# DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSES

**BRAD LITTLE**
Governor
**RUSSELL BARRON**
Administrator

State of Idaho
Division of Occupational and Professional Licenses
Board of Medicine

11341 W Chinden Blvd.
P.O. Box 83720
Boise, ID 83720-0063
(208) 334-3233
dopl.idaho.gov

# 2024 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.

**Idaho Maternal Mortality Review Staff**
Orin Duffin, PharmD – Program Director
Brandy Fitchett, DNP, FNP-BC – Nurse Abstractor
Mia Luginbill, MBA – Research Assistant
Ellis Guzman – Data & Analytics Advisor

**Committee Membership**
Dr. John Eck (MD) – Chair
Dr. Andrew Spencer (MD) – Vice-Chair
Dr. Magni Hamso (MD, MPH)
Dr. Kena Lackman (MD)
Dr. Julie Meltzer (MD)
Dr. Spencer Paulson (MD)
Faith Krull (CNM)
Krysta Freed (LM, CPM)
Tasha Hussman (MSN, RN)
Jeremy Schabot (B.A.)
Joshua Hall (D-ABMDI)

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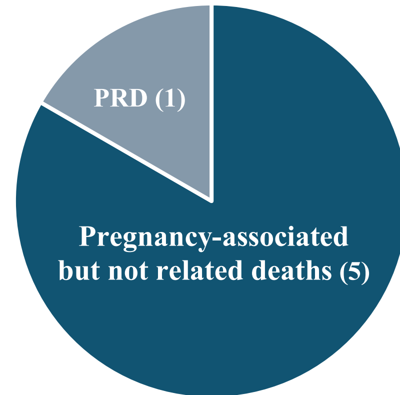
# Pregnancy-Related Deaths

**Pregnancy-Related Death**: The death of a woman, while pregnant or within one (1) year of being pregnant, resulting from complications of the pregnancy, a chain of events initiated by the pregnancy, or aggravation of an unrelated condition by the physiological effects of pregnancy.[1]

**2024 Findings**
In 2024, the Idaho Department of Health and Welfare's Bureau of Vital Records and Health Statistics referred six (6) pregnancy-associated deaths to Idaho's Maternal Mortality Review Committee for analysis. Of these, one (1) was determined to be a pregnancy-related death. This represents an 80% reduction in the number of pregnancy-related deaths compared to 2023.




**Pregnancy-Related Deaths by Year**

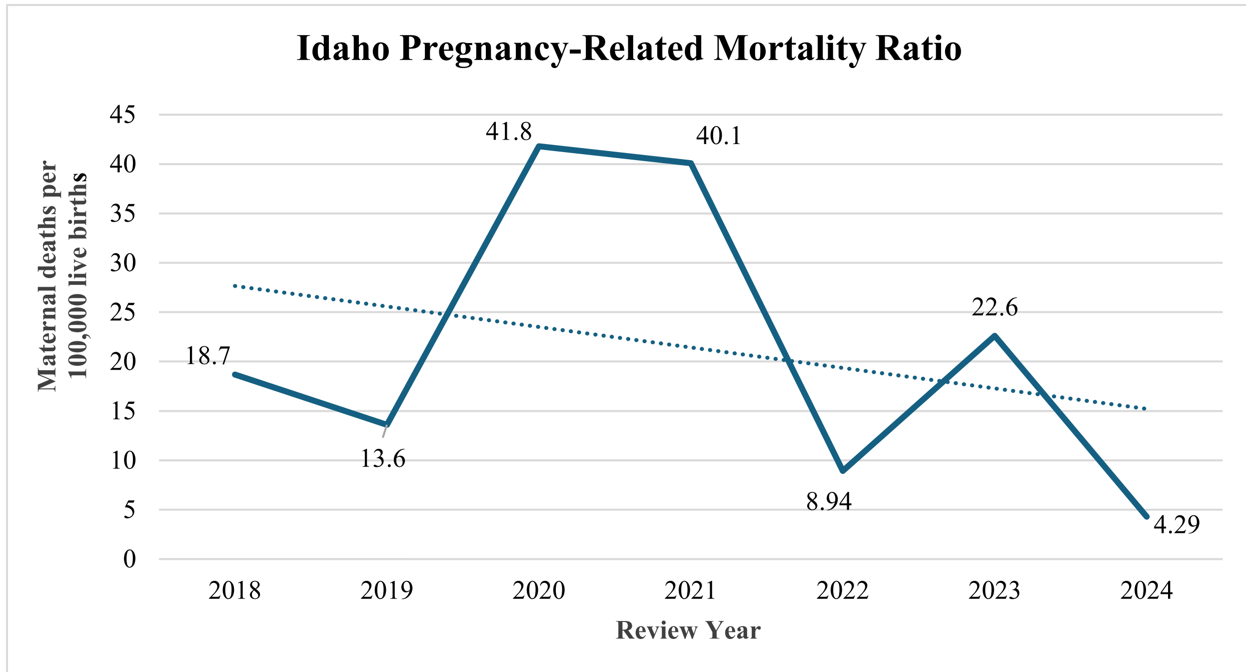
| | 2020 (n=11) | 2021 (n=16) | 2022 (n=10) | 2023 (n=11) | 2024 (n=6) |
|---|---|---|---|---|---|
| Number of PRD | 9 | 9 | 2 | 5 | 1 |

