

2025 Annual Report on Maternal Mortality in New Hampshire

Department of
HEALTH &
HUMAN SERVICES

Division of
Public Health

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Dedication

This report is dedicated to the individuals who died during pregnancy or within one year postpartum in New Hampshire. We respectfully honor their lives and recognize the profound impact of this loss on their families and communities. We extend our deepest condolences to the loved ones of those who died. We would also like to express sincere gratitude to families who participated in key informant interviews, which provide invaluable insight on strategies to prevent future deaths.

As we consider the findings of this report, we reaffirm our commitment to understanding the causes and contributing factors of maternal mortality in New Hampshire, with the goal of improving the health and well-being of all families.

Acknowledgement

We extend our sincere appreciation to the members of the New Hampshire Maternal Mortality Review Committee (MMRC) for their unwavering commitment to improving maternal health outcomes in New Hampshire. A special thanks goes to the New Hampshire Perinatal Quality Collaborative (NHPQC) at Dartmouth Population Health for their invaluable support. The work of examining maternal mortality is both vital and heavy, and each member plays a crucial role in advancing prevention efforts. Thank you for your dedication.

Definitions

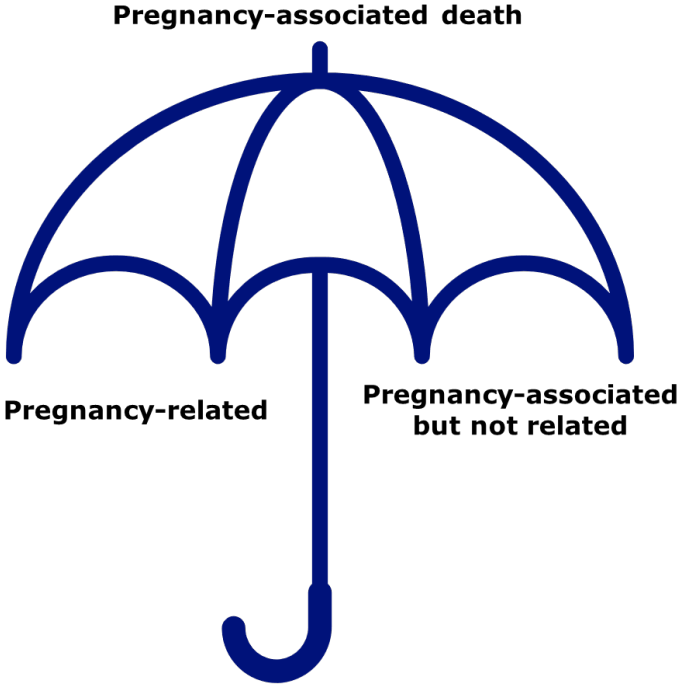
Pregnancy-associated death: Death while pregnant or within one year of the end of pregnancy, irrespective of cause.[1]

Pregnancy-related death: Death while pregnant or within one year of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes.

Pregnancy-associated, but not pregnancy-related death: Death while pregnant or within one year of the end of pregnancy due to a cause unrelated to pregnancy.

Preventable: 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.

Figure 1. Maternal Mortality definitions



[1] NH General Court, RSA 132-29. Maternal Mortality Review Panel https://gc.nh.gov/rsa/html/X/132/132-29.htm

Executive Summary and Key Findings

Causes: In 2024, New Hampshire recorded five pregnancy-associated deaths, the lowest in five years. Substance use disorder (SUD) continues to be a main driver of maternal mortality in New Hampshire. From 2020 to 2024, nearly half of all pregnancy-related deaths were due to drug overdose, followed by cardiovascular conditions, embolisms, and suicide. The majority of pregnancy-related deaths attributable to substance use disorder and mental health conditions were among women who were Medicaid beneficiaries.

Contributing Factors and Stressors: Mental health conditions accounted for 60% of overdose and suicide deaths, with other noted stressors including unemployment, child protection involvement, prior suicide attempts, domestic violence, and recent trauma.

Timing: Over half (61.9%) of the pregnancy-related deaths occurred between 43 days to 1-year postpartum.

Location: Most (57%) pregnancy-related deaths in New Hampshire occurred at home, underscoring the significant role of postpartum mental health and substance use in driving maternal mortality.

Preventability: In New Hampshire, 76.2% of pregnancy-related deaths were considered preventable, compared with 87% nationally.

Recommendations: The 2024 recommendation themes include the need for improved treatment coordination and continuity of care; ongoing clinical education; improved mental health and substance use disorder screening and referral practices; and consistency in mental health crisis mobilization.

Background

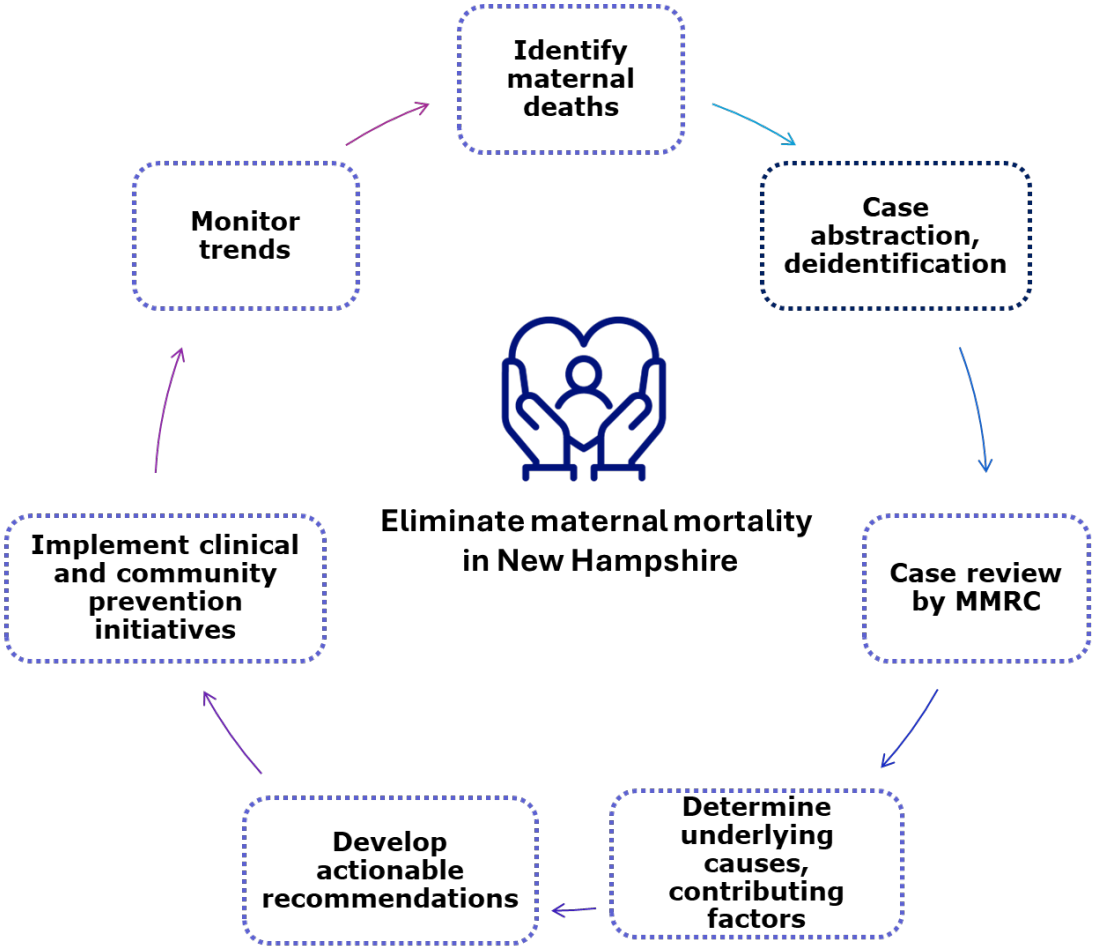
The New Hampshire Maternal Mortality Review Panel, commonly referred to as the Maternal Mortality Review Committee (MMRC), was established in 2010 with RSA 132:30 and the accompanying rule He-P 3013. Administered within the New Hampshire Department of Health and Human Services (DHHS), Division of Public Health (DPH), Bureau of Family Health and Nutrition (BFHN), Maternal and Child Health Section (MCH), the oversight and management of the MMRC is performed by the MCH Perinatal Nurse Consultant and the MCH Epidemiologist. Programmatic support is provided by the New Hampshire Perinatal Quality Collaborative (NHPQC) housed within the Dartmouth Health, Northern New England Perinatal Quality Improvement Network (NNEPQIN). This organization is legislatively named as the clinical body to work with MCH to collect, abstract, and organize maternal death case reviews. The NHPQC perinatal outreach nurse serves as the MMRC coordinator, case abstractor, and key informant interviewer. The multidisciplinary MMRC conducts comprehensive reviews of de-identified maternal deaths, identifies contributing factors, and makes actionable recommendations to prevent future deaths.

This report summarizes pregnancy-associated deaths among New Hampshire residents that occurred in 2024, along with five-year aggregate data (2020-2024) on pregnancy-related deaths. Five-year aggregate data on pregnancy-associated deaths are also included in Appendix A.

The MMRC reviews all maternal deaths that occur among New Hampshire residents, regardless of the place of occurrence. A standardized decision guide structures the Committee’s review to determine the underlying cause of death, contributing factors, additional stressors, preventability, and actionable recommendations for implementation by clinical, community, and public health partners.

The maternal mortality review process begins with the identification of maternal deaths, followed by case abstraction and deidentification. The MMRC then reviews each case to determine underlying causes and contributing factors. Based on these findings, the Committee develops actionable recommendations, which inform clinical and community prevention initiatives. Ongoing monitoring of trends helps guide continuous improvement and supports the goal of eliminating maternal mortality in New Hampshire.

