2020 MATERNAL DEATHS IN IDAHO

A report of findings by the Maternal Mortality Review Committee

Key Findings

- Eleven women died in Idaho while pregnant or within one year of pregnancy.
- All eleven deaths were determined to be preventable.
- Nine of the eleven deaths were determined to be pregnancy-related.
- Eight of the eleven women were Medicaid participants.
- The most common contributing factors in these eleven women's deaths were: lack of knowledge regarding importance of event, treatment, or follow up and lack of continuity (see full report for definitions).
- The most common underlying cause of death was mental health conditions, which includes deaths related to suicide, substance use disorder, overdose/poisoning, and unintentional injuries determined by the MMRC to be related to a mental health condition. This was followed by cardiovascular conditions and infection.
- Idaho's 2020 MMRC Pregnancy-Related Mortality Ratio (PRMR) was 41.8 pregnancy-related deaths per 100,000 live births. This is an increase from the 2019 MMRC PRMR of 13.6 and the 2018 MMRC PRMR of 18.7.

Key Recommendations

- The Idaho Legislature should remove the sunset date on Title 39, Chapter 96, so that the MMRC can continue.
- A Statewide Perinatal Quality Collaborative should be established to promote best practice and multidisciplinary care for pregnant women.
- Idaho Medicaid should expand coverage for pregnant women to 12 months postpartum, regardless of pregnancy outcome.
- Facilities, systems, and communities should increase access, education, and funding for mental health resources across the state, including access to mental health care providers for patients both in-person and by telehealth.
- Facilities and systems should increase funding and access for maternal medical specialty consultative options for providers (e.g., mental health and chronic disease).
- Facilities should institute communication channels between providers for better coordination of care for patients, especially for patients with mental health disorders, chronic disease, or other potentially high-risk scenarios that have been identified.
- Facilities should have a better health information exchange, where electronic health record systems can interface and allow for providers to obtain records and care notes from previous providers both internal and external to their hospital system.
- Coroners should send decedents that meet the definition of pregnancy-associated death for an autopsy and/or toxicology if the decedents are less than 50 years of age and and do not appear to have sustained trauma.

Idaho maternal & child health

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