divorced	0	0%
Never Married	5	50%
Unknown/Not specified	-	-
Education		
8th Grade or Less	1	10%
9th-12th grade; No Diploma	1	10%
High School Grad or GED completed	5	50%
Some College; No Degree	0	0%
Associate's Degree	2	20%
Bachelor's Degree	1	10%
Master's Degree	0	0%
Doctorate or Professional Degree	0	0%
Not specified	-	-

Table 1 - Demographics of pregnancy-associated deaths, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

District of Residence

The numbers shown below indicate the health district where each woman resided prior to her death. It does not indicate where the woman died. Due to the small number of deaths in Idaho, the deaths are displayed by health district and not at the county level. Refer to Figure 3 for a map of Idaho's health districts.

District of Residence	Number of Deaths	Percent
Health District 1	2	20%
Health District 2	0	0%
Health District 3	3	30%
Health District 4	0	0%
Health District 5	1	10%
Health District 6	0	0%
Health District 7	4	40%

Table 2 - District of Residence, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

Timing of Deaths

Deaths were most common while the woman was pregnant (50%), followed by being pregnant within 43 to 365 days before death (30%) (Figure 6).

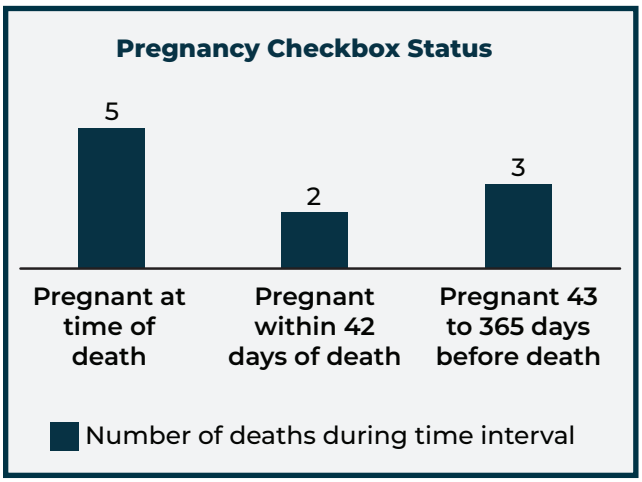

Figure 6 - Pregnancy Checkbox Status, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

Entry to Prenatal Care

Half of the women who died (50%) entered prenatal care during the first trimester (1 to 12 weeks gestation), followed by 30%, who entered care during the second trimester (Table 3). Entry into prenatal care refers to how far along the woman was during her pregnancy when she attended her first prenatal care appointment.

Entry into Prenatal Care	2018	
	Number	Percent
No Prenatal Care	1	10%
First Trimester	5	50%
Second Trimester	3	30%
Third Trimester	0	0%
Unknown	1	10%

Table 3 - Entry Into Prenatal Care, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

Pregnancy-associated vs. pregnancy-related

After reviewing the deaths, the MMRC members determined that 40% of the deaths were pregnancy-related. Half of the deaths were determined to be pregnancy-associated, but the committee was unable to determine pregnancy-relatedness (Table 4). This means that the committee was not able to determine if the woman would have died had she not been pregnant.

The Idaho pregnancy-related mortality ratio (PRMR), or number of pregnancy-related deaths per 100,000 live births, was 18.7. This number comes from analyzing and reviewing deaths to determine their cause. This ratio is often used as an indicator to measure a state's or the nation's health. With continued annual MMRC reviews, we will have the ability to analyze our PRMR more in depth and compare our PRMR to the U.S. PRMR. The most current U.S. PRMR available is from 2016 and was 16.9 per 100,000 live births.

18.7
pregnancy-related deaths per 100,000 live births

Pregnancy-Relatedness Status	2018	
	Number	Percent
Pregnancy-Associated, but NOT -Related	1	10%
Pregnancy-Related	4	40%
Pregnancy-Associated but Unable to Determine Pregnancy-Relatedness	5	50%

Table 4 - Pregnancy Relatedness Status, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program

Causes of Death

As part of the review, the committee decides whether they agree with the cause of death listed on the death certificate. In 8 (80%) of the deaths, the committee did agree with the cause of death listed, in 2 (20%) of the deaths, they did not. This does not necessarily mean the causes of death listed were incorrect; however, MMRC's often have more information available to them than the person who filled out the death certificate.

