Additional Meeting Materials

BOARD OF HEALTH

WASHINGTON STATE MATERNAL MORTALITY REVIEW PANEL

FINDINGS AND RECOMMENDATIONS FROM THE 2025 REPORT

Deborah (Debs) Gardner, MPH, MFA, Washington State Department of Health
Anne (Annie) McHugh, MPH, Washington State Department of Health

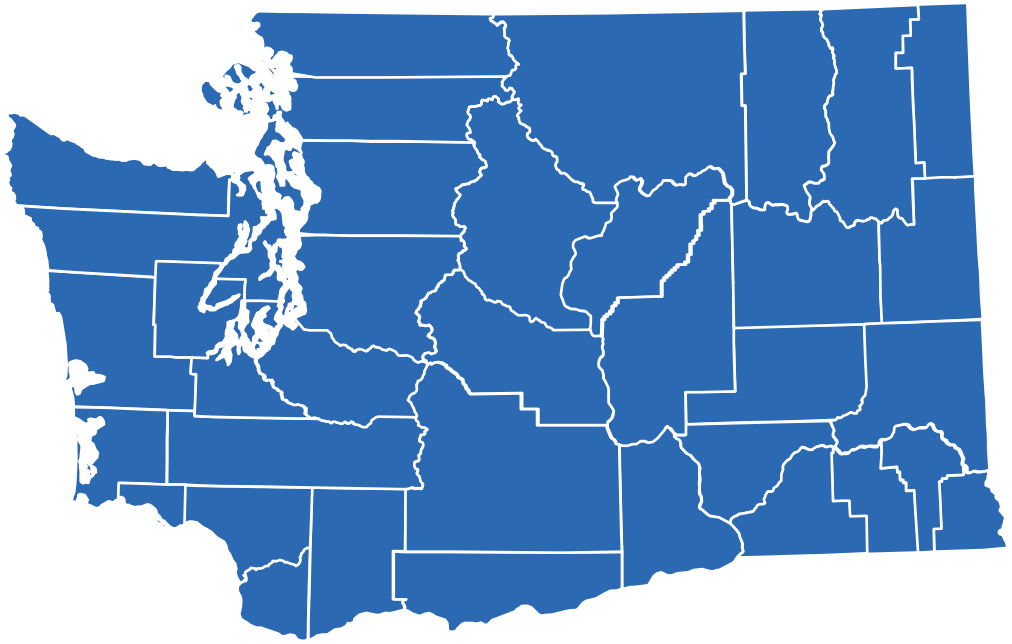
OVERVIEW AND BACKGROUND: Washington State's MMRP

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 through up to one year after** the end of pregnancy.
- Requires a **legislative report** every 3 years.
- Enables DOH to **access** medical and other **records** to prepare for review.

Washington State Maternal Mortality Review Panel

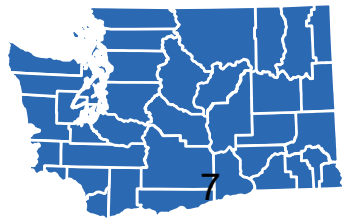
- At **Washington State Department of Health (DOH)**
- **80+ members** last term; 100+ this new term
- About **35–50** members **per review meeting**
- **Breadth** of **clinical** and **non-clinical** expertise and backgrounds, including priority focus on **American Indian / Alaska Native** communities



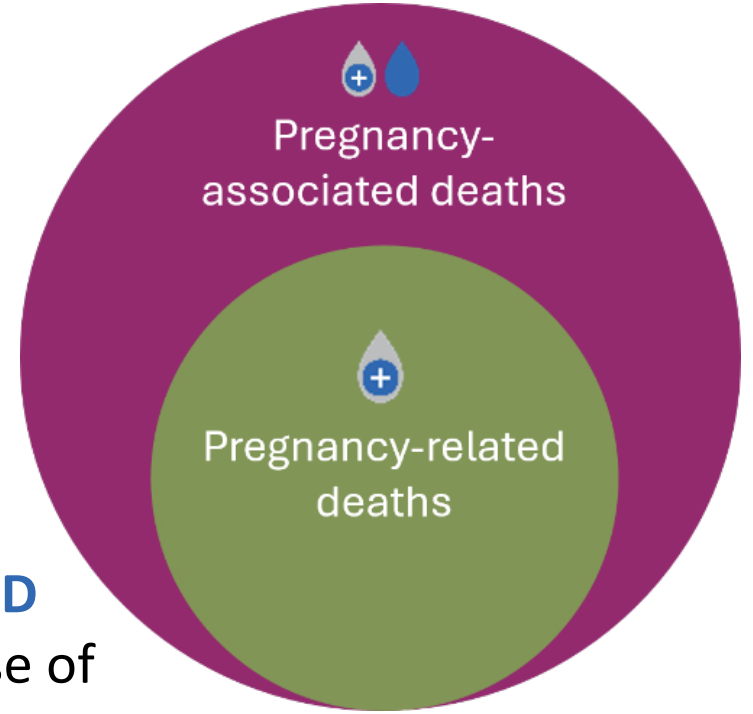
Washington's MMRP: A Wealth of Expertise

