



**DIVISION OF OCCUPATIONAL &
PROFESSIONAL LICENSES**





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2022 MATERNAL MORTALITY REPORT

In accordance with Idaho Code §54-1806(12), the Board of Medicine is issuing its annual Maternal Mortality Review report. The Maternal Mortality Review Committee operates independently of any disciplinary actions or investigations conducted by the Board of Medicine. No disciplinary proceedings will be recommended to the Idaho Board of Medicine based on committee findings.

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Executive Summary

Key Definitions

Pregnancy-Associated Death: The death of a woman while pregnant or within one (1) year of being pregnant, regardless of cause. This includes two categories:

- **Pregnancy-Associated but not Related Death:** Death due to a cause unrelated to pregnancy.
- **Pregnancy-Related Death:** Death due to pregnancy complications, events initiated by pregnancy, or aggravation of an existing condition by pregnancy.

2022 Key Findings

The Idaho Maternal Mortality Review Committee reviewed fifteen (15) deaths and determined that ten (10) met the criteria for pregnancy-associated deaths for calendar year 2022. Of those, seven (7) were classified as pregnancy-associated but not related, and two (2) were classified as pregnancy-related. This represents a 37.5% decrease in the number of pregnancy-associated deaths and a 77.8% decrease in the number of pregnancy-related deaths compared to 2021. One (1) pregnancy-associated death was classified as undetermined due to a lack of a post-mortem autopsy and limited medical records.

Pregnancy-Relatedness	2018 (n=10)		2019 (n=5)		2020 (n=11)		2021 (n=16)		2022 (n=10)	
Pregnancy-Associated Deaths	10	100%	5	100%	11	100%	16	100%	10	100%
Pregnancy-Related Deaths	4	40%	3	60%	9	82%	9	56%	2	20%
Pregnancy-Associated but not Related Deaths	6	60%	2	40%	2	18%	7	44%	7	70%
Unable to Determine									1	10%

- The 2022 Pregnancy-Related Mortality Ratio was 8.94 maternal deaths per 100,000 live births.
- All pregnancy-associated deaths in 2022 were either somewhat or likely preventable.
- The greatest number of pregnancy-associated deaths (60%) occurred in women who were pregnant at time of death.
- The committee found no direct evidence in the records reviewed that any of the 2022 pregnancy-associated deaths were attributable to discrimination.
- A failure of the healthcare system was a contributing factor in both pregnancy-related deaths.
- No pre-existing comorbidities, such as mental health, substance use disorder, or obesity were identified in either of the pregnancy-related deaths.

Key Recommendations

- Refer all women with an underlying medical condition(s) that may affect pregnancy, whether they are considering getting pregnant or are currently pregnant, to a maternal-fetal medicine physician, or at minimum their provider should consult with a maternal-fetal medicine physician.
- Educate all pregnant and postpartum women about medication safety during pregnancy and breastfeeding, and encourage continuation of their prescribed medication until they can have a discussion with their provider.
- Ensure there is adequate care coordination and communication among all healthcare providers, inclusive of out-of-state physicians and staff.
- When postpartum patients report any new or concerning symptoms, providers and other healthcare personnel should have a low threshold for recommending an in-person evaluation or emergency care.
- Use shared decision-making to plan for potential complications or emergency situations when a patient's religious, moral, or cultural beliefs may require accommodations to maintain compliance with standard of care.
- Birthing facilities, including hospitals with limited resources, should have a contact hospital available for consultation and potential transfer in emergency situations beyond the resource capabilities of that facility.
- Since the inception of the maternal mortality review committee, inconsistencies have been observed among county coroners, including the number of incorrectly marked cases (e.g. indicating pregnant or postpartum status when not applicable) and variations in record availability. Consider reviewing the current regulatory requirements to ensure standardization when deemed necessary and appropriate.

Conclusion

While Idaho has seen a decline in pregnancy-related deaths in 2022, the Maternal Mortality Review Committee report highlights the need for continued efforts to improve maternal health outcomes. The recommendations focus on increasing awareness, education, and access to health care, particularly for at-risk populations.

- Idaho Maternal Mortality Review Committee

TABLE OF CONTENTS

INTRODUCTION	6
2022 FINDINGS	10
REVIEW OF PREGNANCY-ASSOCIATED DEATHS.....	13
REVIEW OF PREGNANCY-RELATED DEATHS	17
ACCESS & RESOURCES	19
RECOMMENDATIONS.....	20

INTRODUCTION

DEFINITIONS

Centers for Disease Control and Prevention Pregnancy Mortality Surveillance System (PMSS): Provides information on pregnancy-related deaths, which includes deaths during pregnancy and up to a year after the end of pregnancy. The PMSS ratio excludes injury deaths from review.¹

ICD-10 Codes: The International Classification of Diseases, Tenth Revision, is a standardized system for coding diseases and medical conditions (morbidity) data. It is also the system for coding causes of death on death certificates.²

Healthy People 2030 Initiative (MICH-04) Obstetrics Caused Pregnancy-Related Ratio: Used by the U.S. Department of Health and Human Services as a quantitative measure of the number of Pregnancy-Related obstetric caused deaths per 100,000 live births.³ This counting methodology aligns with the international definition of maternal death.

- Numerator: number of female deaths due to obstetric causes (ICD-10 codes: A34, O00-O95, O98-O99) while pregnant or within forty-two (42) days of being pregnant.
- Denominator: Total number of live births per year in Idaho.

Maternal Death:

- As defined by the Idaho Maternal Mortality Review Committee: The death of a woman from any cause during pregnancy or within one (1) year following the end of the pregnancy.
- As defined by Health and Human Service's Office of Disease Prevention and Health Promotion: The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within forty-two (42) days of termination of pregnancy, irrespective of the duration and site of the pregnancy.³ This definition is used to calculate the MICH-04 Obstetric Caused Pregnancy-Related Ratio.