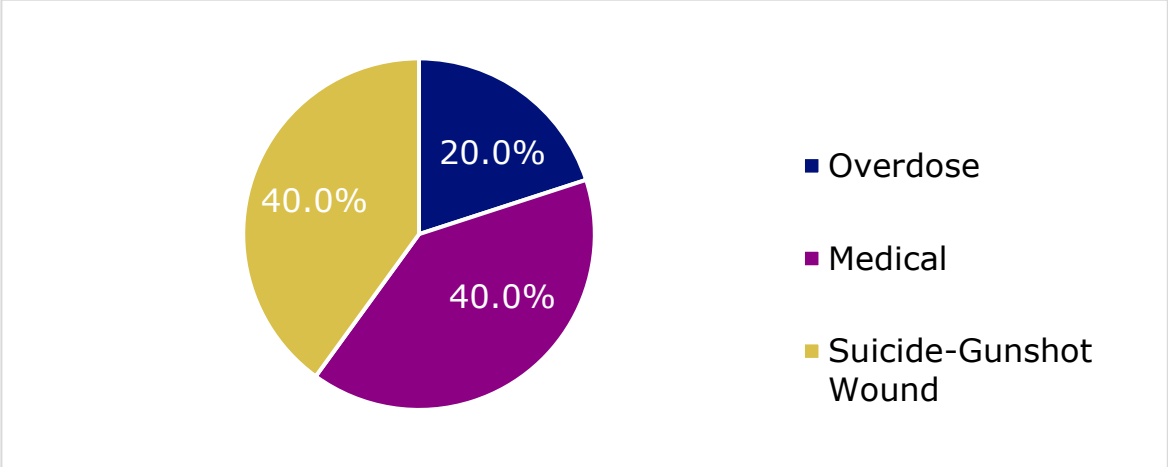
Figure 2. Maternal Mortality Review Process



Pregnancy-Associated Deaths: 2024

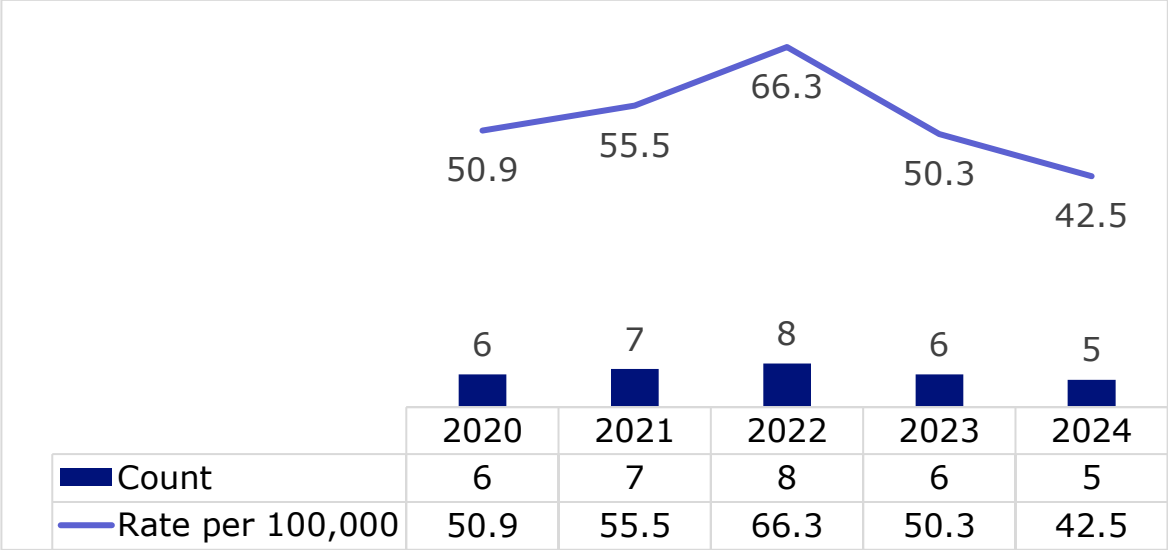
In 2024, five pregnancy-associated deaths were recorded in New Hampshire. Unlike previous years, only one overdose death was identified. There were two deaths due to suicide and two from medical causes. Three deaths occurred during the postpartum period (43 days to one year postpartum).

Figure 3. Cause of death, 2024 Pregnancy-Associated Death



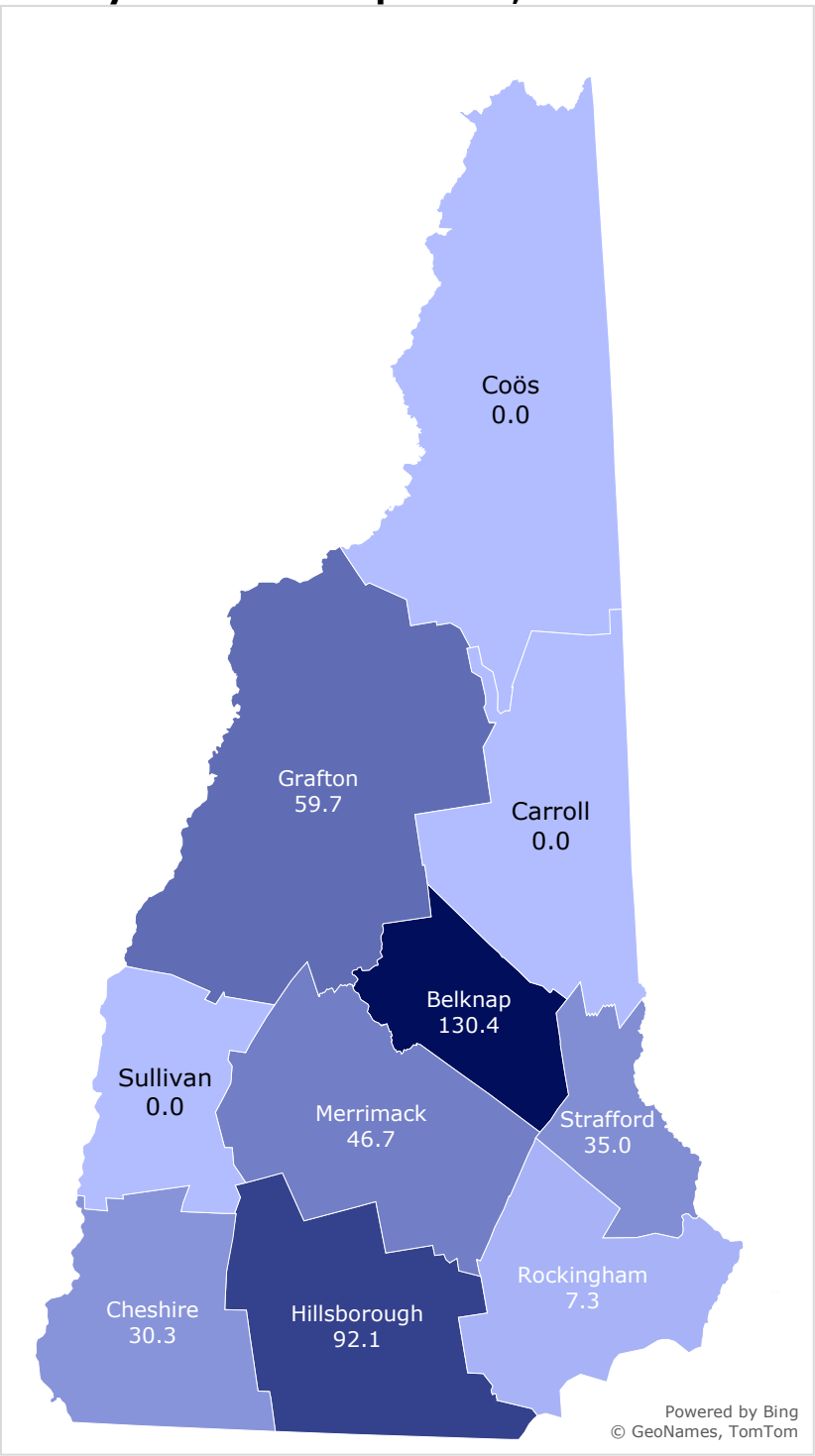
Between 2020 and 2024, pregnancy-associated deaths in New Hampshire ranged from five to eight annually, with the highest number occurring in 2022. The lowest maternal mortality rate during this period was recorded in 2024, with approximately 43 deaths per 100,000 live births.

Figure 4. The Number and Rate per 100,000 of Pregnancy-Associated Deaths by Year of Occurrence in New Hampshire



	2020	2021	2022	2023	2024
Count	6	7	8	6	5
Rate per 100,000	50.9	55.5	66.3	50.3	42.5

Figure 5. Rate of 2020-2024 Pregnancy-Associated Deaths by Mother's County of Residence per 100,000 Live Births



Between 2020 and 2024, most pregnancy-associated deaths (19 of 31) occurred in Hillsborough County, which had the largest share of New Hampshire resident births (34.5%) and the second-highest maternal mortality rate, **92 deaths per 100,000 live births**. Although Belknap County accounted for only 4.0% of births statewide, it experienced the highest maternal mortality rate of **130 deaths per 100,000** live births. This is driven by a small number of births relative to the number of maternal deaths. No pregnancy-associated deaths were reported in Coos, Carroll, or Sullivan counties, which had the fewest births in the state (1.8%, 2.6%, and 2.9%, respectively).

Pregnancy-Related Deaths in New Hampshire: 2020-2024

Between 2020 and 2024, the New Hampshire MMRC determined that two-thirds of maternal deaths (67.8%) were pregnancy-related, and 76.2% of those deaths were determined to be preventable. The remaining cases were either pregnancy-associated but not directly related to pregnancy or the MMRC was unable to determine relatedness due to insufficient information (16.1% each).