Since the inception of the Idaho MMRC, the total number of pregnancy-related deaths has remained variable. As additional review years are released, gross trends may emerge showing potential gaps in maternal care. 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.

**2024 Statistics**
The Pregnancy-Related Mortality Ratio indicates the projected likelihood of a woman dying while pregnant or up to one (1) year postpartum per 100,000 live births. Accuracy of the PRMR is dependent on the consistent analysis and categorization of pregnancy-associated deaths by the MMRC.

$$\text{2024 Idaho PRMR} = \frac{\text{1 PRD}}{\text{23,285 live births}} \times 100{,}000 = 4.29$$

[1] For additional information on types of pregnancy deaths and for other definitions, refer to Appendix C.



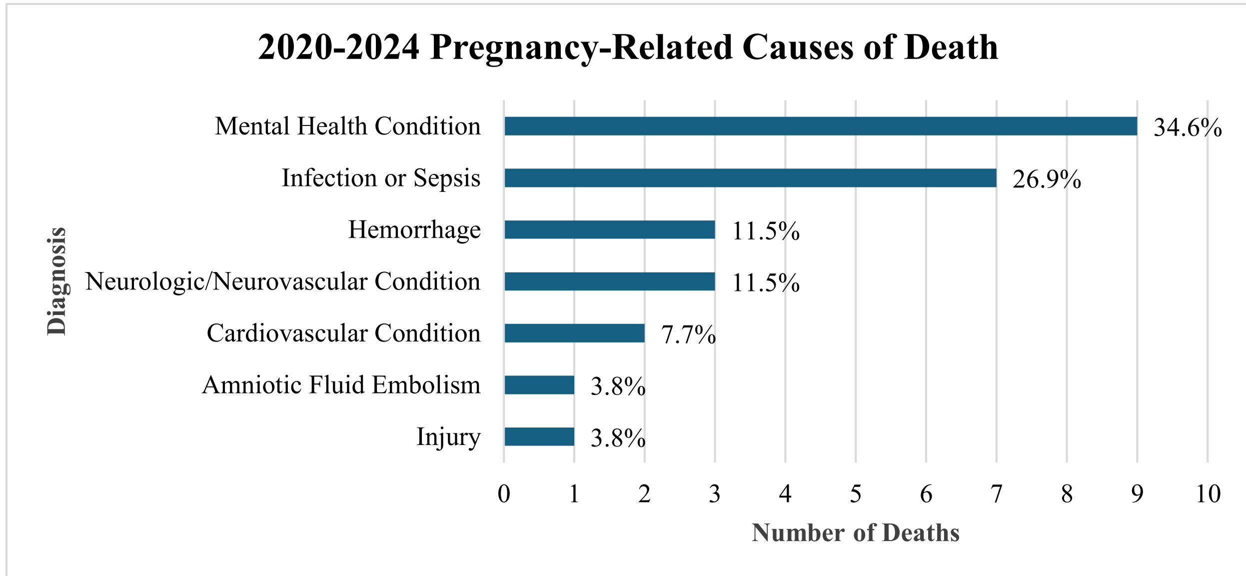

The Centers for Disease Control and Prevention Pregnancy Mortality Surveillance System PRMR uses a methodology similar to the Idaho PRMR, however, it excludes injury deaths from its calculation.[2] This contrasts with the Healthy People 2030 Initiative (MICH-04), which uses a narrower methodology: pregnancy starting at conception and lasting up to forty-two (42) days postpartum, consistent with international standards.[3]

| Idaho vs. U.S. Maternal Mortality Statistics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Idaho vs. U.S. Statistics** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Idaho PMSS Ratio | 18.7 | 13.6 | 32.5 | 22.3 | 8.94 | 13.58 | 4.29 |
| United States PMSS Ratio | 17.3 | 17.6 | 24.9 | 33.2 | 21.5 | 18.7 | |
| **Healthy People 2030 Initiative (MICH-04) Ratio** | | | | | | | |
| Idaho MICH-04 | | | | | 8.94 | 13.6 | 4.29 |
| United States MICH-04 | 17.4 | 20.1 | 23.8 | 32.9 | 22.3 | 18.6 | |

[2] 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
[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

As of 2024, Idaho had 11.41 fewer maternal deaths per 100,000 live births than the stated Healthy People 2030 Initiative goal of 15.7.

$$2024 \text{ MICH-04 PRMR} = \frac{1 \text{ PRD}}{23{,}285 \text{ births}} \times 100{,}000 = 4.29$$




For the only pregnancy-related death in 2024, the cause was determined to be from infection or sepsis.

- The woman had private health insurance coverage during the pregnancy and up to her death.
- This death may likely have been prevented if there were one or more reasonable changes made by the patient, community, provider, facility, or healthcare system.
- No evidence of racial discrimination was observed by the committee in any of the records reviewed.