Maternal Mortality Review Committee (MMRC): Multidisciplinary group that convenes at the state or local level to comprehensively review deaths that occur during or within one (1) year of the end of pregnancy.⁴ Maternal Mortality Review Committees are designed to identify ways to improve behaviors, health and healthcare delivery before, during, and after pregnancy.

¹ U.S. Centers for Disease Control and Prevention. (2024, November 21). *PMSS: Frequently asked questions*. <https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/faqs.html>

² U.S. Centers for Disease Control and Prevention. (2024, June 7). *ICD-10-CM*. <https://www.cdc.gov/nchs/icd/icd-10-cm/index.html>

³ U.S. Department of Health and Human Services. (n.d.). *Reduce maternal deaths – MICH-04*. Healthy People 2030. <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-maternal-deaths-mich-04>

⁴ U.S. Centers for Disease Control and Prevention. (2024, May 15). *About maternal mortality review committees*. <https://www.cdc.gov/maternal-mortality/php/mmr/index.html>

Pregnancy-Associated Death (PAD): The death of a woman from any cause, while pregnant or within one (1) year of being pregnant, regardless of the duration and location of the pregnancy. This represents the total number of maternal deaths within the state of Idaho and is subdivided into two (2) categories:

- Pregnancy-Associated but not Related Death: A pregnancy-associated death due to a non-pregnancy related cause.
- Pregnancy-Related Death (PRD): A pregnancy-associated death resulting from one of the following:
 - Complications of the pregnancy itself.
 - A chain of events initiated by the pregnancy.
 - Aggravation of an unrelated condition by the physiological effects of pregnancy.

Pregnancy-Related Mortality Ratio (PRMR): Used by most state MMRCs to calculate the number of pregnancy-related deaths (women who were pregnant at time of death or within one (1) year of being pregnant) per 100,000 live births.

- Numerator: Number of pregnancy-related deaths per year
- Denominator: Number of live births per year

Urban: As defined by the Idaho Department of Health and Welfare, counties in which the largest city has more than 20,000 residents; nine (9) of Idaho's forty-four (44) counties meet criteria to be classified as urban.⁵

FEDERAL GOAL

The U.S. Department of Health and Human Services, through its Healthy People 2030 Initiative (MICH-04), has set the goal of decreasing the number of female deaths due to obstetric causes while pregnant or within forty-two (42) days of being pregnant to 15.7 per 100,000 live births.⁶

IDAHO GOAL

Prevent maternal deaths in the state of Idaho.

⁵ Idaho Department of Health & Welfare. (2022, September 15). *County population urban v. rural*. <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=23351&dbid=0&repo=PUBLIC-DOCUMENTS>

⁶ U.S. Department of Health and Human Services. (n.d.). *Reduce maternal deaths – MICH-04*. Healthy People 2030. <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-maternal-deaths-mich-04>

REVIEW PROCESS

Case Identification

The Idaho MMRC relies on the accurate submission and reporting of death certificates within the state. The Idaho Department of Health and Welfare Bureau of Vital Records and Health Statistics provides MMRC staff with the names of the women who qualify for MMRC review for a given year. Maternal deaths are identified through:

- Linkage of a woman's death certificate to a fetal birth certificate or death record that occurred within one year of the mother's death.
- Death certificate with the pregnancy status/history box checked.
- Confirmation of pregnancy status through available healthcare records.

Records Request

All pertinent medical (hospital, prenatal care, primary care, mental health, autopsy reports, etc.) and non-medical (coroner reports, obituaries, social media, news reports, etc.) records are acquired to determine what factors may have contributed to a woman's death.

Case Abstraction

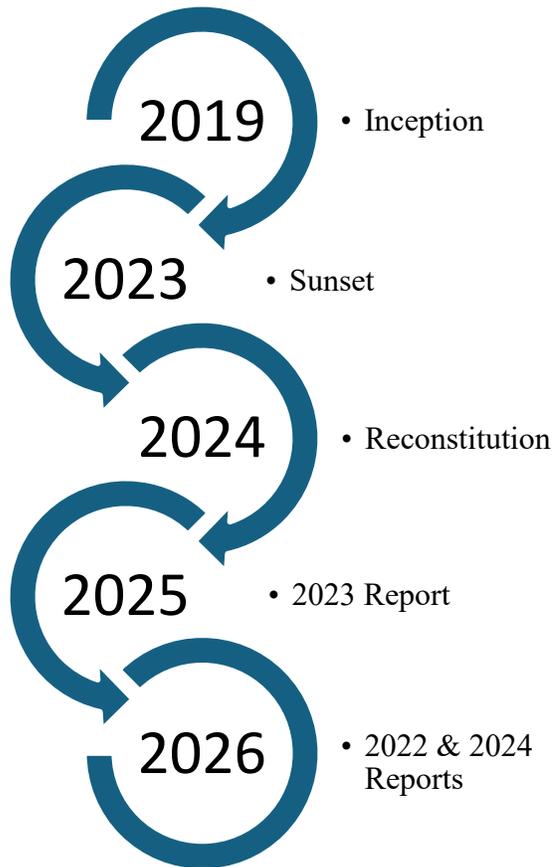
All medical and non-medical records received are reviewed for relevance, ordered chronologically, de-identified, and summarized for the committee to review.