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



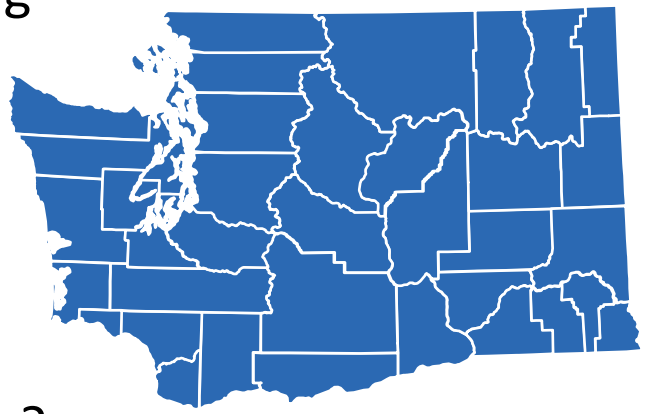
PREGNANCY-ASSOCIATED DEATHS: *all maternal deaths from any cause* during pregnancy or up to 1 year after—regardless of whether the death was related to pregnancy.

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

- 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**
- **Storytelling**
  - Experiences in pregnancy, birth, and postpartum
  - Success stories from previous report recommendations
- **Addendum** from **American Indian Health Commission**

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

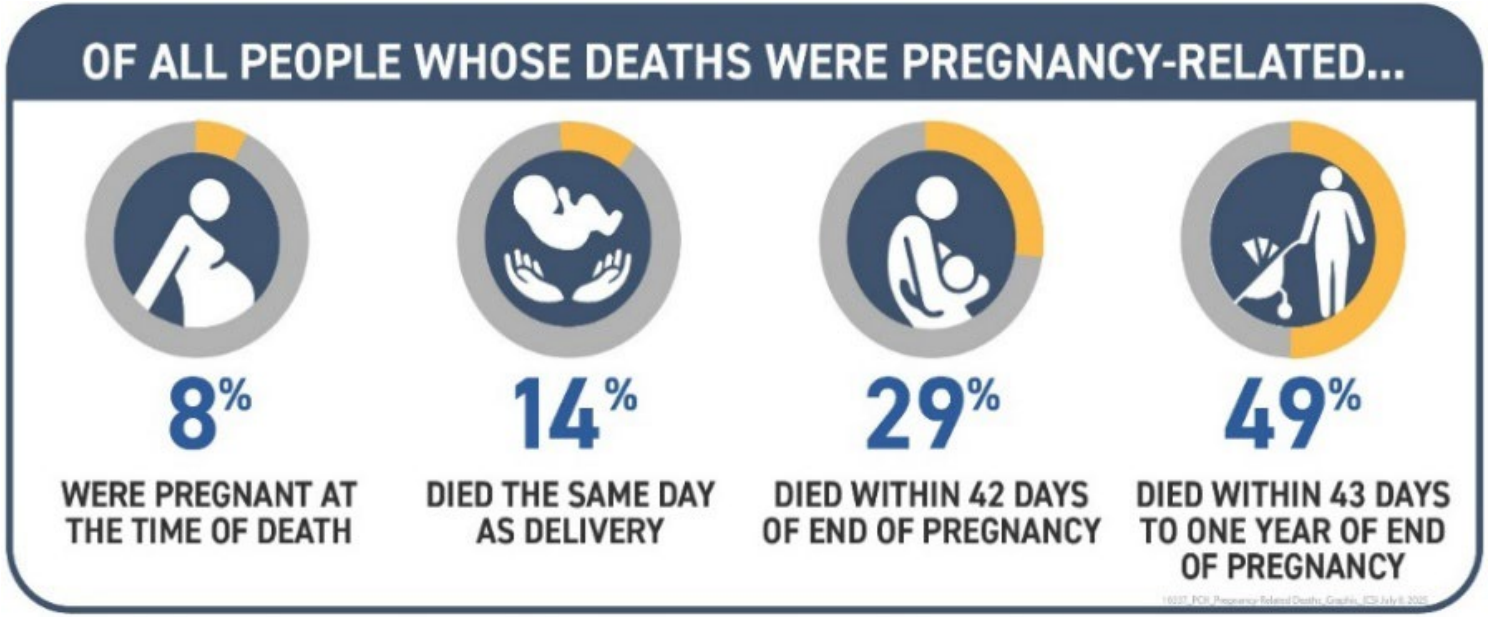
Identifying Racism, Discrimination, and Bias

