

Strengthening our Collective Caring

Lessons from Cases of Maternal Deaths by Overdose

What is Maternal Mortality Review?

To uncover lessons from deaths, it helps to have multiple people with different perspectives review each case. In Maternal Mortality Review, a review team typically involves medical, behavioral health and public health professionals, community partners and other relevant experts. This multi-disciplinary team systematically reviews the chain of events leading to the deaths of any state resident that occurs during pregnancy or up to one year after the end of the pregnancy. The MMR Committee determines if the death was likely due in any way to the pregnancy, and if there are improvements to the maternal health system of care that could prevent future deaths. Looking across cases, researchers use the data to generate, summarize, and share insights to promote maternal health and wellbeing.

The Delaware Maternal and Child Death Review Commission's **Maternal Mortality Review (MMR)** Committee examines every death of a Delaware resident that occurs during pregnancy or up to one year after the end of a pregnancy—referred to here as maternal deaths. The work of the Commission was written into state law because it is clear that by looking carefully at cases of death, Delaware can uncover steps that could safeguard lives and promote community health and wellbeing.

Findings from MMR case reviews provide insights on the systems we have built for collective caregiving, such as prenatal health care, delivery and postpartum care, mental health care, and substance use treatment. This brief summarizes findings on maternal deaths from overdose, where care breaks down, and what we can do to strengthen our systems to prevent, reduce, and treat substance use disorder.

We offer these insights at a pivotal moment in addressing overdose deaths. Because states came together to hold pharmaceutical companies accountable for the opioid epidemic, Delaware now has settlement funds to help repair the harm caused by flooding our communities with dangerous, deadly drugs. Settlement funds represent a meaningful opportunity to create the conditions for healing, protect our families and communities from the harm opioid misuse can cause, and prevent opioid use disorder.

Findings

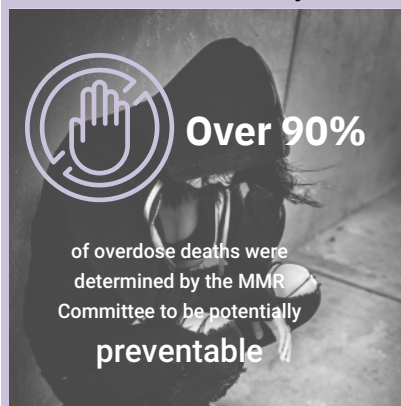
For the last five years, overdose has been the leading cause of death in cases brought before the state's MMR Committee. Delaware is not alone in this: overdose is a leading cause of death among all young women, pregnant or not, in both Delaware and the U.S.



of **maternal deaths** reviewed between 2020-2024 were due to overdose

The Delaware MMR Committee reviewed 46 cases in the last five years (2020-2024). Of these 46 cases, 28 (61%) were women who died of an overdose, making overdose the **number one cause of death reviewed**.

Preventability



Looking more deeply into these cases, key MMR findings are as follows:

- **More than 90% of overdose deaths could have been prevented.** Based on a systematic review of the chain of events leading to each death, MMR committees determined that in 93% of cases, the death may have been averted by a reasonable change to a contributing factor.

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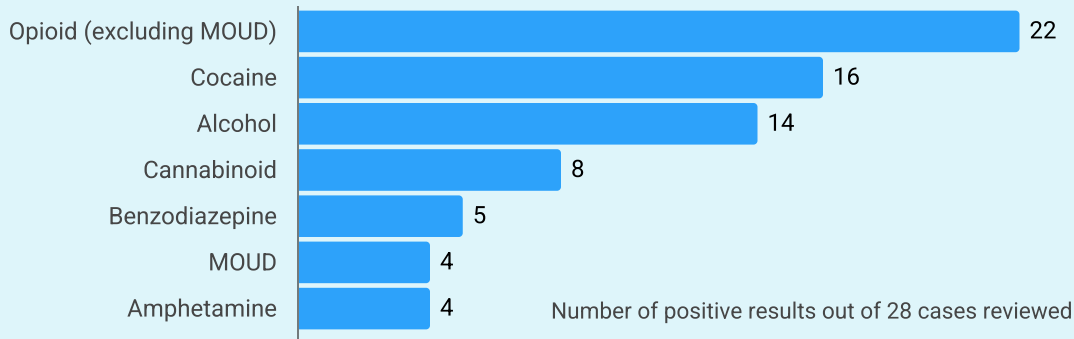
Findings

- **Most maternal overdose deaths are not related to pregnancy itself.**

In 75% of maternal overdose deaths reviewed, the death was not pregnancy related. Fourteen percent of overdose deaths were determined to be likely pregnancy related, meaning that the woman's being pregnant was part of the chain of events that resulted in her death.

- **75% of maternal overdose deaths involved an opioid, most often fentanyl.** Among cases that had a positive toxicology test at the time of death, the most common substance found was fentanyl, a potent synthetic opioid.