Committee Review

Prior to each committee meeting, members are given adequate time to review materials and prepare for discussion. During a review meeting, each case is systematically discussed to (1) confirm that it falls within the purview of the MMRC and, if so, (2) determine the following:

- Was the death pregnancy-related?
- What was the cause of death?
- Was the death preventable?
- What factors contributed to the death?
- What recommendations, if any, should be provided to prevent this type of death from occurring in the future?

BACKGROUND INFORMATION



- In 2019, House Bill 109 established Idaho’s MMRC and provided that it would sunset on July 1, 2023 if not renewed. The Legislature granted Idaho Department of Health and Welfare statutory authority to constitute a committee and ascertain records relating to maternal deaths within the state.⁷
- The Idaho MMRC sunset on July 1, 2023.
- House Bill 399 was proposed during the 2024 legislative session to re-establish the Idaho MMRC. It was signed into law, moving the MMRC from the Idaho Department of Health and Welfare to the Idaho Board of Medicine.⁸
- January 31, 2025, marked the first report that the reconstituted MMRC furnished to the Legislature. The MMRC began by analyzing 2023 data, as it was the most recent data available at the time.

⁷ Idaho State Legislature. (2019). *House Bill 109*. <https://legislature.idaho.gov/sessioninfo/2019/legislation/h0109/>

⁸ Idaho State Legislature. (2024). *House Bill 399*. <https://legislature.idaho.gov/sessioninfo/2024/legislation/h0399/#::~:~:text=MATERNAL%20MORTALITY%20%E2%80%93%20Adds%20to%20existing,data%20on%20maternal%20mortality%20rates>

2022 FINDINGS

In 2022, fifteen (15) deaths were identified for review by the Idaho Health and Welfare Bureau of Vital Records and Health Statistics. The Idaho MMRC reviewed all fifteen (15) cases and determined that five (5) did not meet the pregnancy-associated inclusion criteria as there was not sufficient evidence to show that the decedent was pregnant at time of death or within one (1) year. Of the ten (10) confirmed pregnancy-associated deaths, two (2) were pregnancy-related and seven (7) were pregnancy-associated but not related. In the one (1) remaining case, due to a lack of available medical records, the committee was unable to determine whether pregnancy contributed to the death.

Since the inception of the Idaho MMRC in 2018, total maternal deaths, specifically pregnancy-related deaths, have remained variable. As additional review years are released, gross trends may emerge showing potential gaps in maternal care. Although each death is tragic, the small number of annual deaths relative to total live births is statistically insignificant, making it difficult to rely solely on annual data to draw broad conclusions about healthcare safety and delivery in Idaho. This information should not serve as the only basis for changes to care protocols or health legislation in the state.

Pregnancy-Relatedness	2018 (n=10)		2019 (n=5)		2020 (n=11)		2021 (n=16)		2022 (n=10)	
Pregnancy-Associated Deaths	10	100%	5	100%	11	100%	16	100%	10	100%
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Unable to Determine									1	10%

Pregnancy-Associated but not Related:

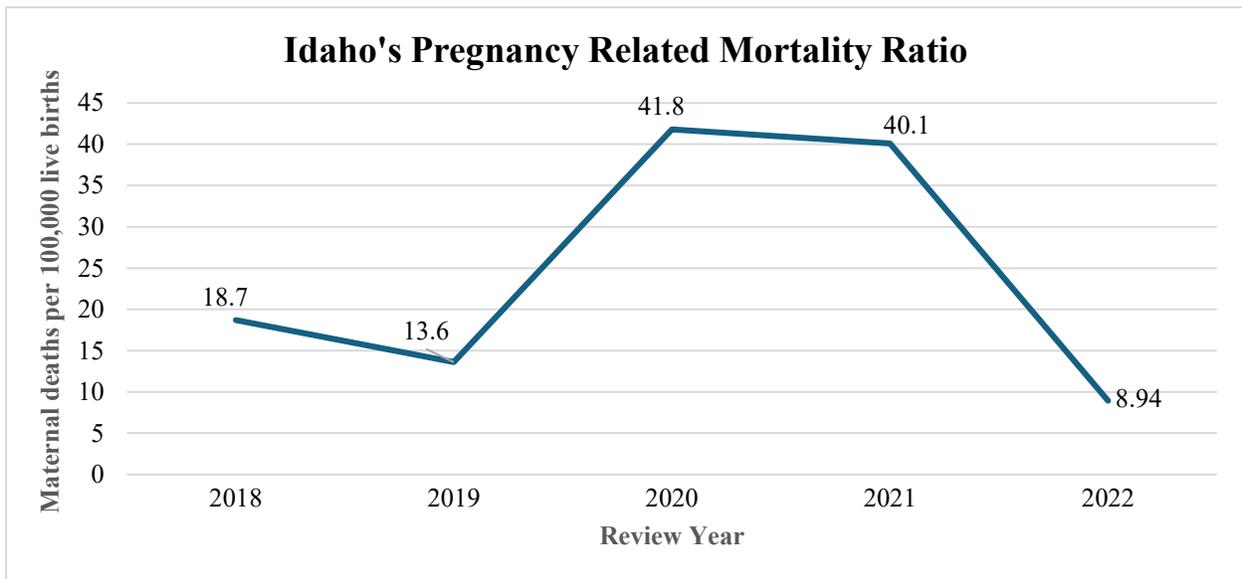
Of the seven (7) pregnancy-associated but not related deaths, three (3) were caused by vehicular accidents, and in each of these cases, the women were not wearing seatbelts. One (1) additional death resulted from a biking-related accident, and one (1) resulted from unsafe heating practices that led to unintentional carbon monoxide poisoning. The remaining two (2) deaths were attributable to pre-existing medical conditions.