Figure 6. MMRC Determinations on Pregnancy Relatedness, 2020-2024 NH Resident Maternal Deaths

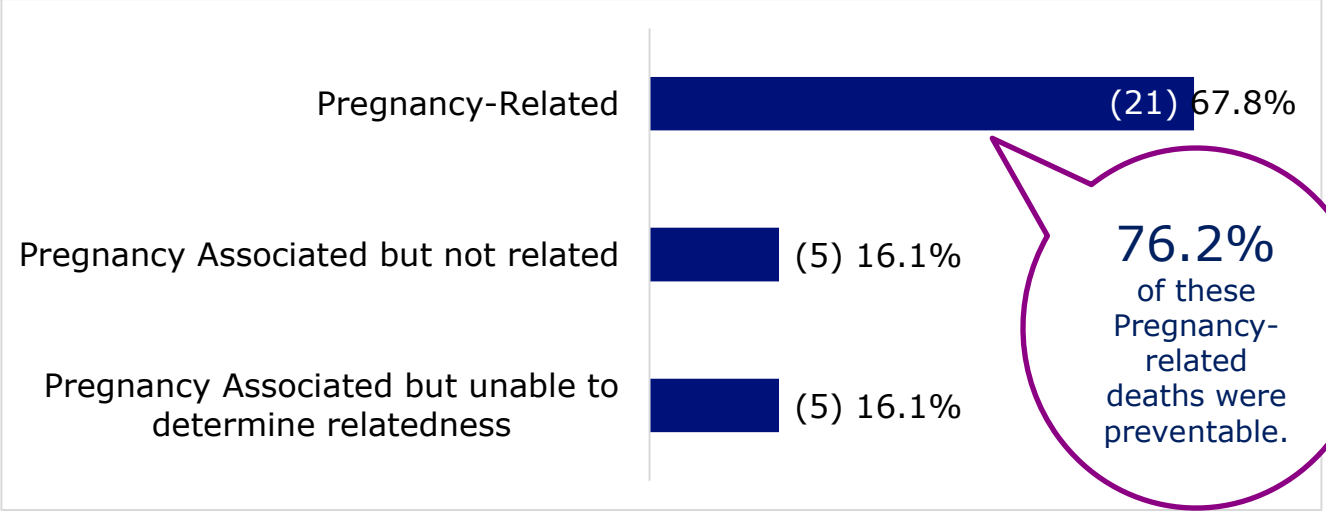
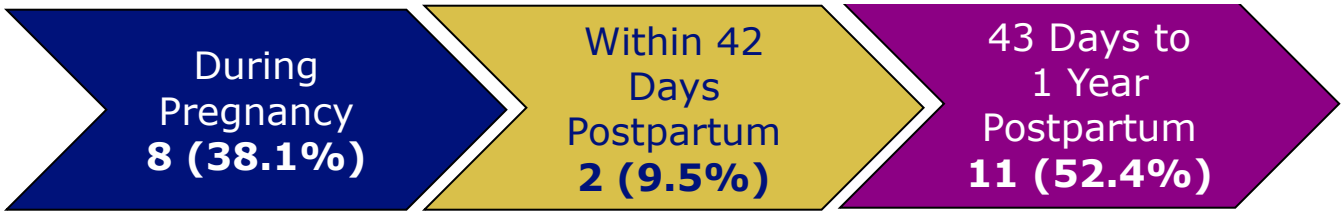


Figure 7. Deaths by Timing of Death in Relation to Pregnancy, 2020-2024 NH Pregnancy-Related Deaths

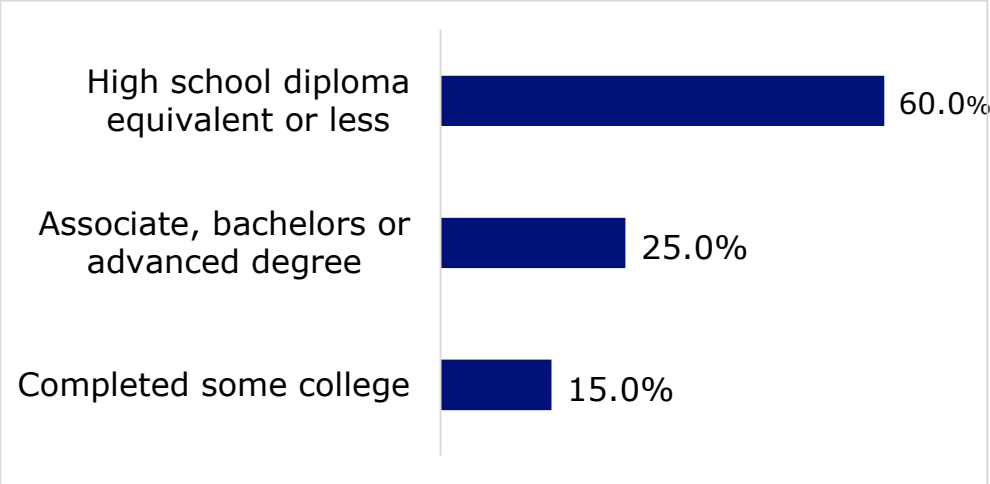


Includes deaths that occur before labor begins.

High-risk period immediately following delivery, including labor and up to 6 weeks postpartum.

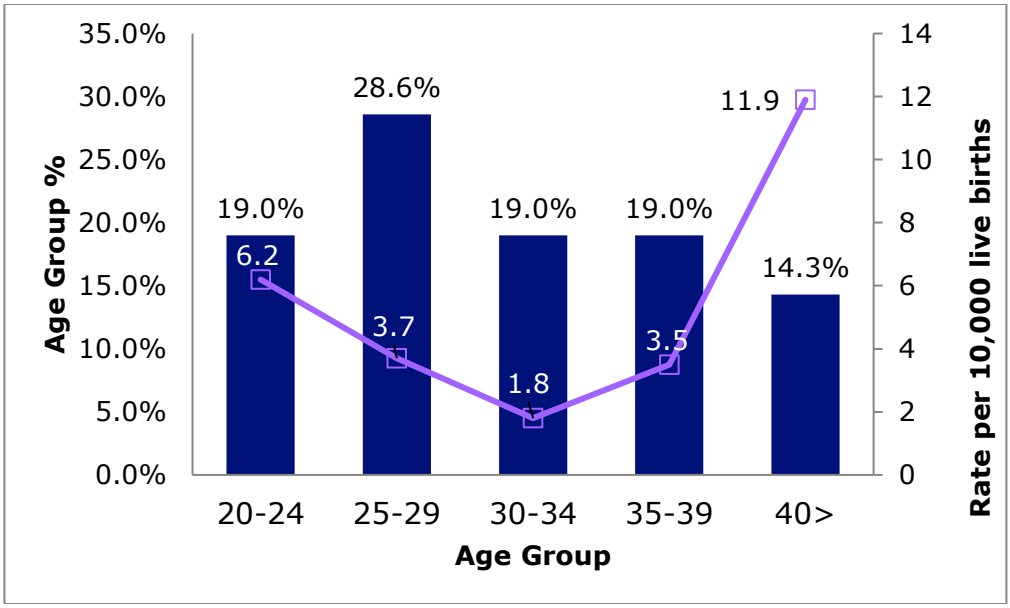
Often overlooked, but accounts for the largest share of maternal deaths.

Figure 8. Pregnancy-Related Deaths by Mother's Education Level, 2020-2024



Consistent with previous years, most pregnancy-related deaths occurred among women with a high school education or less, with **77.7%** of **overdose deaths** occurring among this group.

Figure 9. Pregnancy-Related Deaths by Age Group and Rates per 10,000 Births, 2020-2024

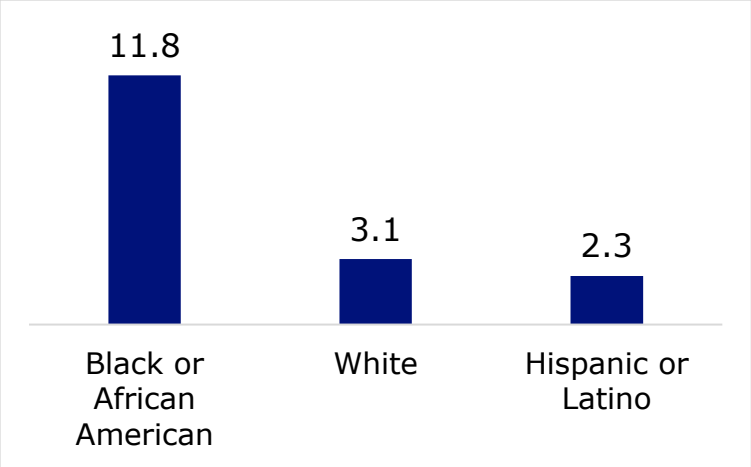


- Pregnancy-related deaths in New Hampshire occurred across all age groups.
- The largest proportion, 28.6% of all deaths occurring during this period, was among those aged 25–29, whereas national data show that most deaths occur among individuals aged 30–34.[2]
- The highest age specific mortality rate was among women aged 40 and older, with 11.9 deaths per 10,000 live births, indicating increased risk with advanced maternal age; however, due to small numbers, the rates for this population (40

[2] Pregnancy-Related Deaths Among American Indian or Alaska Native Women: Data from Maternal Mortality Review Committees | Maternal Mortality Prevention | CDC