Polysubstance use, namely the combination of fentanyl plus another drug such as cocaine, is the most common cause of maternal overdose deaths.

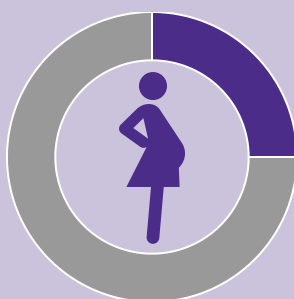


Number of positive results out of 28 cases reviewed

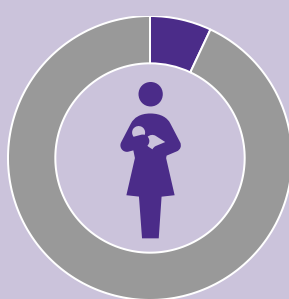
MOUD=Medications for Opioid Use Disorder such as buprenorphine and methadone

- **Most maternal overdose deaths occur months after delivery.** Two-thirds of maternal deaths (68%) occurred in the late postpartum period, defined as 6 weeks to 1 year after pregnancy. During this time, stresses such as lack of sleep, increased caregiving demands, health and mental health challenges, and financial strain can compound, just as visits to health care providers begin to taper off. These factors can combine to increase the risk of return to use for women with substance use disorder.

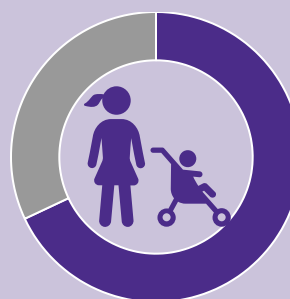
The late postpartum is the riskiest time for a woman to die of overdose.



25%
Pregnancy



7%
Early postpartum
0-42 days



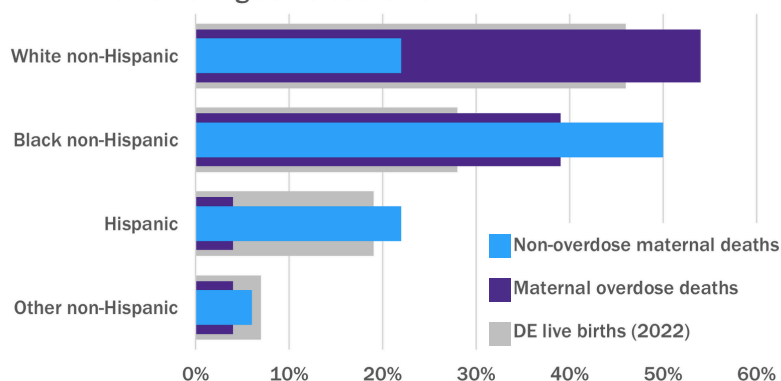
68%
Late postpartum
42-365 days

- **Compared to other causes of maternal death in Delaware, overdose deaths occur more evenly across racial groups.** Overdose deaths among Black and White women were roughly proportional to the overall share of live births among each group.¹ For other, non-overdose causes of maternal death, Black women are disproportionately affected when compared to White women in Delaware.

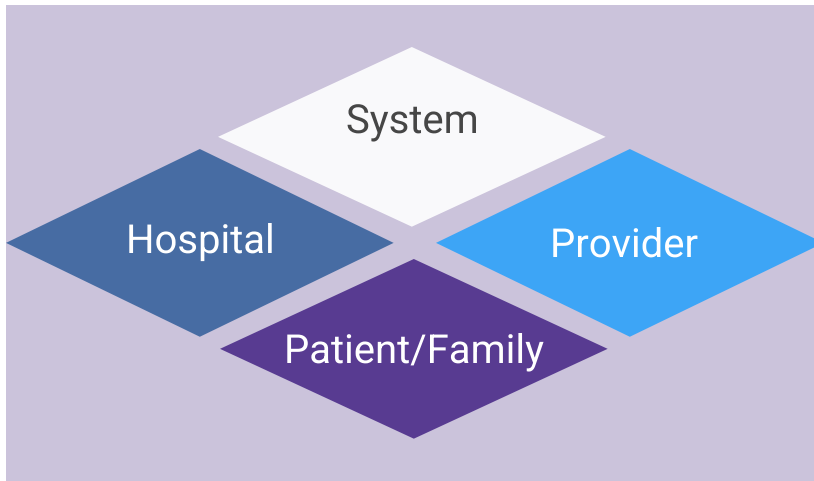
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- **Maternal overdose deaths are comparatively rare among Hispanic women in Delaware.** Hispanic women accounted for 19% of live births in the state, 4% of maternal overdose deaths, and 22% of maternal deaths from other causes.

The racial disparity is most noticeable for **non-overdose** causes of maternal deaths with Black and Hispanic women being at increased risk.