Pregnancy-Related:

In 2022, two (2) deaths were determined to be pregnancy-related, which represents a 77.8% decrease compared to 2021. The committee determined that, in the case of both pregnancy-related deaths, one (1) or more healthcare failures acted as a contributing factor.

The Pregnancy-Related Mortality Ratio indicates the likelihood of a woman dying while pregnant or up to one (1) year postpartum. Accuracy of the PRMR is dependent on the consistent analysis and categorization of pregnancy-associated deaths. In 2022, there were two (2) pregnancy-related deaths in Idaho and 22,380 live births. The calculated PRMR was 8.94.

$$2022 \text{ Idaho PRMR} = \frac{2 \text{ PRD}}{22,380 \text{ live births}} \times 100,000 = 8.94$$



The table below displays Idaho’s PRMR alongside the U.S. PRMR provided by the Centers for Disease Control and Prevention Pregnancy Mortality Surveillance System. Direct comparison is difficult to make given the relatively small sample size of the Idaho PRMR. Even one pregnancy-related death in Idaho has the potential to shift the PRMR above the national average. Furthermore, the PMSS does not include injury deaths.⁹ Additional U.S. maternal mortality statistics can be accessed through the CDC website.

Pregnancy-Related Mortality Ratio					
Idaho vs. U.S. Statistics	2018	2019	2020	2021	2022
State of Idaho	18.7	13.6	41.8	40.1	8.94
United States	17.3	17.6	24.9	33.2	21.5

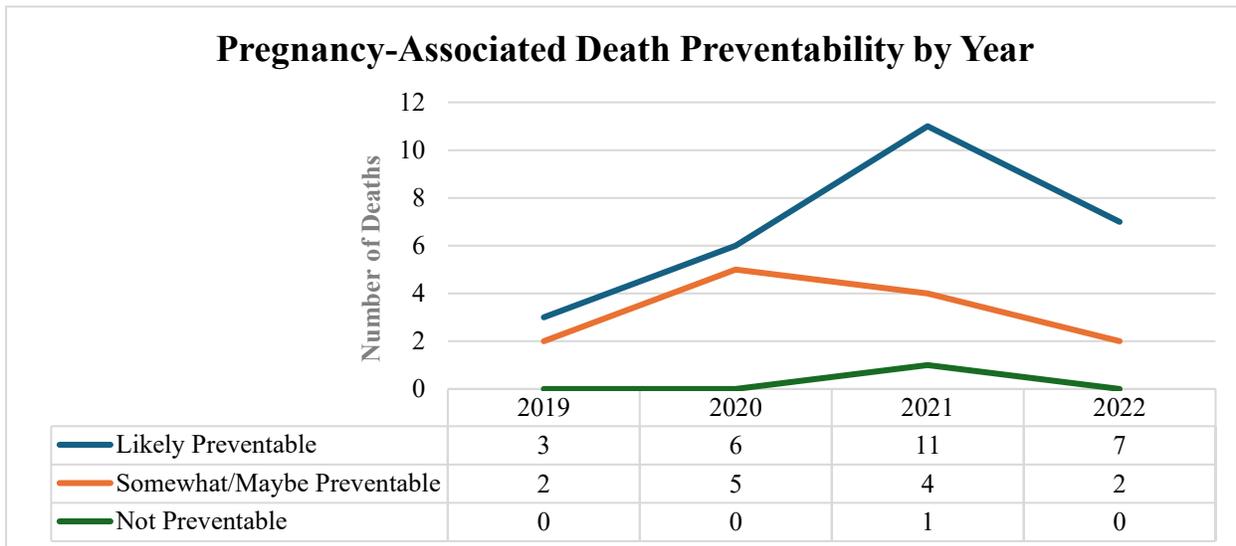
⁹ U.S. Centers for Disease Control and Prevention. (2024, November 21). *PMSS: Frequently asked questions*. <https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/faqs.html>

The Healthy People 2030 Initiative (MICH-04) methodology uses the same definitions as the international community and is used to compare maternal deaths between different nation-states. Maternal deaths included in the ratio are limited to deaths only attributed to select medical diagnostic codes (ICD-10 codes: A34, O00-O95, O98-O99 which excludes suicides) while pregnant or within forty-two (42) days of being pregnant¹⁰. As of 2022, Idaho had 6.76 fewer maternal deaths per 100,000 live births than the stated Healthy People 2030 Initiative goal of 15.7.

$$2022 \text{ MICH-04 PRMR} = \frac{2 \text{ PRD}}{22,380 \text{ births}} \times 100,000 = 8.94$$

MICH-04 Pregnancy-Related Mortality Ratio					
Idaho vs. U.S.	2018	2019	2020	2021	2022
State of Idaho					8.94
United States	17.4	20.1	23.8	32.9	22.3

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 by the patient, community, provider, facility, or healthcare system.¹¹ Of the forty-two (42) cases the MMRC has reviewed since 2019, approximately 95% were determined to have some level of preventability. The committee found that all pregnancy-associated deaths (excluding the one (1) case with an undetermined cause) in 2022 were either somewhat or likely preventable. For example, one (1) of the pregnancy-related deaths may have had an altered outcome if adequate care coordination and more consistent follow-up had been provided.