# Appendix A: Pregnancy-Related Recommendations

**2024 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.

**2024 Healthcare System**

- Promote proper triage of patient complaints during the postpartum period as a crucial step in preventing complications, including maternal death.
- Prioritize pulmonary embolism screening, follow-up, and monitoring in women who have miscarried and have a recent history of a deep vein thrombosis, especially in younger patients with contributing risk factors.
- In acute care settings, ensure appropriate monitoring of pregnant and postpartum patients along with timely ordering, interpretation, and redrawing of labs.

**Ongoing Recommendations**

- 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.
- Ensure adequate patient education and awareness of signs and symptoms of postpartum complications such as sepsis or infection, pre-eclampsia, and hemorrhage.
- 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.
- Healthcare providers should familiarize themselves with available mental health resources for pregnant and postpartum women.
- 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.

**Conclusion**

While Idaho has seen a decline in pregnancy-related deaths in 2024, the MMRC 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



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# Appendix B: 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 16 hospitals with this designation.[4]

**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/.[5]

Idaho Health and Welfare compile 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.[6]

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.[7]

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.[8]

**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.[9]

[4] 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
[5] Idaho Crisis & Suicide Hotline. (n.d.). *Resources*. https://idahocrisis.org/resources
[6] 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
[7] Idaho Department of Health & Welfare. (2025, November 25). *Resources*. https://healthandwelfare.idaho.gov/services-programs/behavioral-health/resources-0
[8] Idaho Perinatal Quality Collaborative. (2025, October 23). *IDPQC severe hypertension in pregnancy and postpartum initiative*. https://public.3.basecamp.com/p/f2j8wUD19DikDnWaSrQjTuiX
[9] Organization of Teratology Information Specialists. (n.d.). *MotherToBaby*®. https://mothertobaby.org/

# Appendix C: Glossary

**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.[10]

**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.[11]

**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.[12] 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: Number of live births per year.