The committee-identified underlying causes of death are shown in Figure 7. The underlying cause of death refers to the disease or injury which initiated the chain of events leading to death or the circumstances of the accident or violence which produced the fatal injury.[6]

The most common underlying cause of death was mental health conditions (30%). This includes death due to mental health disorders, substance use disorders, or other unintentional injuries determined by the MMRC to be related to a mental health condition. The next most common underlying cause of death was traumatic injuries (20%). Figure 7 displays the primary underlying causes of each woman's death.

Committee-Identified Underlying Cause of Death

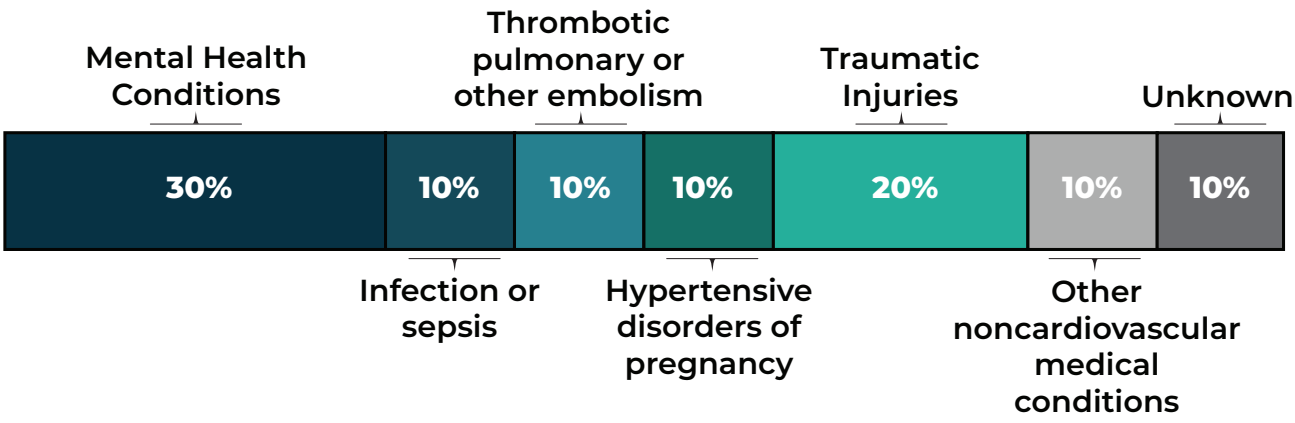

Figure 7 - Underlying Cause of Death, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

The committee also evaluates whether mental health conditions, obesity, or substance use disorder contributed to the death. Contributing factors are significant conditions contributing to the death, but not resulting in the underlying cause of death. The results are included in tables 5 through 7. The committee uses "probably" when there isn't specific proof of each condition, which is especially difficult when determining if mental health conditions contributed to the death.

6. Maternal Mortality Review Committee Decision Form - https://reviewtoaction.org/rsc-ra/term/68

Mental Health Conditions – Did mental health conditions contribute to the death?	2018	
	Number	Percent
No	4	40%
Yes	0	0%
Probably	3	30%
Unknown	3	30%

Table 5 - Mental Health Conditions, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

Obesity– Did obesity contribute to the death?	2018	
	Number	Percent
No	6	60%
Yes	2	20%
Probably	1	10%
Unknown	1	10%

Table 6 – Obesity, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

Substance Use Disorder – Did substance use disorder contribute to the death?	2018	
	Number	Percent
No	4	40%
Yes	4	40%
Probably	0	0%
Unknown	2	20%

Table 7 - Substance Use Disorder, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

The MMRC members determine if a death was preventable by answering a yes or no question. The committee members found that all deaths (100%) could have been prevented. Per the MMRC decision form, a death is considered preventable if the committee 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.[7] The committee then decides the chance of being able to alter the outcomes: good chance, some chance, no chance, or unable to determine. In 70% of the deaths, the committee determined there was a good chance or some chance to alter outcomes. In 30% of the deaths, the committee determined that the deaths were preventable; however, at the time of the review there was not enough information to determine the chance to alter the outcome. For this reason, they were categorized as "unable to determine" (Table 8).

Chance to Alter Outcome	2018	
	Number	Percent
No chance	0	0%
Good chance	2	20%
Some chance	5	50%
Unable to determine	3	30%

Table 8 - Chance to Alter Outcome, 2018
Data Source: Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Maternal Mortality Review Program.

7. Maternal Mortality Review Committee Decision Form - https://reviewtoaction.org/rsc-ra/term/68

Committee Recommendations

Recommendations made by the committee are placed into five categories based on where the recommendation should occur. The committee works to ensure that recommendations are "actionable," meaning that recommendations follow a format that identifies who should be responsible for implementing the recommendation, what the recommendation is, and when the recommendation should happen. The committee made a total of 33 recommendations.