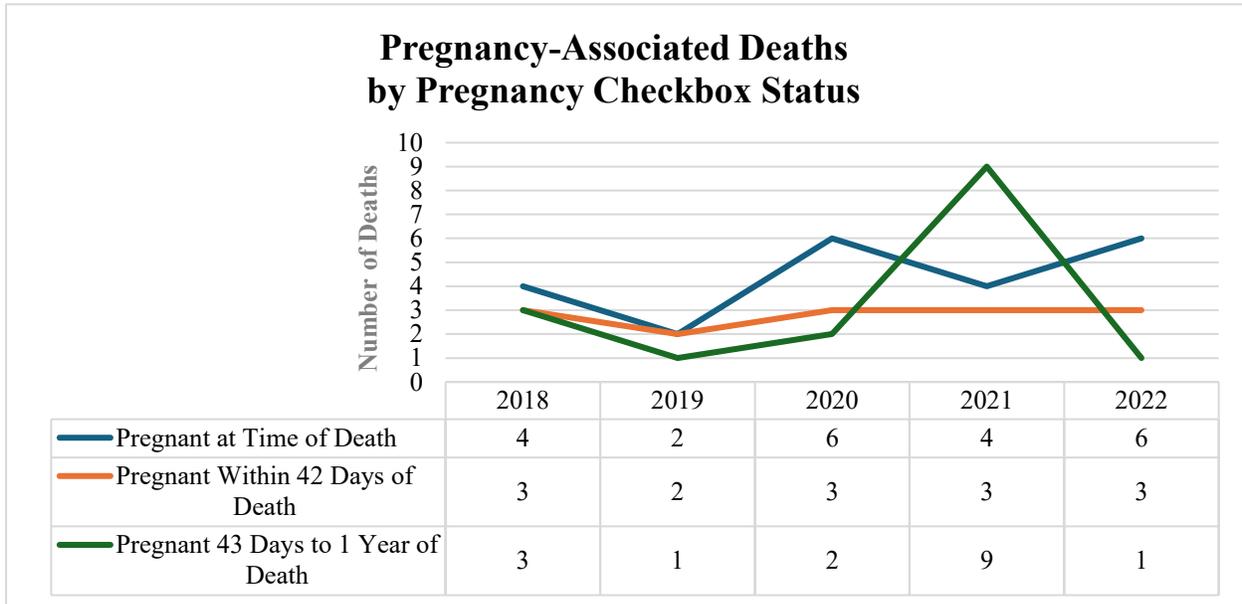


¹⁰ U.S. Department of Health and Human Services. (n.d.). *Reduce maternal deaths – MICH-04*. Healthy People 2030. <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-maternal-deaths-mich-04>

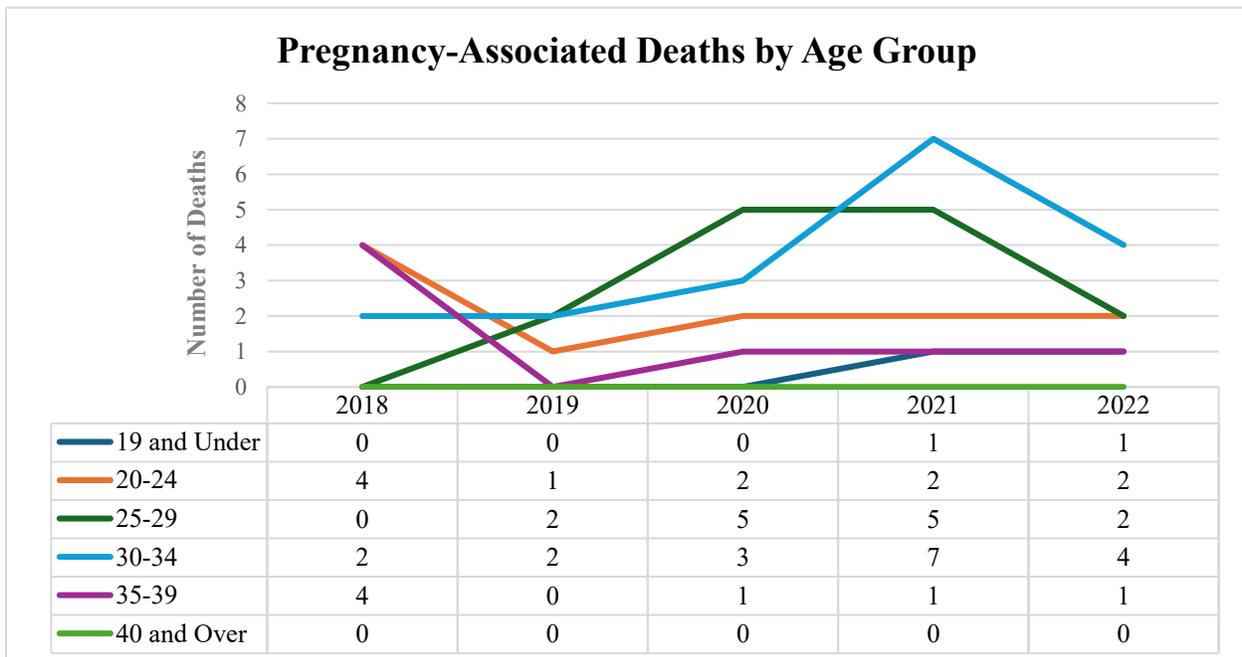
¹¹ U.S. Centers for Disease Control and Prevention. (2024, September 25). *Preventing pregnancy-related deaths*. <https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html>