**Idaho PMSS Ratio:** A pregnancy-related death during or within one (1) year of the end of pregnancy from any cause related to or aggravated by the pregnancy excluding injury deaths (suicides, overdoses, and homicides) as defined by CDC's PMSS.

**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.[12] This definition is used to calculate the MICH-04 Obstetric Caused Pregnancy-Related Ratio.

[10] 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

[11] 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

[12] 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

**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.[13] Each MMRC is designed to identify ways to improve behaviors, health and healthcare delivery before, during, and after pregnancy.

**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 maternal mortality review committees 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 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.[14]

## 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.[15]

## IDAHO GOAL

Prevent maternal deaths in the state of Idaho.

[13] U.S. Centers for Disease Control and Prevention. (2024, May 15). *About maternal mortality review committees*. https://www.cdc.gov/maternal-mortality/php/mmrc/index.html

[14] 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

[15] 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

# Appendix D: Review Process

**Case Identification**
The 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.

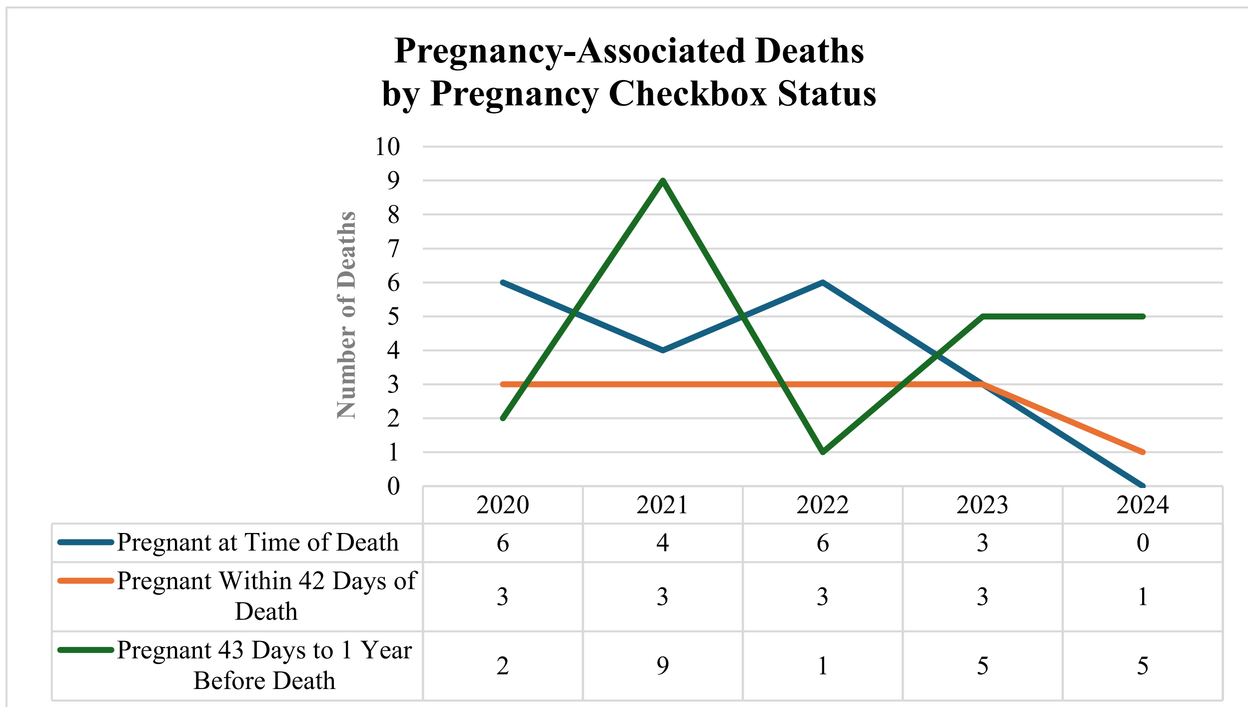
**Committee Review**
Prior to each committee meeting, members are given adequate time to review materials and prepare for discussion. During a review meeting, each case is systematically discussed to (1) confirm that it falls within the purview of the MMRC and, if so, (2) determine the following:

- 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?