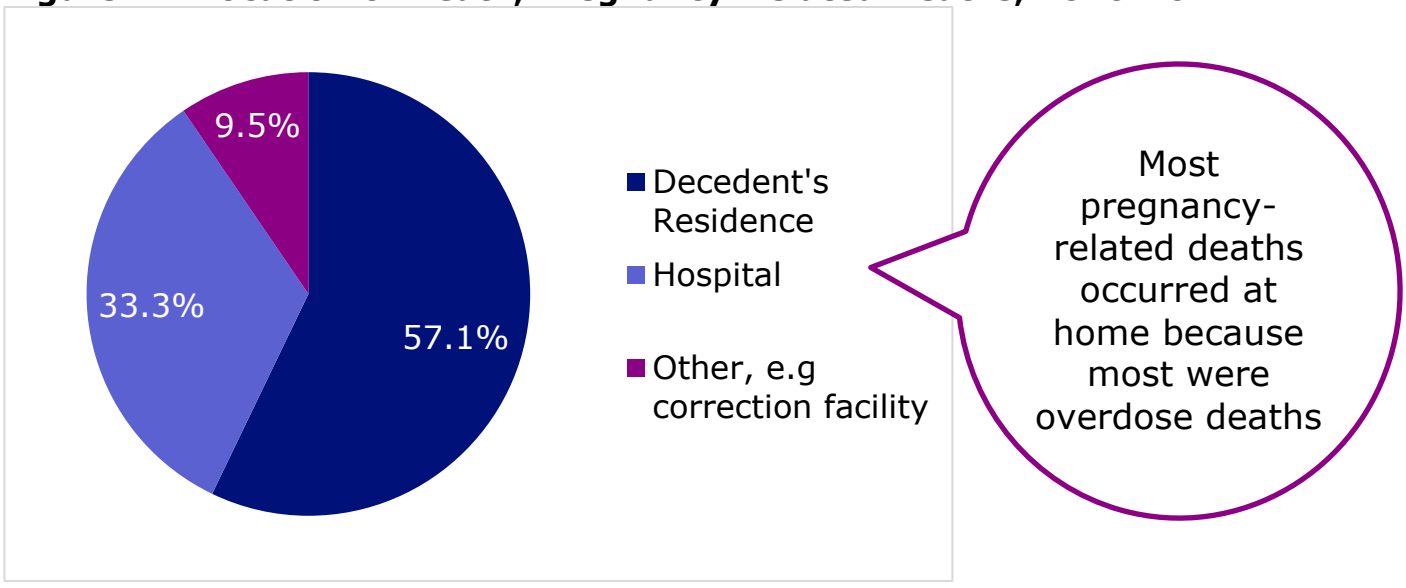
years and older) are considered unstable and may not accurately reflect true differences.

Figure 10. Rate of Pregnancy-Related Deaths by Decedent's Race and Ethnicity per 10,000 Live Births, 2020-2024



Although most pregnancy-related deaths in New Hampshire occurred among non-Hispanic White women (80.9%), adjusting for the number of deliveries shows that Black or African American women had the highest mortality rate at 11.8 per 10,000 live births. However, due to small counts, the rates for both Black or African American and Hispanic or Latino women are considered unreliable/unstable and should be interpreted with caution. Even so, the pattern aligns with national data, where Black or African American women consistently experience the highest pregnancy-related mortality ratios.[3]

Figure 11. Location of Death, Pregnancy-Related Deaths, 2020-2024



[3] Data from the Pregnancy Mortality Surveillance System | Maternal Mortality Prevention | CDC

Causes of Pregnancy-Related Deaths, 2020-2024

Between 2020 and 2024, drug overdose (mainly involving fentanyl) caused about 43% of pregnancy-related deaths among New Hampshire residents, compared with 50% during 2019-2023. Given the substantial overlap between these periods and the small number of deaths contributing to the most recent data, this difference should be interpreted cautiously and likely reflects minor year-to-year variation rather than a true change in cause distribution. Heart-related conditions made up 24% of deaths, and amniotic fluid or pulmonary embolism accounted for 19%. Deaths from suicide by gunshot wounds and other medical causes were less common.

Figure 12. Causes of Pregnancy-Related Deaths among NH Residents (2020-2024 MMRC Case Reviews)

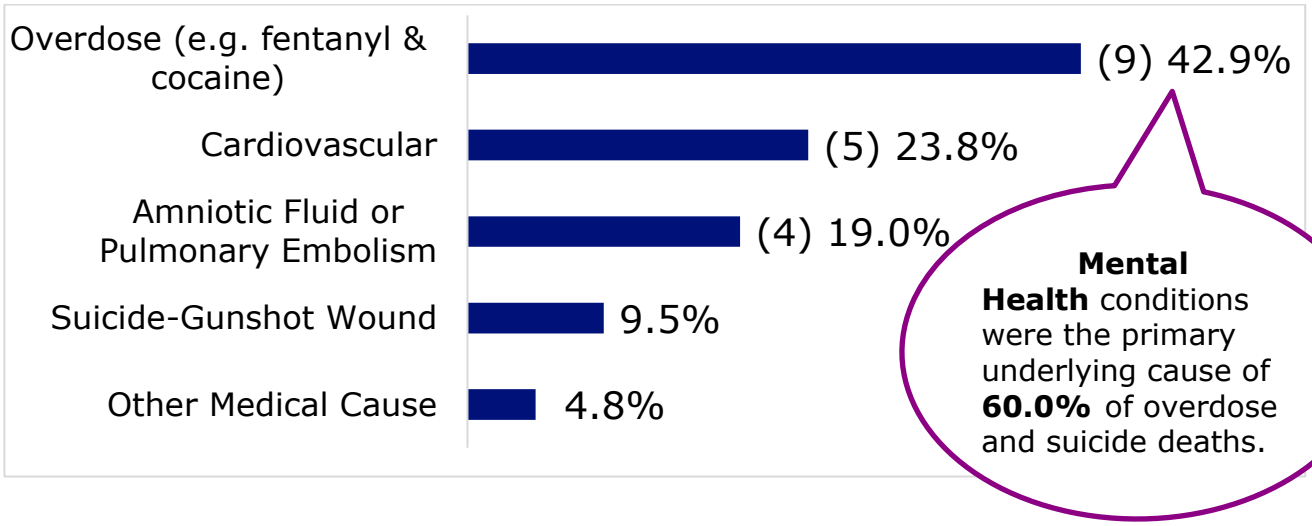


Figure 13. Distribution of Pregnancy-Related Deaths by Cause and Payor Type, 2020–2024

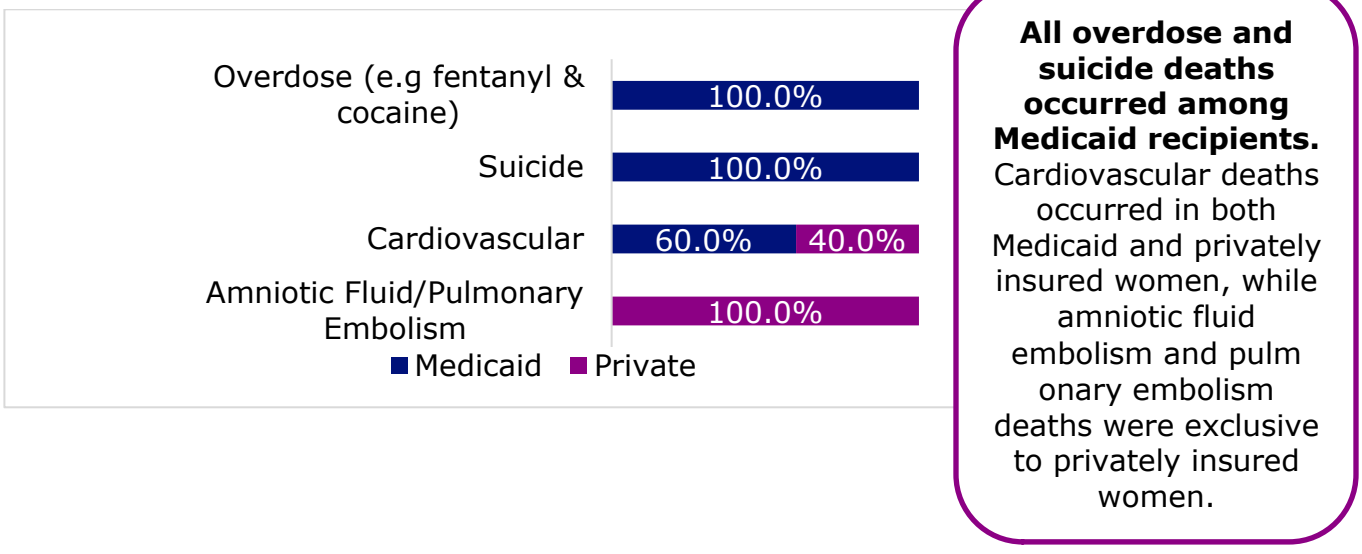
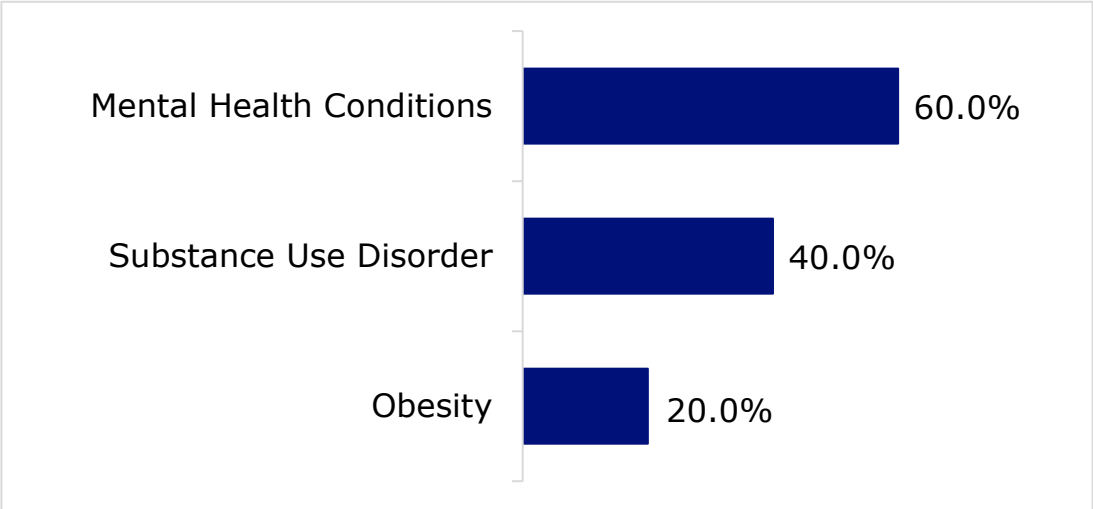