Where Collective Caregiving Can Be Strengthened



MMR review identifies harmful events, missed opportunities for prevention, and other factors in a patient's life that were part of the chain of events leading to her death. These careful reviews identified an average of eight contributing factors for each case of maternal overdose death. Recurring themes point us to ways to strengthen the vital conditions for health before pregnancy and our collective caregiving during and after pregnancy.

This section summarizes contributing factors found in different points on a patient's journey – and what we can do about them.

System

Risks identified

- **Breakdowns in continuity or coordination of care:** In many cases reviewed, women had multiple medical and social risk factors and were receiving care at different sites, but there was no evidence that providers communicated to co-manage care. In other cases, gaps in care occurred during or following incarceration.

80%
of women who died were
on Medicaid

What can we do

- **Collaboration across hospitals and insurers:** Providers and payers should collaborate to optimize care coordination for women identified as high-risk.
- **Care coordinators and peer support specialists:** Professional support is crucial for guiding patients through the healthcare system, ensuring consistent follow-up, and preventing patients from disengaging across various care levels and sites.
- **Focus on Medicaid MCOs:** 80% of women who died of an overdose were insured through Medicaid. A significant opportunity exists to leverage Medicaid Managed Care Organizations (MCOs) to support women at the highest risk of overdose death.
- **Obstetric Needs Assessment Form:** Medicaid MCOs utilize their Obstetric Needs Assessment Form to identify pregnant patients and connect them with their MCO care coordination team. These teams can then develop care plans and solicit input from the woman's providers.
- **Support for pregnancy during incarceration:** It is essential that an Obstetric Needs Assessment Form be completed for every incarcerated pregnant person within the Department of Corrections system. This will facilitate connections to Medicaid MCO care coordination, ensure adequate support, improve discharge planning, and provide follow-up after release.

Hospital

Risks identified

- **Breakdowns in continuity or coordination of care:** In some cases of death, women had received care at an emergency department, but were not connected to a medical home, a care coordinator, or other ways to access necessary follow-up care.
- **Insufficient support with referrals to care:** In some cases, patients with multiple, complex medical and social needs were instructed to call for a follow-up appointment, when best practices involve ensuring that the appointment is scheduled prior to discharge from a hospital.
- **Breakdowns in communication:** In some cases, primary care providers were not informed that their patient had received emergency department care for a serious condition that needed follow up.

What can we do

- **For pregnant and postpartum patients:** Birthing hospitals should collaborate with Medicaid managed care organizations (MCOs) to embed MCO care coordinators on-site. This ensures all patients are connected with their MCO care coordination team after delivery.
- **For patients with complex care needs:** Birthing hospitals should consider hiring a nurse navigator to assist with discharge planning and early postpartum follow-up.
- **For high-risk patients in the Emergency Department:** Hospitals and healthcare facilities should explore ways to provide 24/7 access to care coordination and referral services, with a focus on pregnant patients.

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Provider

Risks identified

- **Uneven quality of care:** In some cases, providers did not use a standardized, best-practice approach to care for substance use disorder. This hindered their ability to recognize risk factors; escalate care based on risk; manage comorbidities like pain or withdrawal symptoms; and offer harm reduction strategies to engage patients.
- **Missed opportunities for assessment:** Providers sometimes failed to fully assess the risk of substance use disorder, risks stemming from health-related social needs, exposure to violence, or ongoing traumatic experiences.
- **Lack of communication:** Inadequate communication among providers meant that some providers were unaware of significant events in a patient's history that may have impacted their plan of care.

A prescription for change in Delaware



The HelpIsHereDE.com website has a provider resource page. Visit it to learn how to prevent, screen and refer for SUD.

helpisherede.com/health-care-providers

What can we do

- **Ongoing trainings:** To reduce discriminatory treatment of patients with Substance Use Disorder (SUD), state agencies and professional organizations should provide ongoing training for healthcare providers that fosters a scientific understanding of SUD as a treatable, chronic condition that is best managed with empathetic, evidence-based care.
- **Harm reduction resources available statewide:** To reduce the risk of harm from substance use, state agencies should educate women's health and primary care providers about resources available through HelpIsHereDE.com, such as free access to Narcan (naloxone) kits, fentanyl test strips and needle exchange.
- **Team-based, coordinated care plans:** To promote effective communication among all involved in a patient's care, healthcare systems should make it a standard practice to develop team-based, collaborative care plans. This living document, developed with input from both patient and providers, ensures that care for physical, mental, and social needs is coordinated.