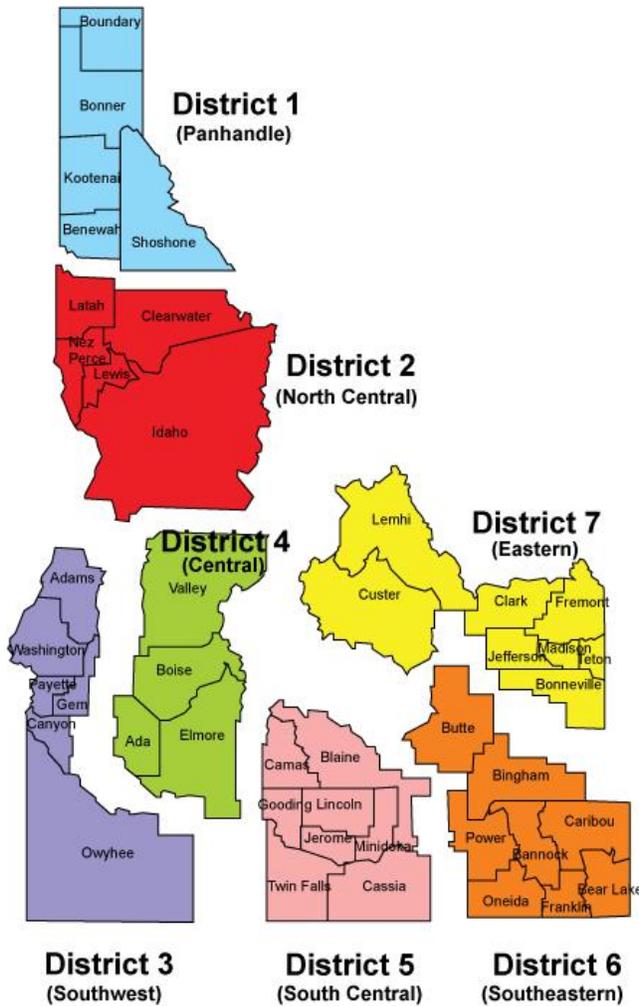
Review of Pregnancy-Associated Deaths

The graph below reflects the timing of death as recorded on the death certificate. In 2022, the greatest number of pregnancy-associated deaths (60%) occurred in pregnant women. This is consistent with the broader trend, in which the largest percentage (42.3%) of maternal deaths since 2018 have occurred in women who were pregnant at the time of death. Both pregnancy-related deaths in 2022 occurred within forty-two (42) days of the end of the pregnancy.



The age group that experienced the highest number of maternal deaths in 2022 were those aged 30-34. Women aged 40 and over experienced no recorded maternal deaths from 2018 to 2022.





To better protect the identities of the deceased, the table below uses public health districts as the smallest geographical unit to represent where each woman resided prior to her death.

Of the 2022 pregnancy-associated deaths in Idaho, seven (7) of the women lived in an urban county, while three (3) lived in a rural county.

With the advancement of telehealth offerings, pregnant and postpartum women living in both rural and urban areas may take advantage of enhanced access to providers throughout the state of Idaho.

Pregnancy-Associated Deaths by Public Health District					
	2018 (n =10)	2019 (n= 5)	2020 (n=11)	2021 (n=16)	2022 (n=10)
Panhandle	2	0	1	1	2
North Central	0	2	0	0	0
Southwest	3	0	4	4	2
Central	0	0	0	7	1
South Central	1	2	3	1	5
Southeastern	0	1	3	1	0
Eastern	4	0	0	2	0

Non-Hispanic White women and Hispanic White women have accounted for 84.6% of all maternal deaths in the state of Idaho from 2018 to 2022, while accounting for 91.9% of the total state population according to a 2020 census.¹² The table below provides a further breakdown.

- Non-Hispanic White women accounted for 60% of pregnancy-associated deaths in 2022, while accounting for 78.9% of the population.
- Hispanic White women accounted for 30% of pregnancy-associated deaths in 2022, while accounting for 13.0% of the population.
- American Indian/Alaskan Native women accounted for 10% of pregnancy-associated deaths in 2022, while accounting for 1.4% of the population.

The 2024 MMRC findings are statistically insignificant due to the infrequency of maternal deaths compared to live births in the state. This report should not serve as the only basis for changes to healthcare delivery or legislative initiatives.

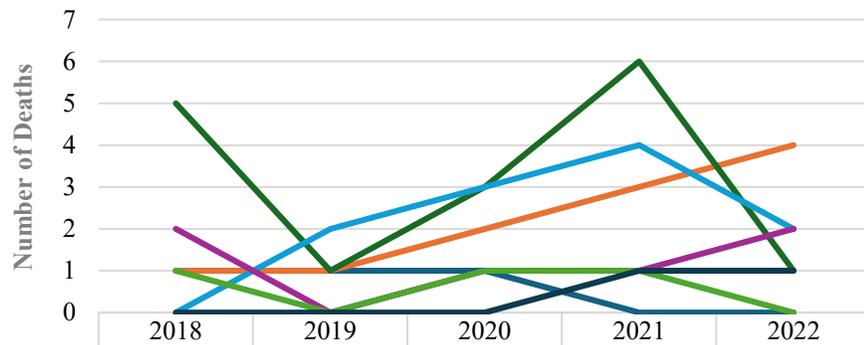
The committee found no direct evidence in the records reviewed that any of the 2022 pregnancy-associated deaths were attributable to any form of discrimination.

Pregnancy-Associated Deaths by Race/Ethnicity					
	2018 (n=10)	2019 (n=5)	2020 (n=11)	2021 (n=16)	2022 (n=10)
Hispanic	2	0	1	3	3
Non-Hispanic White	4	4	10	11	6
Non-Hispanic Black	0	0	0	1	0
American Indian/Alaska Native	1	1	0	0	1
Asian	0	0	0	0	0
Pacific Islander	1	0	0	1	0
Bi-racial	2	0	0	0	0

Current trends indicate that increased educational attainment is correlated with a lower likelihood of dying while pregnant or within one (1) year postpartum. In 2022, 70% of all pregnancy-associated deaths occurred in individuals whose highest educational attainment was below an associate degree. Both women who were classified as having a pregnancy-related death had at least a high school diploma or GED; however, neither obtained a bachelor’s degree.