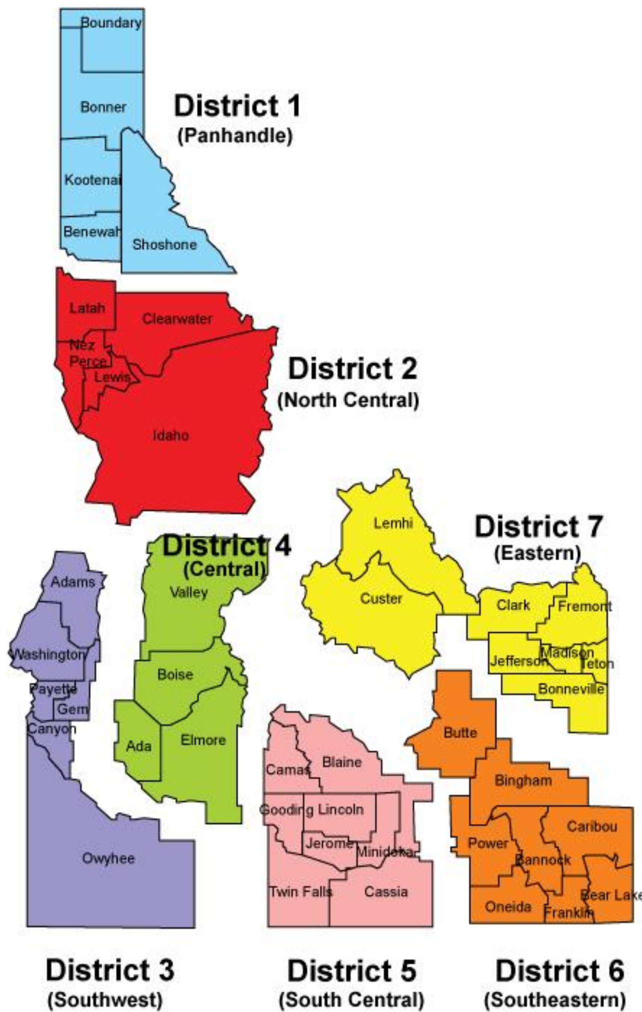
# Appendix E: Pregnancy-Associated Deaths

Five (5) of the six (6) pregnancy-associated deaths in 2024 were determined to be pregnancy-associated but not related. Of these, one (1) resulted from cancer, one (1) from a motor vehicle accident, one (1) from a drug overdose, and two (2) from suicide. Suicides are classified as pregnancy-associated but not related when there is a history of suicidal ideation or attempts prior to the pregnancy or if the suicide is associated with an unrelated event.

The graph below reflects the timing of death as recorded on the death certificate. In 2024, the greatest number of pregnancy-associated deaths (83.3%) occurred in women who were pregnant forty-three (43) days to one (1) year before death. Since 2020, 40.7% of maternal deaths have occurred during that same period.




| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Pregnant at Time of Death | 6 | 4 | 6 | 3 | 0 |
| Pregnant Within 42 Days of Death | 3 | 3 | 3 | 3 | 1 |
| Pregnant 43 Days to 1 Year Before Death | 2 | 9 | 1 | 5 | 5 |




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.