Figure 14. Committee Determinations on Factors Contributing to Pregnancy-Related Deaths, 2020-2024

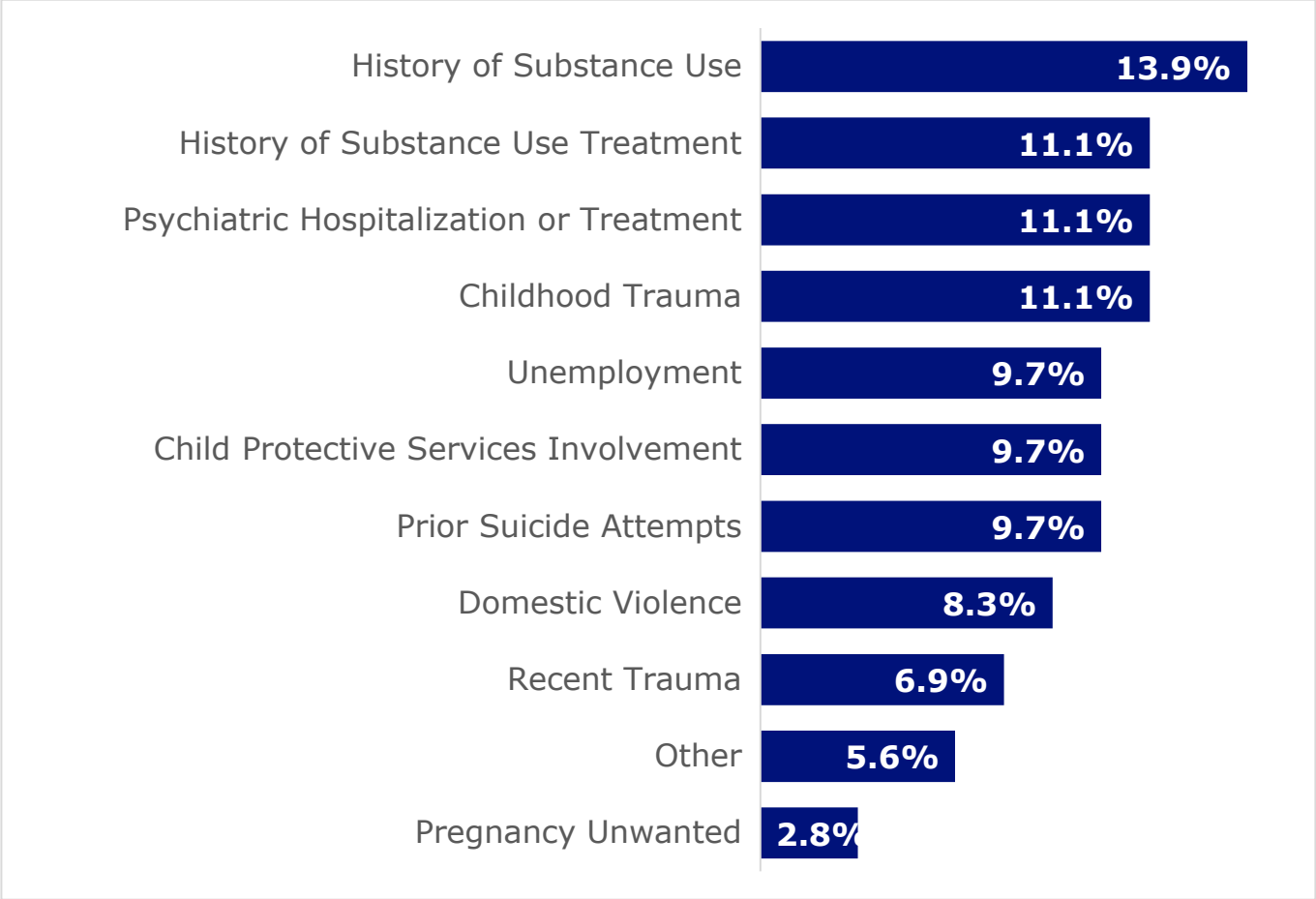


From 2020 to 2024, the committee found that mental health conditions and substance use disorder were the most frequent contributors to pregnancy-related deaths. In addition to these findings, more than one-quarter of pregnant women in New Hampshire report a perinatal mental health condition during pregnancy, according to a recently published Maternal Health Outcomes data brief, highlighting the burden of mental health to pregnant and postpartum women in New Hampshire.

History of Social and Emotional Stressors Determined from the Decedent's Social and Environmental Profile

Between 2020 and 2024, the MMRC identified several common social and emotional stress factors among pregnancy-related deaths. The most frequently identified stressor was history of substance use (13.9%), followed by history of substance use treatment, psychiatric hospitalization or treatment, and childhood trauma (each 11.1%). Additional contributing factors included unemployment, child protective services involvement, and prior suicide attempts (each 9.7%), as well as domestic violence (8.3%) and recent trauma (6.9%). A smaller proportion of cases involved other stressors (5.6%) or pregnancies identified as unwanted (2.8%).

Figure 15. History of social and emotional stress for 2020-2024 Pregnancy-Related Deaths



Housing Instability as a Contributing Factor in Pregnancy-Related Deaths

The two figures below illustrate maternal housing arrangements at the time of death and experiences of housing instability. For nearly half (47.6%) of pregnancy-related deaths reviewed, clinical charts lacked information on housing stability during pregnancy. Among cases with available housing data, 19.0% of women had experienced homelessness (unhoused) (Figure 16). As presented on Figure 17, most women (71.4%) who died from overdose were living with a relative at the time of death, which is an indicator of housing instability. Over one quarter of women (28.6%) were renting or in another type of living arrangement at the time of death. The number of mothers who experienced homelessness or were not living independently highlights the social and economic challenges that may impact an individual's health and well-being, including access to and engagement with health care and mental health services.[4]

[4] Zeeck E, Le L, Watson K, Richards J. Housing Instability: What Works Evidence Accelerator. Summarizing Effective Strategies for MCH. Strengthen the Evidence for MCH Programs. National Center for Education in Maternal and Child Health, Georgetown University, Washington DC. May 2024.

Figure 16. Maternal Unhoused Experience Before, During and After Pregnancy Among Pregnancy-Related Deaths, 2020-2024

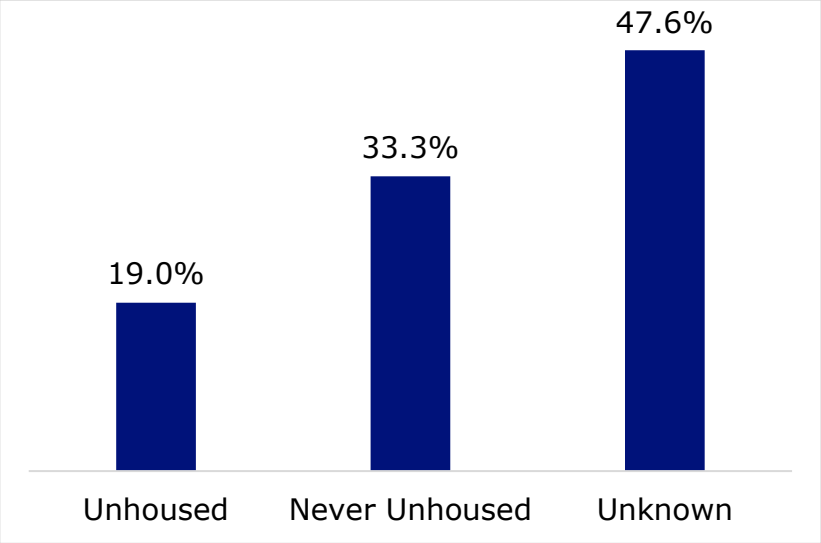
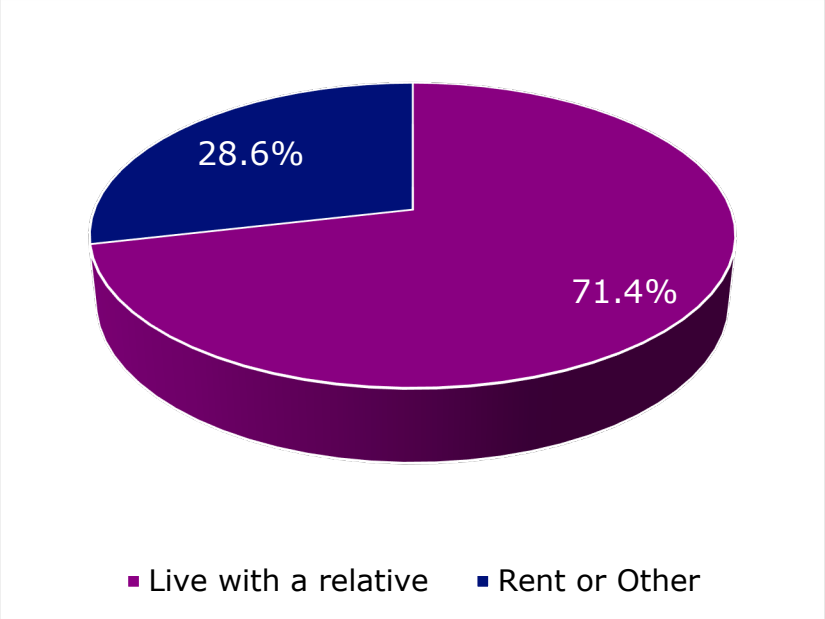


Figure 17. Maternal Living Arrangements at the Time of Pregnancy-Related Overdose Deaths, 2020-2024



https://www.mchevidence.org/documents/accelerators/Housing-Instability-Evidence-Accelerator.pdf

2020-2024 Summary of Recommendations

The following table displays a summary of the recommendations made by the MMRC between 2020-2024. Nearly half of all recommendations over the last five years focus on either substance use disorder or mental health.