Provider Recommendations

- Providers should admit patients with uncontrolled blood pressure or diabetes to inpatient hospital stay during the prenatal care period in order to stabilize blood pressure or blood sugar related issues.
- Providers should assist patients in accessing and utilizing services (i.e. Medicaid, drug treatment).
- Providers should implement the American College of Obstetricians and Gynecologists standard of care for postpartum visits occurring 2-3 weeks after delivery.
- Providers should educate patients on intimate partner violence during their prenatal and postpartum care.
- Providers should give more extensive education to patients on risk factors and when to follow-up or seek care regarding symptoms, especially in patients with identified risk factors in the prenatal and postpartum periods.
- Providers should ask patients the One Key Question® (Would you like to become pregnant in the next year?) to all women between the ages of 18-50.
- Communication between prenatal providers and substance use disorder providers should take place when the patient is or has been seen by both. This communication should occur during the prenatal and postpartum periods.

Facility Recommendations*

- Facilities that provide prenatal, labor and delivery, and postnatal care to women should provide or have access to social work or case management services.
- Clinics and facilities should provide education on effective domestic violence screening.
- Facilities should emphasize the importance of postpartum visits two weeks after delivery in postpartum discharge instructions.
- Facilities should use validated/Edinburgh Postnatal Depression Scale screening tools at 1st prenatal visits, labor and delivery hospitalization, and 1st postpartum follow-up visit for depression, anxiety, and intimate partner violence. Screening should always be done privately with the patient.
- All facilities and clinics should screen for substance abuse disorders when a patient seeks reproductive care.
- Facilities should explore options for in-patient drug rehabilitation in both the pregnancy and postpartum periods that keeps mother and child(ren) together.
- Facilities should institute communication channels between providers, especially if potential high-risk scenarios have been identified in the prenatal, labor and delivery, and postpartum periods.
- Facilities should integrate a team-based care approach especially in situations where a patient is presenting with abnormal findings while in prenatal care, labor and delivery, or postpartum.
- Facilities should implement asking One Key Question® (Would you like to become pregnant in the next year?) to all women between the ages of 18-50.
- As needed, facilities should involve a health advisor/community health worker during a patient's prenatal and postnatal care to explain and convey barriers to compliance and importance of recommendations.
- Facilities should have a sepsis protocol in place that addresses pregnant and postpartum women.

*Facilities may include hospitals, birthing facilities, and clinics.

- Facilities should draw labs and perform blood pressure checks on pregnant and postpartum women when they present to the emergency room with abnormal signs or symptoms.

System Recommendations

- The State of Idaho should expand state-funded substance abuse treatment services and education for pregnant and postpartum women.
- Insurance companies should expand insurance coverage for pregnant and postpartum women with substance abuse disorders.
- Public Health should reduce barriers to referrals between providers and domestic violence agencies, especially for pregnant and postpartum women.
- Public Health should provide nutrition counseling to pregnant women who are identified as obese.
- Public Health should expand the availability of and training for naloxone for the public, especially for pregnant and postpartum women.
- Medicaid should expand coverage for pregnant women to 12 months postpartum, regardless of pregnancy outcome.
- Coroners should have a standardized, consistent policy for maternal deaths.
- Coroners should send decedents for an autopsy and/or toxicology if the individual is less than 50 years of age and the decedent does not appear to have sustained trauma.
- The State of Idaho should increase funding for autopsies.
- The State of Idaho should address legislation regarding autopsies for pregnant and postpartum women.
- The State of Idaho should increase the number of programs that provide wrap around services. This includes medication assisted treatment, obstetric services, counseling, and/or psychology services.
- Subsidized housing programs should prioritize housing for pregnant women.

Community Recommendations

- Communities and faith-based organizations should work to destigmatize intimate partner violence, especially for pregnant and postpartum women.

Summary

The MMRC will continue to meet annually and review the prior years' deaths. The findings and recommendations from these meetings will be published in an annual report through June 30, 2023, when the current statute is set to expire. Reports will be provided to the Idaho legislature and made available for the public to review.

Additionally, the MMR Program will focus on creating Idaho's first Perinatal Quality Collaborative to provide a venue to implement and measure the effect of recommendations made by the MMRC. With the two programs working in tandem, Idaho will have the ability to reduce maternal mortality and morbidity, and ultimately improve the health of Idaho's women.

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