¹² United States Census Bureau. (n.d.). *Idaho*. <https://data.census.gov/profile/Idaho?g=040XX00US16>

Pregnancy-Associated Deaths by Level of Educational Attainment



	2018	2019	2020	2021	2022
8th Grade or Less	1	1	1	0	0
9th-12th Grade, No Diploma	1	1	2	3	4
High School Diploma or GED	5	1	3	6	1
Some College, No Degree	0	2	3	4	2
Associate's Degree	2	0	1	1	2
Bachelor's Degree	1	0	1	1	0
Advanced Degree (Masters or Doctorate)	0	0	0	1	1

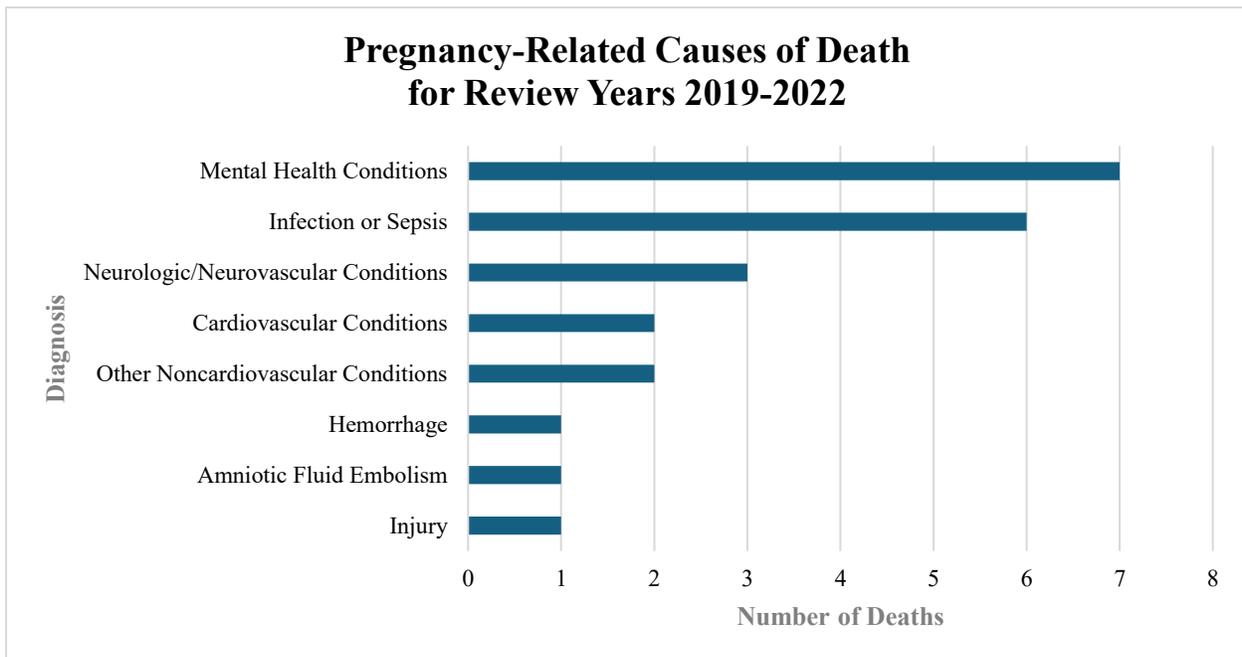
Since the inception of the MMRC, the highest accumulated risk group based on marital status has been unmarried women, who have accounted for 63.5% of all recorded pregnancy-associated deaths reviewed from 2018 to 2022. This trend continued in 2022 with 60% of all pregnancy-associated deaths and 100% of pregnancy-related deaths occurring in women who were never married.

Pregnancy-Associated Deaths by Marital Status

	2018 (n=10)	2019 (n=5)	2020 (n=11)	2021 (n=16)	2022 (n=10)
Married	5	0	5	5	4
Married, but Separated	0	0	0	0	0
Widowed	0	0	0	0	0
Divorced	0	1	2	4	0
Never Married	5	4	4	7	6

Review of Pregnancy-Related Deaths

2022 Pregnancy-Related Causes of Death		
Cause	Deaths (n=2)	Percentage of Deaths
Hemorrhage	1	50%
Infection or Sepsis	1	50%



- According to the CDC, infection was the leading cause of pregnancy-related death in the United States in 2021, and hemorrhage was the fourth leading cause.¹³
- No pre-existing comorbidities, such as mental health, substance use disorder, or obesity were identified in either of the 2022 pregnancy-related deaths.
- Of these pregnancy-related deaths, one (1) delivery was vaginal and the other an emergency C-section.
- Both of these pregnancy-related deaths occurred in the early postpartum period in an inpatient facility. One (1) woman had been discharged and later returned for care, and the other had not yet been discharged.

¹³ U.S. Centers for Disease Control and Prevention. (2025, August 22). *Pregnancy-related deaths: Data from maternal mortality review committees*. https://www.cdc.gov/maternal-mortality/php/data-research/mmrc/?CDC_AAref_Val=https%3A%2F%2Fwww.cdc.gov%2Fmaternal-mortality%2Fphp%2Fdata-research%2Fmmrc-2017-2019.html&cove-tab=1. Data for 2022 is unavailable.

At the time of death, both women had health insurance coverage. Both were privately insured, with one (1) having secondary coverage through Medicaid. Based on historical Idaho MMRC findings, most women who die are insured at time of death, either through a private payer or Idaho Medicaid.