Recommendation Topic, 2020-2024	Percent
SUD services, training, education, treatment, and clinical care improvements	28.8%
Mental health conditions and suicide training, education, and clinical care improvements	16.8%
Expansion of postpartum insurance coverage and support; promotion of existing services	8.0%
DCYF and/or social work collaboration	8.0%
Collaboration with corrections/law enforcement	6.4%
Clinical education on perinatal cardiac/cardiovascular conditions	6.4%
Collaboration with PCPs and urgent care centers	4.0%
Abstraction/records/case identification recommendations	4.0%
COVID/flu/respiratory/infectious disease	2.4%
Fatality review coordination	1.6%
Grief support for surviving family	1.6%
Address delayed or inadequate prenatal care	1.6%
Public awareness around maternal health warning signs	1.6%
Culturally and linguistically appropriate care	1.6%
Collaboration with EMS	1.6%
Telehealth/tele-OB, innovative models for care delivery	1.6%
Housing supports	0.8%
Cancer screening and care coordination	0.8%
MMRC legislation	0.8%
Trauma-responsive care (ACES, sexual violence)	0.8%
Collaboration between maternal health and early-childhood professionals	0.8%

2024 Case Recommendations

Circumstance	Recommendation	Status
Care Coordination		
Patient lost to follow up, need for more streamlined care coordination.	NHPQC to coordinate with Dartmouth Health Pediatric Maternal Health Navigator Pilot program to identify barriers and reinforce follow-up for postpartum care appointments by June 2026.	Complete
	NHPQC to explore and disseminate a recommended effective telehealth model for postpartum care as an option for low-risk patients by June 2026.	In progress
Need for mental health treatment coordination when inpatient mental health options are unavailable.	NHPQC to disseminate mental health navigation resources to obstetric inpatient and outpatient clinics and perinatal mental health resources to mental health centers and emergency departments. Resources include: NH Rapid Response Access Point and Crisis System Resources (988, Mobile Crisis, Crisis Centers), Strong As Granite, 211, peer mental health navigators, NHPQC programs, Postpartum Support International, and NH Mom Hub).	In progress
Inadequate financial support/priority of postpartum care and follow up.	NNEPQIN to present on opportunities for improving billing practice to optimize postpartum care by June 2026.	In progress
Provider Education and Clinical Care		
Need for provider knowledge on addiction recovery care and parental support services.	NHPQC to engage with the NH Division for Children, Youth and Families (DCYF) to share the Community Voice/Photo Voice and Emotional Journey Mapping by December 31, 2025	Complete
	An NHPQC regional coalition will collaborate with perinatal patients and the Division of Children, Youth and Family Services to design and pilot a parenting support program by March 31, 2026.	In progress
Need for providers to conduct assessment of patient access to lethal means	Collaborate with statewide experts in suicide prevention and response to explore initiatives tailored for perinatal populations by June 2026. Include promotion of 988 as a crisis resource.	In progress
Inadequate clinical recognition and treatment of postpartum psychosis	NHPQC to provide clinical education webinar for providers on recognition, treatment, and consulting resources for suspected or atypical presentation of psychosis by February 28, 2026.	Complete

Community Resources		
Inconsistent access to methadone program due to barriers associated with transportation	NH DHHS to develop and promote patient-facing resources offered by the Managed Care Organizations which includes transportation, peer support, and case management resources by December 31, 2025.	In progress
Opportunity for school and childcare teams to potentially detect concerns for mental health crisis	NHPQC to provide NH Alliance for Early Childhood Coalitions information on urgent maternal warning signs with the link to the resource to distribute to daycare centers (i.e. via newsletters) by June 2026	Complete
Need for suicide postvention and resources for suicide survivors identified by law enforcement and healthcare	NHPQC to collaborate with the NH Suicide Prevention Council to explore post-suicide intervention resources for surviving families by June 2026	In progress
	MMRC Abstractor to collaborate with the New Hampshire State Police to understand the police response related to suicide attempts for the maternal health population to improve case review and development of recommendations by June 2026.	In progress
Case Identification		
Need for hospitals to recognize and report maternal deaths up to one year postpartum and need for autopsy in cases of maternal death	By the end of 2025, the State Medical Examiner's Office will update workflow for determining which pregnancy-associated deaths are reviewed.	Complete

2024 Program Updates

The DHHS Maternal and Child Health (MCH) Section and partnering organizations strive to improve maternal health outcomes and eliminate maternal mortality through leadership, partnerships, and data-driven programs. In 2024, DHHS program staff and partners worked to disseminate maternal mortality data to healthcare organizations, community partners, and policymakers. Increasing awareness of the causes of maternal death catalyzes proactive approaches to prevention.

Maternal Mortality Data

- New Hampshire MMRC maternal overdose death data was included as a priority in the NH DHHS 2024-2025 Roadmap, Objective 6.2: *Reduce maternal overdose deaths from 62.5% in SFY 2023 to 50% in SFY 2025*. Throughout 2024, several DHHS divisions including Public Health, Medicaid, and DCYF, along with community partners, worked on statewide strategies aimed at reducing maternal death due to overdose, including increasing access to prenatal and postpartum services for Medicaid beneficiaries, and promoting substance use disorder screening and Plans of Safe Care with birthing hospitals and prenatal clinics.
- The MCH Epidemiologist presented maternal mortality data to key partners in perinatal health during the annual Northern New England Perinatal Quality Improvement Network fall conference and other national and statewide meetings, including the national Alliance on Innovation on Maternal Health meeting, the NH Annual Breastfeeding Taskforce webinar, the NH Women Infant and Children (WIC) conference, and the NH Perinatal Substance Exposure Collaborative.

MMRC Operations and Data Quality

- In 2024, the MMRC eliminated the backlog of maternal mortality cases, which facilitated rapid dissemination of clinical and non-clinical recommendations to the perinatal workforce in New Hampshire.
- Proposed legislation was introduced to update RSA132:29 to reflect best practices for maternal mortality review operations.
- MCH successfully completed the first year of the 2024-2029 co-operative agreement with the Centers for Disease Control and Prevention (CDC) "Enhancing Reviews and Surveillance to Eliminate Maternal Mortality" (ERASE-MM) program, which provides federal grant support to increase maternal mortality review capacity in 46 states.

Maternal Mental Health Initiatives

- In May 2024, Governor Sununu proclaimed May 5th through May 11th as New Hampshire Maternal Mental Health Awareness Week, reinforcing the state's commitment to addressing maternal mental health as a leading underlying cause of maternal mortality. This declaration heightened awareness and spurred statewide efforts to identify and support mothers facing perinatal mental health challenges.
- MCH developed the Medicaid Prenatal and Postpartum Care Programs webpage highlighting the importance of early prenatal care, timely postpartum care, and the incentives available to pregnant and postpartum women insured by New Hampshire Medicaid.



- MCH staff collaborated with Medicaid and other partners on the development of the statewide doula and lactation counselor certification process. These providers will be eligible for Medicaid reimbursement in 2026.
- MCH contracted with nine community health centers (CHCs) to improve maternal mental health screening and referral rates. As part of this contract, CHCs track four maternal health measures: depression screening within 12 weeks postpartum with documented follow-up if positive; postpartum visit within 12 weeks of delivery; tobacco use screening with cessation and counseling; and substance use screening during each trimester with appropriate intervention or referral when needed.
- In 2024, DHHS provided funding for a new project to improve access to mental health resources for pregnant and postpartum women in New Hampshire. The NH Mom Hub clinical staff have expertise in perinatal mental health and provide individualized help to pregnant and postpartum women and their providers to improve access to mental health services.

Recommendations in Action

Numerous partners and projects contribute to the implementation of MMRC recommendations to improve maternal health in New Hampshire. The Maternal Health Task Force, run by the NHPQC, began mobilizing 11 regional coalitions of healthcare providers, parents, and public health/social service agencies to improve local and statewide access to services for pregnant and postpartum Granite Staters and their families. Through 2024, the Task Force developed a strategic plan to strengthen maternal health and promote overall wellness across all communities in New Hampshire.

Alliance for Innovation in Maternal Health (AIM)

DHHS and the NHPQC continue to implement the Alliance for Innovation in Maternal Health (AIM) project, with funding from the Health Resources and Services Administration (HRSA)[5]. This clinical quality improvement project, implemented at all 15 birthing hospitals across the state, trains and supports clinical teams through the implementation of patient safety bundles on key maternal health topics.

- **Patient Safety Bundles for Safer Birth:** Patient safety bundles are structured quality improvement projects that implement evidence-informed best practices in clinical settings. Driven by maternal mortality data identifying substance use disorder and mental health as the leading causes of maternal death in New Hampshire, birthing hospitals across the state have been implementing and sustaining two patient safety bundles since 2023: *Care for Pregnancy and Postpartum Patients with Substance Use Disorder* and *Perinatal Mental Health Conditions.* Each bundle provides activities for each birthing hospital to educate and prepare clinical staff about specific health conditions, methods for screening, and how to refer patients to services and to establish specific pathways for care coordination.
    - **Bundle 1 - Caring for Pregnant and Postpartum Patients with Substance Use Disorder**: The percentage of birthing hospitals that have fully implemented a validated verbal screening tool for diagnosis of opioid use and substance use disorders

Care for Pregnant and Postpartum People with Substance Use Disorder

[5] The NH AIM project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $200,000 with zero percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

increased from 46.7% in Quarter 1 of 2023 to 86.7% in Quarter 4 of 2024. The number of providers and nurses at participating birthing hospitals who received clinical education on caring for pregnant patients with substance use disorder increased from 55.8% in Quarter 1 of 2023 to 72.1% in Quarter 4 of 2024.