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

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

RCW 70.54.450

Prepared by the Prevention and Community Health Division

Washington State Department of HEALTH

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.

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.

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.

2.21 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.

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**.

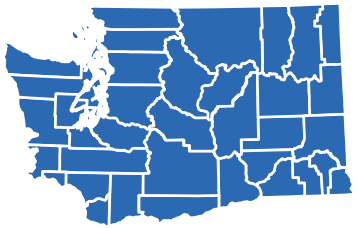
3.11 State and local agencies, along with community-based organizations, should deliver ongoing, culturally relevant messaging about **how to safely access perinatal care**, including for **immigrant and refugee communities**. This includes language-specific messages about **health insurance access,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

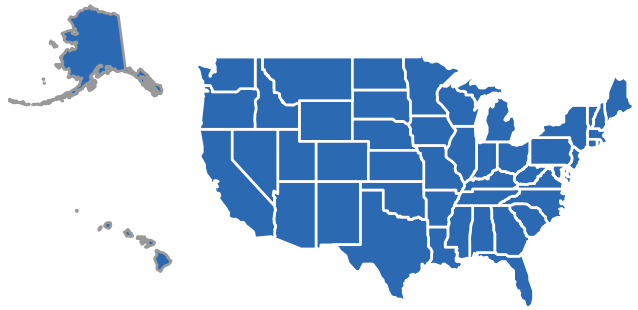
3.12 The Department of Health, Health Care Authority, and local health jurisdictions should work together with and **fund Tribal- and Indigenous-led provider training programs** that emphasize **culturally relevant health care and communication**.

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.

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

Implementing Recommendations

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?

Deborah (Debs) Gardner, MPH, MFA
Maternal Mortality Review Coordinator
Washington State Department of Health
deborah.gardner@doh.wa.gov

Anne (Annie) McHugh, MPH
Epidemiologist III
Washington State Department of Health
anne.mchugh@doh.wa.gov

Report to the Legislature

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

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Prepared by the Prevention and Community Health Division

Washington State Department of HEALTH

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King County

Teresa Mosqueda
Councilmember, District 8
Metropolitan King County Council

June 12, 2026

Megan Veith, Policy Director, and Kelly Cooper, Legislative Director
Washington State Department of Health
Executive Office of Prevention, Safety, and Health
Health Systems Quality Assurance Division
P.O. Box 47877
Olympia, WA 98504
Delivered via email to Megan.Veith@doh.wa.gov & Kelly.Cooper@doh.wa.gov

RE: Improving access to massage licensure

Dear Director Veith and Director Cooper,

Thank you very much for meeting with my team and me last month to discuss issues around equitable access to massage licensure. I appreciated hearing more about the ways in which the State Department of Health is looking to take meaningful steps to lower the barriers that are preventing many prospective and current massage workers—particularly immigrant, low-income, and non-English-speaking Asian women—from accessing Washington's massage licensure system. As a follow up to that conversation and the subsequent King County Board of Health May work session on this topic, I remain concerned about the barriers to accessing licensure, due to language, financial hurdles, and other challenges.

As Chair and in partnership with the Board Members signed below, we stand ready to work with your team to collectively address and reduce these hurdles. We stand ready to be partners with the State Department of Health to advance our shared commitment to equitable access to public health services and worker well-being. State law changes that removed requirements for language accommodations also make clear that the state has the authority and ability to make licensure more accessible by improving access and advancing reasonable accommodations via the administrative rule-making process or additional legislation.