2022 Pregnancy-Related Deaths by Health Insurance Status		
Status	Number of Deaths (n=2)	Percentage of Deaths
Insured	2	100%
Uninsured	0	0%

ACCESS & RESOURCES

Federal Resources

The Centers for Medicare and Medicaid Services (CMS) tracks Birthing-Friendly Hospitals and Health Systems. To earn this designation, hospitals and health systems report their progress on the CMS's Maternal Morbidity Structural Measure to the Hospital Inpatient Quality Reporting Program. The measure identifies whether a hospital or health system has:

- Participated in a statewide or national perinatal quality improvement collaborative program; and,
- Implemented evidence-based quality interventions in hospital settings to improve maternal health.

Idaho currently has 15 hospitals with this designation.¹⁴

State Resources

Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. The Idaho Crisis and Suicide Hotline is available to call or text 24 hours a day, 7 days a week. Individuals may call or text 9-8-8 or visit the website online at <https://idahocrisis.org/>.¹⁵

Idaho Health and Welfare compiles a directory of names, addresses, and telephone numbers of public and private agencies that provide services and financial aid for pregnancy and child health services.¹⁶

A list of resources for individuals struggling with substance use disorder, including for pregnant and postpartum women, is also available through Idaho Health and Welfare.¹⁷

The Idaho Perinatal Quality Collaborative has published a *Severe Hypertension in Pregnancy and Postpartum* toolkit aimed at preventing maternal morbidity and mortality related to hypertensive disorders.¹⁸

Additional Resources

MotherToBaby® provides information on health conditions, medications, and other exposures during pregnancy and breastfeeding, with resources for providers and patients including research publications, fact sheets, and interactive tools. The website is supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.¹⁹

¹⁴ Centers for Medicare & Medicaid Services. (n.d.). *Birthing-friendly hospitals and health systems*. <https://data.cms.gov/provider-data/birthing-friendly-hospitals-and-health-systems>

¹⁵ Idaho Crisis & Suicide Hotline. (n.d.). *Resources*. <https://idahocrisis.org/resources>

¹⁶ Idaho Department of Health & Welfare. (2022, August 19). *Pregnancy directory*. <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3892&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1>

¹⁷ Idaho Department of Health & Welfare. (2025, November 25). *Resources*. <https://healthandwelfare.idaho.gov/services-programs/behavioral-health/resources-0>

¹⁸ Idaho Perinatal Quality Collaborative. (2025, October 23). *IDPQC severe hypertension in pregnancy and postpartum initiative*. <https://public.3.basecamp.com/p/f2j8wUD19DikDnWaSrQjTuiX>

¹⁹ Organization of Teratology Information Specialists. (n.d.). *MotherToBaby®*. <https://mothertobaby.org/>

RECOMMENDATIONS

Legislature

- Consider allocating future federal grant funding for rural communities to critical access hospitals to ensure appropriate birthing care.
- Continue to foster a regulatory environment that ensures licensed healthcare professionals can provide care commensurate with their education, training, and experience to help ensure quality healthcare for both the mother and child.
- Since the inception of the Idaho MMRC, inconsistencies have been observed among county coroners, including the number of incorrectly marked cases (e.g. indicating pregnant or postpartum status when not applicable) and variations in record availability. Consider reviewing the current regulatory requirements to ensure standardization if deemed necessary and appropriate.

Healthcare System

- Refer all women with an underlying medical condition(s) that may affect pregnancy, whether they are considering getting pregnant or are currently pregnant, to a maternal-fetal medicine physician, or at minimum their provider should consult with a maternal-fetal medicine physician.
- Each provider responsible for managing a pregnant woman's health should ensure there is adequate care coordination and communication among all healthcare providers, inclusive of out-of-state physicians and staff.
- Screen pregnant and postpartum patients for a history of drug use. A positive history should prompt additional testing, such as an echocardiogram, especially if the patient is experiencing symptoms of cardiac distress.
- Use additional caution when assessing pulmonary emboli, as current risk-stratification tools may not properly account for the heightened risk in pregnant and postpartum patients.
- When postpartum patients report any new or concerning symptoms, providers and other healthcare personnel should have a low threshold for recommending an in-person evaluation or emergency care.
- Hospitals should stay up to date on innovative devices used to treat postpartum hemorrhage such as the JADA® system and Bakri® balloon and offer simulation-based training opportunities.
- Both public and private payers should consider reviewing their birthing reimbursement policies to ensure rural hospitals are able to carry JADA®, Bakri®, and other innovative treatments and receive appropriate reimbursement for their use.
- Use shared decision-making to plan for potential complications or emergency situations when a patient's religious, moral, or cultural beliefs may require accommodations to maintain compliance with standard of care.
- Birthing facilities, including hospitals with limited resources, should have a contact hospital available for consultation and potential transfer in emergency situations beyond the resource capabilities of that facility.

Communities

- All pregnant and postpartum women should wear a seatbelt when in a motor vehicle.
- Pregnant women should not consume alcohol, illegal drugs, or any other substance that is incompatible with pregnancy.
- Pregnant and postpartum women should not drive while under the influence of an intoxicating substance.
- Companies providing employee housing should ensure that buildings comply with all safety and heating standards, such as installation of carbon monoxide detectors, in accordance with state law.

Joint Recommendations

- Postpartum women should receive thorough education on the signs and symptoms of infection, pre-eclampsia, pulmonary embolism, and hemorrhage. Providers should educate the women regarding when to contact their office versus present to the emergency department.
- Educate all pregnant and postpartum women about medication safety during pregnancy and breastfeeding, and encourage continuation of their prescribed medication until they can have a discussion with their provider.
- Pregnant and postpartum women with epilepsy should be monitored closely. Labs should be continued and may need to be performed more frequently to determine whether a medication dosage change is necessary.
- Pregnant and postpartum women with epilepsy should be educated on the importance of rescue medications and offered a prescription when such a medication is available and accessible.