- **Bundle 2 - Perinatal Mental Health Conditions:** Implementation of the Perinatal Mental Health Condition (PMHC) bundle in New Hampshire birthing hospitals is showing solid progress. The referral and treatment rates for patients diagnosed with a PMHC in 2024 increased from 67.2% in quarter 1 to 75.8% in quarter 4. This illustrates how quality improvement approaches can improve care processes.



- **AIM Urgent Maternal Warning Signs**: The Urgent Maternal Warning Signs initiative was adopted as part of the AIM project to direct pregnant and postpartum women and their families to appropriate and timely care for obstetric complications. The warning signs include the most concerning causes of maternal morbidity and mortality and provide clear guidance on seeking care with an obstetrician and/or emergency provider. This resource is also used in ongoing education for clinicians serving pregnant and postpartum patients and is available in seven languages. In 2024, NHPQC began rollout of this key educational resource to birthing hospitals, community spaces, clinics, and correctional facilities throughout the state.



- **AIM Clinical Consultation and Training:** Through the AIM project, the NHPQC offered clinical consultation office hours for healthcare providers with Dartmouth Health psychiatric provider Becca Casey, APRN. Weekly office hours were available for providers, nurses, and care team members to bring case management or general perinatal mental health questions, as well as one-on-one consultations and lunch and learn presentations on perinatal mental health conditions. There is also a recorded virtual learning series available for clinicians on topics including postpartum depression, psychiatric emergencies, post-traumatic stress disorder (PTSD) and postpartum obsessive-compulsive disorder (OCD).

- **AIM Clinical Education Webinars:** In 2024, the New Hampshire AIM project webinars and clinical education sessions were attended by birthing hospital clinical staff and community-based providers. Topics included:
    - Creating comprehensive postpartum support
    - A multidisciplinary team approach to more effective discharge planning
    - The importance of SUD and mental health screening and referral data
    - Clinical pearls to help address common barriers in providing mental health care
    - From screening to action: setting the stage for an honest patient discussion
    - Creating a community-wide approach to perinatal mental health

NNEPQIN Clinical Conferences

NNEPQIN provides education at conferences for clinical staff across Northern New England to align maternal mortality prevention initiatives across the region. Conference sessions in 2024 included:

- NNEPQIN Perinatal Community Advisory Council (PCAC): Taking Good Care: What you need to know about me before you start
- Implementing TeamBirth: Bringing Shared Decision Making to Life
- Elective Induction of Labor: Translating Research into Practice with Patients at the Center
- Preparation for Postpartum Hemorrhage through Virtual Reality
- NH DCYF Community Navigator and NH POSC Family Care Planner Pilot
- A Collaborative Approach to Perinatal Mental Health
- Updates to Breastfeeding Guidelines for Patients with Substance Use Disorder
- Responsive Care for Perinatal Mental Health and Substance Use Disorders
- A Collaborative Approach to Perinatal Mental Health Plans of Safe Care

Perinatal Peer Recovery Coach Programming

Past MMRC recommendations highlighted the need for peer recovery coaches in perinatal settings as a strategy to reduce overdose deaths. This evidence-based approach to supporting patients with substance use disorders improves engagement in treatment. In 2024, with the support of additional federal funding, NHPQC launched perinatal peer recovery coach trainings and workforce support groups to help grow this important service for perinatal patients.

Conclusion

The findings presented in this report highlight both the progress made and the persistent challenges that continue to affect maternal health in New Hampshire. While the number of pregnancy-associated and pregnancy-related deaths have declined, most were preventable. Mental health conditions, substance use, and social and economic stressors continue to be key drivers of maternal mortality, particularly in the postpartum period. Ongoing collaboration among healthcare providers, community partners, and state agencies has strengthened prevention strategies, improved data quality, and expanded access to maternal mental health and substance use supports. Continued investment in coordinated, data-driven initiatives, supported by strong clinical and community partnerships, will be essential to eliminating preventable maternal deaths and improving the health and well-being of New Hampshire's families.

Appendix A: Additional Data on Pregnancy-Associated Deaths 2020-2024

Figure 18. Causes of Pregnancy-Associated Reviewed Deaths Occurring among NH Residents (2020-2024)

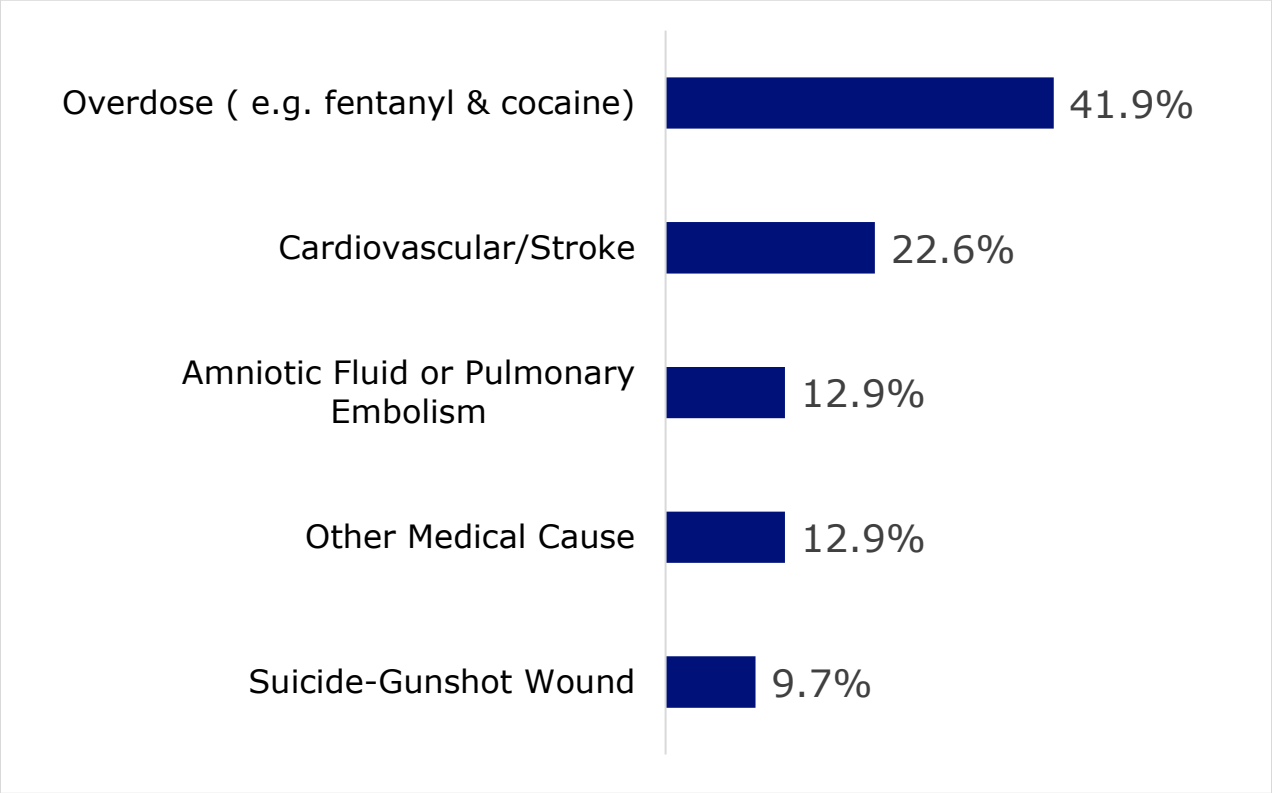


Figure 19. Deaths by Timing of Death in Relation to Pregnancy, 2020-2024 NH Pregnancy-Associated Deaths