All six (6) of the 2024 pregnancy-associated deaths in Idaho involved women who lived in an urban 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**

| | 2020 (n=11) | 2021 (n=16) | 2022 (n=10) | 2023 (n=11) | 2024 (n=6) |
|---|---|---|---|---|---|
| Panhandle | 1 | 1 | 2 | 4 | 0 |
| North Central | 0 | 0 | 0 | 0 | 0 |
| Southwest | 4 | 4 | 2 | 3 | 1 |
| Central | 0 | 7 | 1 | 1 | 2 |
| South Central | 3 | 1 | 5 | 1 | 1 |
| Southeastern | 3 | 1 | 0 | 0 | 2 |
| Eastern | 0 | 2 | 0 | 2 | 0 |

Non-Hispanic White women and Hispanic White women have accounted for 85.2% of all maternal deaths in the state of Idaho from 2020 to 2024, while accounting for 92.1% of the total state population according to population estimates from 2024.[16] The table below provides a further breakdown.

- Non-Hispanic White women accounted for 66.7% of pregnancy-associated deaths in 2024, while accounting for 79.6% of the population.
- American Indian/Alaskan Native women accounted for 16.7% of pregnancy-associated deaths in 2024, while accounting for 1.7% of the population.
- Bi-racial women accounted for 16.7% of pregnancy-associated deaths in 2024, while accounting for 2.9% 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.

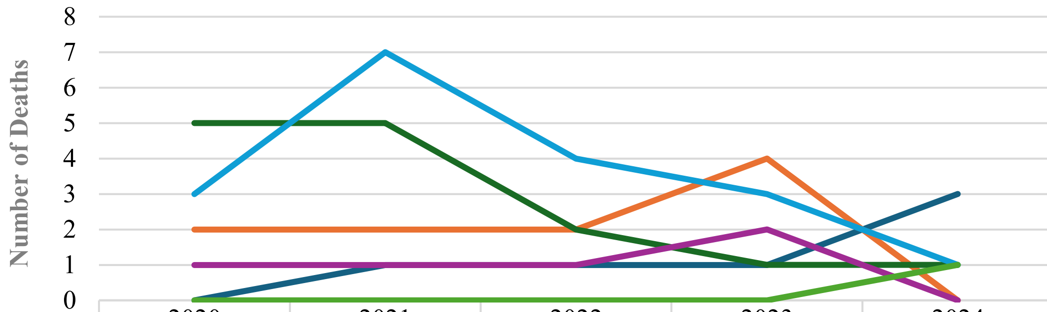
The committee found no direct evidence in the records reviewed that any of the 2024 pregnancy-associated deaths were attributable to any form of racial discrimination.

**Pregnancy-Associated Deaths by Race/Ethnicity**

| | 2020 (n=11) | 2021 (n=16) | 2022 (n=10) | 2023 (n=11) | 2024 (n=6) |
|---|---|---|---|---|---|
| Hispanic | 1 | 3 | 3 | 3 | 0 |
| Non-Hispanic White | 10 | 11 | 6 | 5 | 4 |
| Non-Hispanic Black | 0 | 1 | 0 | 0 | 0 |
| American Indian/ Alaska Native | 0 | 0 | 1 | 2 | 1 |
| Asian | 0 | 0 | 0 | 1 | 0 |
| Pacific Islander | 0 | 1 | 0 | 0 | 0 |
| Bi-racial | 0 | 0 | 0 | 0 | 1 |

[16] United States Census Bureau. (n.d.). *QuickFacts: Idaho*. https://www.census.gov/quickfacts/fact/table/US/PST045224

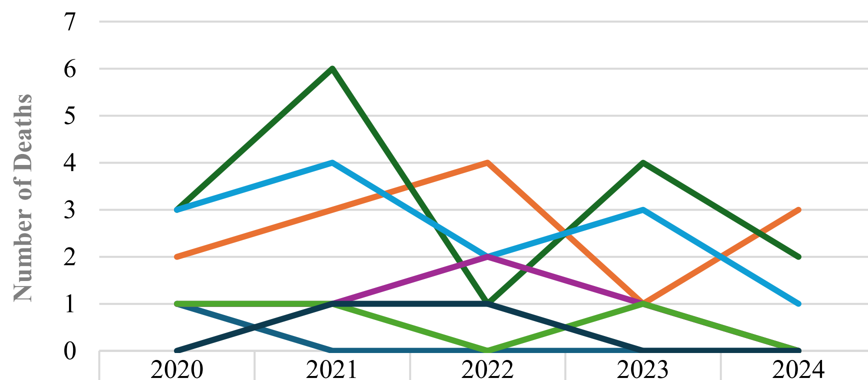
**Pregnancy-Associated Deaths by Age Group**




| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| 19 and Under | 0 | 1 | 1 | 1 | 3 |
| 20-24 | 2 | 2 | 2 | 4 | 0 |
| 25-29 | 5 | 5 | 2 | 1 | 1 |
| 30-34 | 3 | 7 | 4 | 3 | 1 |
| 35-39 | 1 | 1 | 1 | 2 | 0 |
| 40 and Over | 0 | 0 | 0 | 0 | 1 |

Current trends indicate that increased educational attainment is correlated with a lower likelihood of dying while pregnant or within one (1) year postpartum. In 2024, 50% of all pregnancy-associated deaths occurred among individuals who did not complete high school. The individual who died from a pregnancy-related cause had earned a high school diploma or GED.

**Pregnancy-Associated Deaths by Level of Educational Attainment**




| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| 8th Grade or Less | 1 | 0 | 0 | 0 | 0 |
| 9-12th Grade; No Diploma | 2 | 3 | 4 | 1 | 3 |
| High School Diploma or GED | 3 | 6 | 1 | 4 | 2 |
| Some College; No Degree | 3 | 4 | 2 | 3 | 1 |
| Associate's Degree | 1 | 1 | 2 | 1 | 0 |
| Bachelor's Degree | 1 | 1 | 0 | 1 | 0 |
| Advanced Degree (Masters or Doctorate) | 0 | 1 | 1 | 0 | 0 |

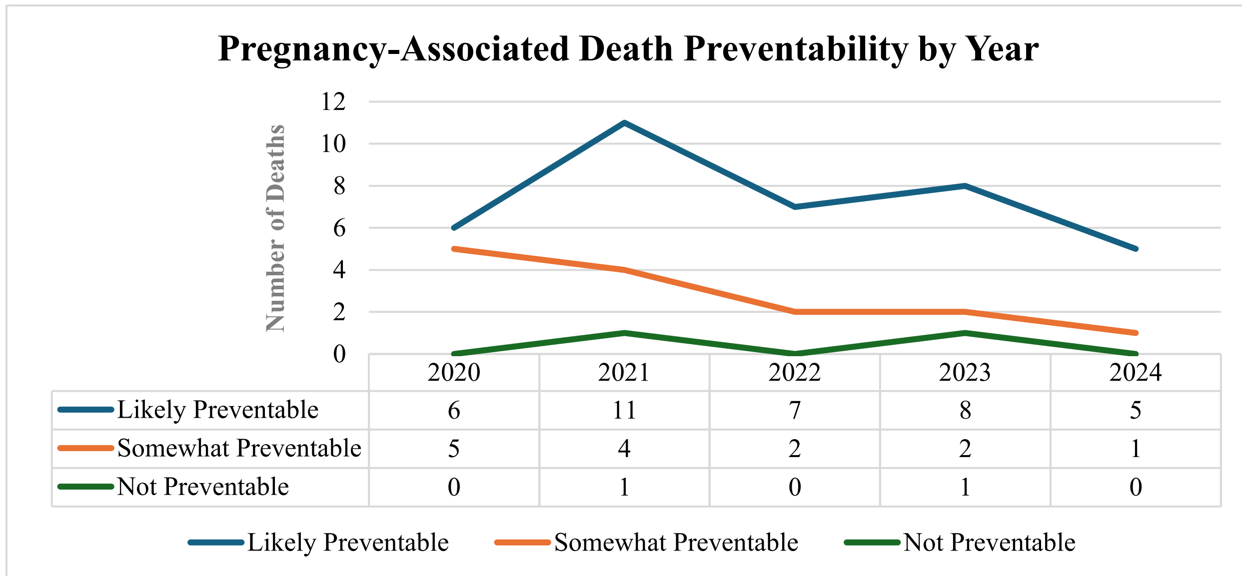
Since the inception of the MMRC, the highest accumulated risk group based on marital status has been unmarried women, who account for approximately 50.7% of all recorded pregnancy-associated deaths reviewed from 2018 to 2024. This trend continued in 2024 with 83.3% of all pregnancy-associated deaths occurring in women who were either divorced or never married.