Patient/Family

Risks identified

- **Adverse experiences during or after childhood:** Serious, negative experiences – such as witnessing or experiencing abuse – can rewire the brain and body in ways that make mental health challenges and substance misuse more likely. Maternal overdose deaths are associated with traumatic experiences. For instance, over half of cases (54%) involved a history of intimate partner violence.
- **Co-occurring mental illness and substance use disorder:** 92% of maternal overdose deaths occurred to women that had both SUD and a serious mental illness, with anxiety, depression, and post-traumatic stress disorder being the most common. Just under half of women (43%) who died from overdose were in SUD treatment at the time of death.
- **Lack of social support:** Reviews found that a pregnant or recently pregnant woman became more susceptible to substance use due to violence, intimidation, or substance use by a partner. In some cases, a woman had lost support because their partner had been incarcerated.

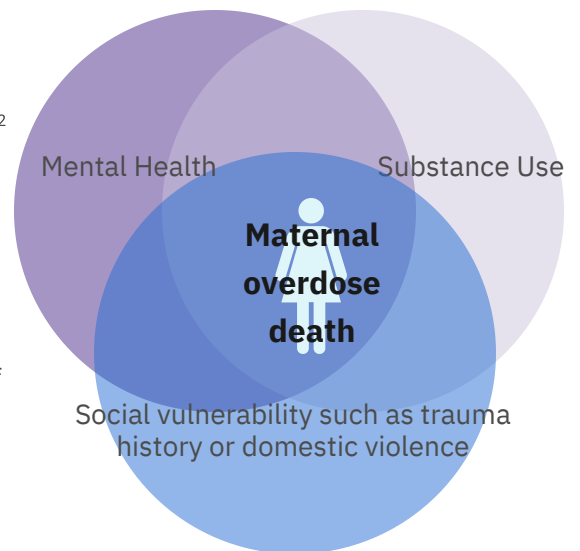
43%
of women were receiving treatment for SUD during or after their pregnancy

What can we do

- **Prevention:** Most adverse experiences can be prevented through improved social policy and programs. Once a potentially traumatic event has occurred, timely support can prevent and reduce further ripple effects.
- **Screening and case management:** To identify patients at higher risk for behavioral health complications, all providers should screen for social risk factors. These patients should then be offered case management services to engage them and address their most pressing needs.
- **Improved access to mental health services:** State agencies, legislation and funding should increase access to mental health and SUD services for all residents.
- **Trauma-informed approaches:** All providers should adopt practices that ensure that patients with a history of adversity or trauma feel safe and can develop a trusting relationship with members of their care team.
- **Services and supports for people who have experienced violence:** The state should fund programs that support people who have experienced violence, including emergency funds that allow pregnant and postpartum women to enact a safety plan.

Key takeaways for providers and programs working with pregnant and postpartum women

- **To determine which patients are at high risk of serious complications, assessments should include physical health, mental health, and social challenges.** The American College of Obstetricians and Gynecologists (ACOG) recommends including social risks in early prenatal assessments.² This helps create personalized prenatal care plans. Patients with identified risks can then receive coordinated care services and other support, allowing women to choose the best options for their needs.
- **A standardized approach to substance use disorder screening and management – both during and after pregnancy, across women’s health and primary care providers – could save lives.** Ongoing training and other forms of institutional support could help to ensure that Delaware’s array of collective caregiving systems are consistent with each other and with current national standards of care.
- **For women with substance use disorder, the late postpartum period (between six weeks and a year after delivery) is especially precarious.** Resources and outreach should be designed to provide continuous, long-term support, ensuring women remain engaged with caregiving systems and are successfully transitioned to a primary medical home.



Overlapping factors put women at highest risk of a maternal overdose death.

- **Treatment plans should account for the use of multiple substances, as polysubstance use is the most lethal condition found at time of death.** Medications for opioid use disorder (MOUD) are effective in managing opioid use, but may not address all withdrawal symptoms or cravings experienced by women with substance use disorder (SUD).
- **Efforts to better coordinate care are essential.** Care coordinators and patient navigators are vital members of the care team in various healthcare settings, including outpatient practices, community programs, and hospitals. Depending on the resources available at the care site, these roles can be filled by diverse professionals such as community health workers, social workers, nurses, or peer support specialists.
- **Women’s health providers and primary care providers have a role to play in promoting coordination of care.** During pregnancy, women with complex medical and social needs should be referred to care coordination services. Completing an Obstetric Needs Assessment Form (ONAF) is a key step to alert Medicaid MCOs of patients who may have various risk factors and need closer follow up. To access the ONAF for each Medicaid MCO, use the QR codes below.



Delaware First Health



Amerihealth Caritas



Highmark Health Options

¹Delaware Center for Health Statistics. (2022). Annual Vital Statistics Report: Live Births. Available at <https://dhss.delaware.gov/dph/hp/annrepvs/>.

²ACOG. (2025). Tailored prenatal care delivery for pregnant individuals. *Obstetrics & Gynecology*, 145(5): 565-577.

Updated October 15, 2025.



For more information, please visit the Delaware Maternal Child Death Review Commission website at <https://courts.delaware.gov/childdeath/>.