As described at the BOH work session, current licensure processes require tens of thousands of dollars in training costs and over 625 hours of schooling. The Federation of State Massage Therapy Board's Massage and Bodywork Licensing Examination is not available in Chinese, further complicating barriers, despite the fact that many workers have years of experience and deep cultural knowledge of traditional Asian massage

King County Courthouse, 516 Third Avenue Suite 1200, Seattle, WA 98104
(206) 477-1008 teresa.mosqueda@kingcounty.gov www.kingcounty.gov/mosqueda

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Councilmember, District 8
Metropolitan King County Council

practices. We reiterate the requests below from workers, and stand ready to support State Department of Health in:

- Improving language access by requesting that the Federation of State Massage Therapy Boards offer its Massage and Bodywork Licensing Examination in Chinese and the other most commonly spoken languages among Washington's immigrant massage workforce, or resume the practice of offering an appropriate alternate form of examination in the most commonly spoken languages to determine equivalent competency;
- Reducing financial barriers by exploring fee waivers, scholarships, or community-based training partnerships;
- Creating alternative pathways to licensure that recognize prior experience, cultural massage traditions, and years of hands-on practice; and
- Continuing to engage directly with worker-led organizations such as the Massage Parlor Organizing Project (MPOP), which has conducted years of outreach to hundreds of Asian massage workers in Washington state and partners with community organizations, including Puget Sound Sage and APALA (AFL-CIO), Seattle chapter.

These steps would align with Martin Luther King Jr. County Labor Council's (MLK Labor) recently passed Resolution in Solidarity with Asian Massage Workers which called for "equitable access to existing state licensure and diversified certification processes for Asian massage workers to have safe and dignified work."

Recent multi-agency raids on Asian massage businesses in King and Pierce Counties have destabilized workers' lives, stripping many of their jobs, belongings, and even access to housing attached to their workplaces. Because unlicensed massage is criminalized, it is used as "evidence" of human trafficking — yet paradoxically, these raids make Asian massage workers *more* susceptible to exploitation as they are driven by necessity to more precarious work and living conditions.

We appreciate your attention to this matter and your ongoing commitment to health equity. We would welcome the opportunity to discuss these recommendations further and explore opportunities for partnership.

King County Courthouse, 516 Third Avenue Suite 1200, Seattle, WA 98104
(206) 477-1008 teresa.mosqueda@kingcounty.gov www.kingcounty.gov/mosqueda

King County

Teresa Mosqueda
Councilmember, District 8
Metropolitan King County Council

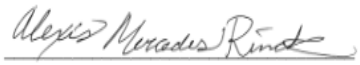
Sincerely,

Teresa Mosqueda
King County Councilmember, District 8, Health Housing & Human Services committee Chair and Board of Health Chair

Dionne Foster
Seattle City Councilmember, Position 9, At-Large, Board of Health Vice Chair for electeds

Quiana Daniels, BS, RN, LPN
Board of Health Vice Chair for non-electeds

Rhonda Lewis
King County Councilmember, District 2, Law & Justice committee Chair



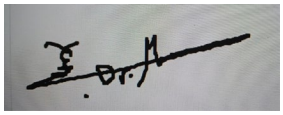
Alexis Mercedes Rinck
Seattle City Councilmember, Position 8, At-Large

Amy Falcone
Kirkland City Councilmember, Sound Cities Association Delegate to Board of Health

Victoria Schroff
Maple Valley City Council Member, Sound Cities Association Delegate to Board of Health

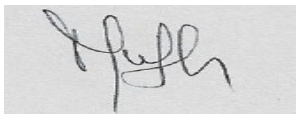
King County Courthouse, 516 Third Avenue Suite 1200, Seattle, WA 98104
(206) 477-1008 teresa.mosqueda@kingcounty.gov www.kingcounty.gov/mosqueda

Teresa Mosqueda
Councilmember, District 8
Metropolitan King County Council



Mustafa Mohammed, MBCHB, MD, MHP, CAAL
Mental health professional and clinician

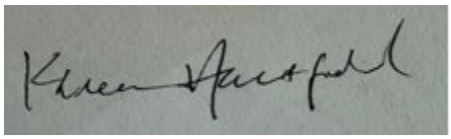
Dr. LaMont D. Green, D.S.W.
Community Organizer, Lived Experience Coalition



Francoise Milinganyo
Executive Director, Congolese Integration Network of WA

Victor Loo
Principal Consultant, Loo Consulting

Esther Lucero, MPP (Diné)
President and Chief Executive Officer, Seattle Indian Health Board



Karen Hartfield, MPH
Clinical Assistant Professor, Health Systems and Population Health, University of Washington School of Public Health

King County Courthouse, 516 Third Avenue Suite 1200, Seattle, WA 98104
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