| Pregnancy-Associated Deaths by Marital Status | | | | | |
|---|---|---|---|---|---|
| | 2020 (n=11) | 2021 (n=16) | 2022 (n=10) | 2023 (n=11) | 2024 (n=6) |
| Married | 5 | 5 | 4 | 4 | 1 |
| Married, but Separated | 0 | 0 | 0 | 0 | 0 |
| Widowed | 0 | 0 | 0 | 1 | 0 |
| Divorced | 2 | 4 | 0 | 1 | 1 |
| Never Married | 4 | 7 | 6 | 5 | 4 |

In 2024, five (5) of the pregnancy-associated deaths involved individuals who were insured: two (2) privately and three (3) through Medicaid. For the remaining case, the records reviewed were unclear regarding the individual's coverage status.

| 2024 Pregnancy-Associated Deaths by Health Insurance Status | | |
|---|---|---|
| Status | Number of Deaths (n=6) | Percentage of Deaths |
| Insured | 5 | 83.3% |
| Uninsured | 0 | 0% |
| Unknown | 1 | 16.7% |

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, community, provider, facility, or systemic factors.[17] Of the fifty-four (54) cases the MMRC has reviewed since 2020, 94.4% were determined to have some level of preventability. The committee found that all pregnancy-associated deaths in 2024 were either somewhat or likely preventable.




| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Likely Preventable | 6 | 11 | 7 | 8 | 5 |
| Somewhat Preventable | 5 | 4 | 2 | 2 | 1 |
| Not Preventable | 0 | 1 | 0 | 1 | 0 |

**Pregnancy-Associated Recommendations**

**2024 Legislature**

- Consider investigating the current access landscape for pregnant and postpartum women, including those incarcerated, for evidence-based treatments, including pharmacologic agents for substance use disorder.

**2024 Healthcare System**

- Each member of the healthcare team is responsible for ensuring proper follow-up and continuity of care for pregnant and postpartum women with mental health conditions.
- Ensure appropriate monitoring and follow-up with pregnant and postpartum patients being treated for substance use disorder.
- Ensure complete and accurate documentation of care rendered to pregnant and postpartum patients.
- Screen pregnant and postpartum patients, as well as those who have recently had a miscarriage, for suicidality using a validated suicide screening tool.
- If a provider deviates from the National Comprehensive Cancer Network (NCCN) guidelines, proper documentation and clinical rationale should be provided to justify the course of therapy.
- Educate pregnant and postpartum patients, especially those who have recently had a miscarriage, about the Suicide & Crisis Lifeline (988) if they show signs of suicidality or depression.

[17] 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

- Providers should ensure proper care coordination, especially between specialists and the obstetrician, when the pregnant or postpartum woman has an underlying condition.
- When evaluating symptoms in pregnant and postpartum women, providers should consider other potential underlying conditions before attributing them to "normal" pregnancy changes.
- After making a referral, the healthcare team should follow up with the pregnant or postpartum patient to monitor progress toward establishing care with the new provider.

**2024 Communities**

- Pregnant and postpartum women should ensure there are no distractions while operating a motor-vehicle to prioritize their safety and the safety of their passenger(s).

**Ongoing Recommendations**

- All women should receive early postpartum care:
    - If complicated (hypertensive, etc.): within three (3) to five (5) days of discharge
    - If uncomplicated: within fourteen (14) days of discharge
- 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.
- 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.
- The Idaho legislature has enacted laws increasing access to virtual care. Providers serving rural populations are encouraged to offer telehealth visits to patients who may not seek, or may delay, care due to distance, cost, or other barriers.