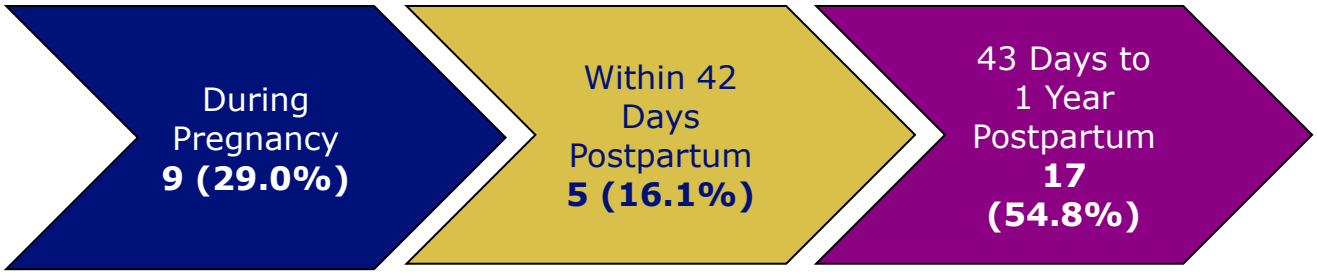


Figure 20. Distribution of 2020–2024 NH Pregnancy-Associated Deaths by Payor

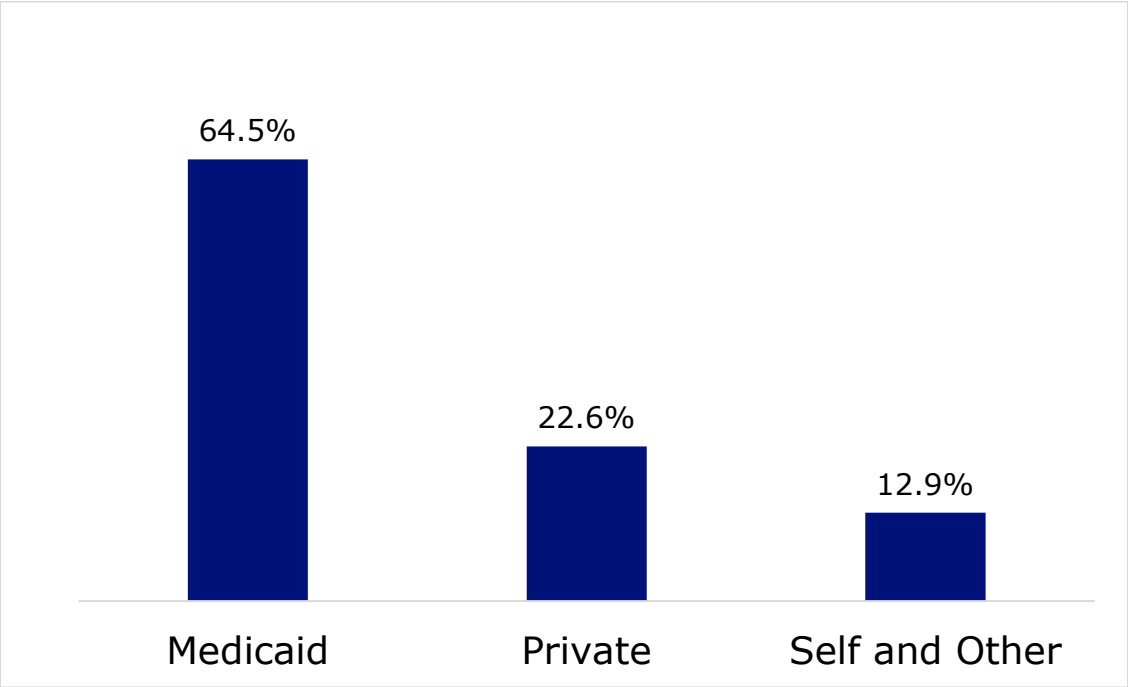


Figure 21. Location of Death, 2020-2024 Pregnancy-Associated Deaths

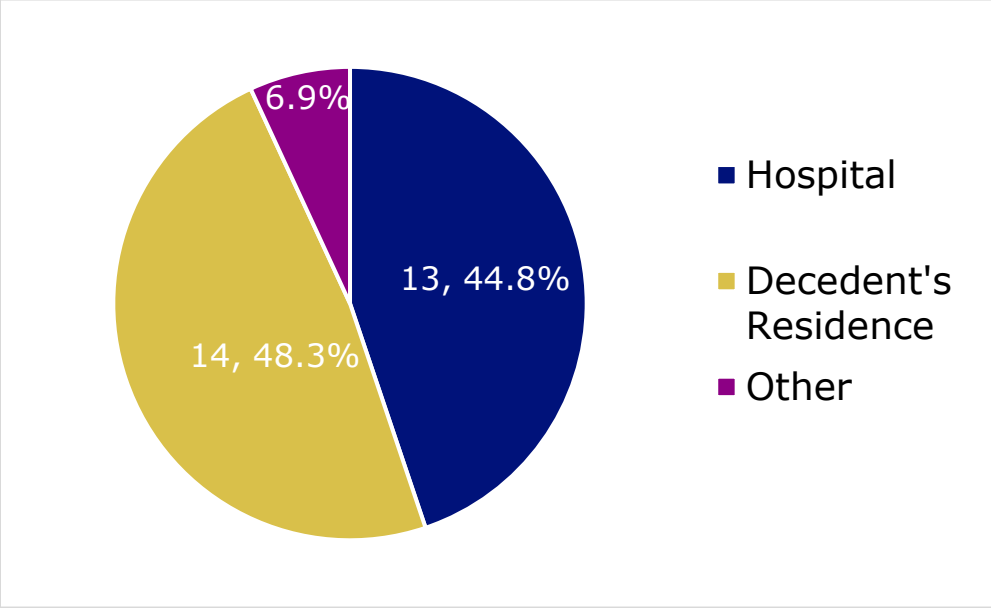


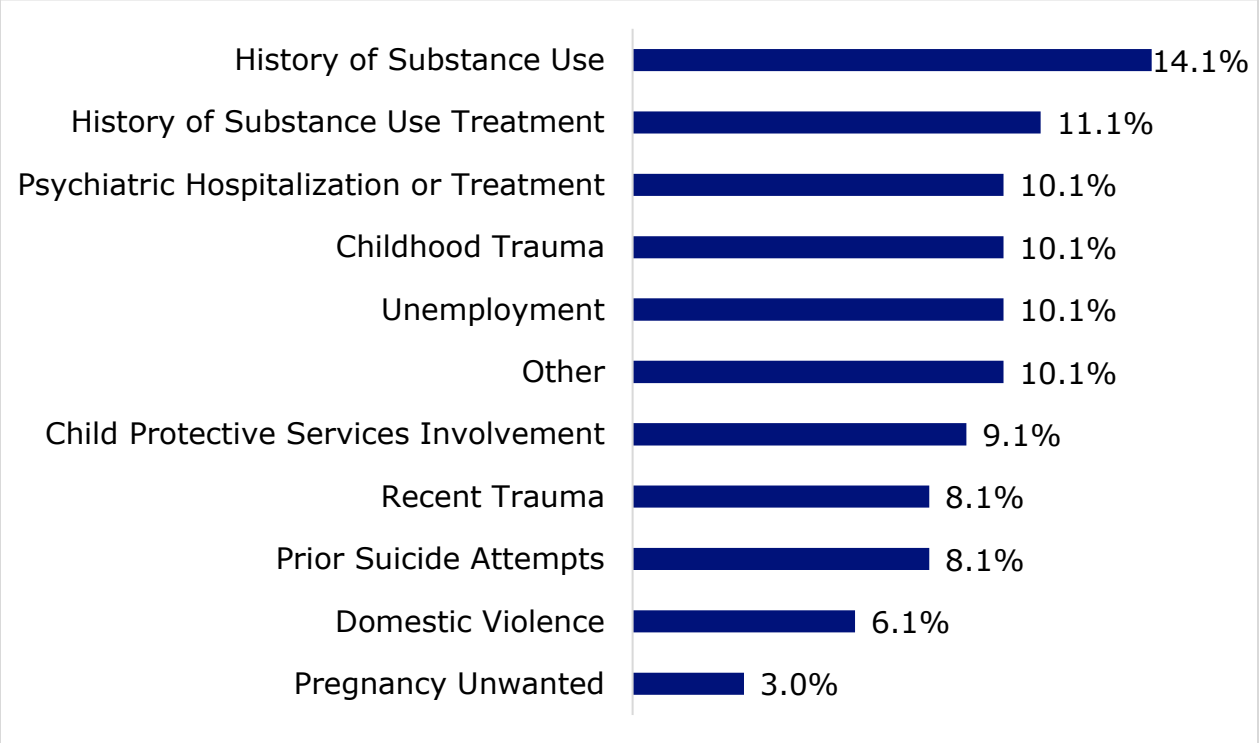
Table 1. Characteristics of Pregnancy-Associated Deaths 2020-2024

Indicator	Number of deaths	Percentage
Death Timing		
During pregnancy	11	34.5%
Within 42 days of pregnancy	3	9.7%
Within 43 days to 1 year of pregnancy	17	54.8%
Total	**31**	**100%**
Education attainment of the mother		
High school diploma equivalent or less	20	64.5%
Completed some college	3	9.7%
Associate Bachelor or Advanced degree	8	25.8%
Total	**31**	**100%**
Age group of the mother (years)		
<25	**4**	12.9%
25-29	**8**	25.8%
30-34	11	35.5%
35-39	4	12.9%
40 and more	**4**	12.9%
Total	**31**	**100%**
Mother's living arrangement at time of death		
Own	3	12.4%
Rent	7	29.2%
Live with relative	**10**	41.7%
Homeless/public housing, Other or unknown	**4**	16.7%
Total (Missing 7)	24	**100%**

Table 2. Selected Committee Determinations on Circumstances Surrounding Death for Pregnancy-Associated Reviewed Cases, 2020-2023

Committee determinations	Yes	%	Probably	%
Did obesity contribute to the death?	5	19.9%	0	0.0%
Did mental health conditions contribute to the death?	15	57.6%	3	11.5%
Did substance use disorder contribute to the death?	16	51.6%	5	16.1%
Was this death a suicide?	4	17.4%	0	0.0%

Figure 22. History of social and emotional stress for 2020-2024 Pregnancy-Associated Deaths



Appendix B: Key Resources



24/7 Immediate Crisis Support

Suicide & Crisis Lifeline
Call or Text **988** | Chat: 988lifeline.org

NH Rapid Response Access Point
Call or Text 1-**833-710-6477** | Chat: nh988.com

National Maternal Mental Health Hotline:
https://mchb.hrsa.gov/programs-impact/national-maternal-mental-health-hotline
Call or Text: **1-833-TLC-MAMA**



Behavioral Health Resources

DHHS Division of Behavioral Health
https://www.dhhs.nh.gov/programs-services/health-care/behavioral-health

988/Rapid Response Access Point Toolkit (NH Healthy Families)
https://www.nhhealthyfamilies.com/content/dam/centene/NH%20Healthy%20Families/Medicaid/pdfs/NHHF_988_Provider_Toolkit_2024.pdf

Suicide Prevention Resources
New Hampshire Suicide Prevention Council
www.PreventSuicideNH.org

NAMI NH
https://www.naminh.org/

American Friends for Suicide Prevention
https://afsp.org/chapter/new-hampshire

Substance Use Disorder Resources

Drug and Alcohol Treatment Locator
https://www.dhhs.nh.gov/programs-services/alcohol-tobacco-other-substance-misuse/nh-drug-alcohol-treatment-locator

The Doorway and 211
https://www.thedoorway.nh.gov/

Public Health and Community Health Resources

DHHS Maternal and Child Health Section
https://www.dhhs.nh.gov/programs-services/population-health/maternal-child-health

DHHS Family and Community Health Section, Home Visiting and Family Resource Centers
https://www.dhhs.nh.gov/programs-services/population-health/family-community-health

Perinatal Resources

New Hampshire Perinatal Quality Collaborative
https://nhpqc.org/resources/

Northern New England Perinatal Quality Improvement Network
https://nnepqin.org/

NH Mom Hub
https://www.hopeonhavenhill.org/momhub/

Postpartum Support International
https://postpartum.net/

Appendix C: MMRC Contact Information

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