Washington State Department of HEALTH

THE COMMUNITY COLLABORATIVE

January14, 2026

Mulki Mohamed, Community Thought Partner

Agenda

- Maria Hines, Blue Sky Minds, Thought Partner Charter Summary
- Deborah Gardner, Anne McHugh, JanMarie Ward, and Cindy Gamble on the Maternal Mortality Panel Report and American Indian Health Commission Addendum
- Jamilia Sherls, Office of Immunization, Changes to Immunization and Q&A
- Announcements and Close

THOUGHT PARTNER CHARTER DISCUSSION

MARIA HINES

COMMUNITY THOUGHT PARTNER 2.0 DRAFT CHARTER DISCUSSION

January 13, 2026

MISSION

Acting as trusted messengers, our mission is to serve as community-rooted *counsel* to Washington State Department of Health leadership and programs, advancing health justice through lived experience, local insight, and shared accountability in statewide public health decision-making.

MEMBERSHIP, COMPOSITION & TERMS

- Force multipliers
- 15 community leaders that reflect the diverse experiences of Washington communities
  - nine regional and six at large
  - priority community representation
  - rural/urban mix
- Potential to include representative(s) from existing programmatic work
- 3 year staggered terms

GOALS

Goal 1. Community Connection & Trust

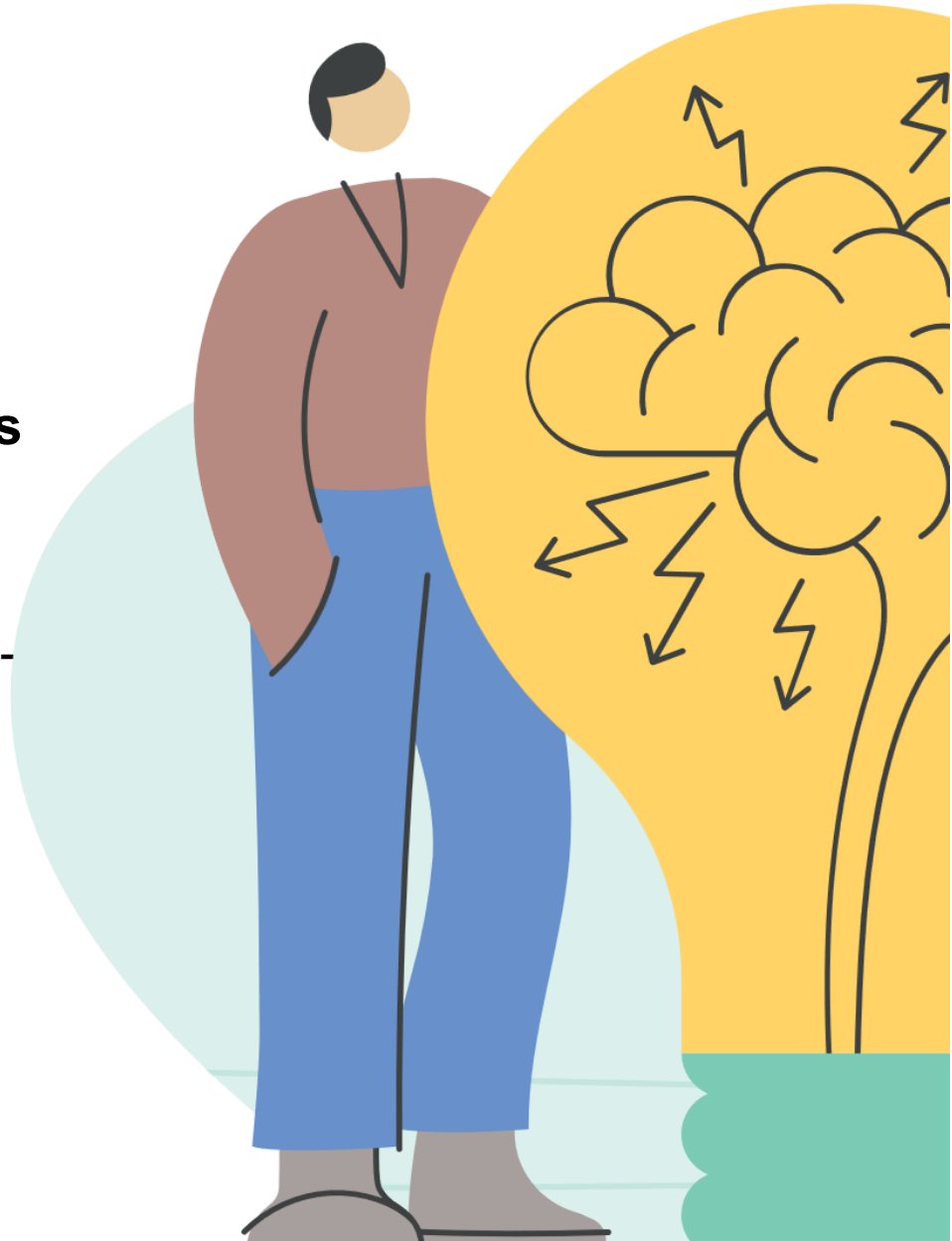
Cultivate authentic, two-way relationships between DOH and Washington's diverse communities by elevating lived experience and building shared accountability and trust.

Goal 2. Advocating the Root Causes of Health Injustices

Advance health justice by giving community leaders a seat at the table and a voice that allows them to weigh in on decisions that impact the root causes of health inequity. Advocate for community-led analysis and solutions that improve structural conditions to improve public health and health care systems.

Goal 3. Policy & Systems Influence

Ensure real-world community insight meaningfully informs DOH policy, budget, and program decisions so state health systems reflect community needs, promote healing relationships, repair harm, and advance equitable outcomes.



EXAMPLE

Thought Partners encourage using leadership voice to share a PSA on the health impacts of chronic stress regarding ICE/Immigration onslaught/enforcement.

REQUESTS FOR DOH LEADERSHIP

- By end of March, develop a public-facing commitment
- Build a relationship with individual Thought Partners
- Establish a unique pathway for Secretary of Health and DOH leadership to communicate openly and bi-monthly
- Create a pathway to actively engage Thought Partners on policy, budgets (request for a separate meeting)
- Provide timely access to relevant public health data (example: health care providers per county)
- Participate in onboarding new Thought Partners and contextualizing departmental work at least twice/year
- Support measurement of progress

OUR COMMITMENTS

- Listen to and stay accountable to the community
- Serve as trusted messengers, carrying community insight between DOH & communities.
- Reinforce diverse community inclusion
- Engage actively in shaping and upholding Thought Partner governance
- Participate consistently and follow through on commitments
- Provide input on DOH policies, programs, and decisions
- Support onboarding and mentoring of new Thought Partners
- Help recruit future Thought Partners
- Review, maintain, and revisit this charter annually

NEXT STEPS/ CLOSING REMARKS

- PSA on health impact of chronic stress by mid-February
- Public-facing commitment between the Thought Partners and DOH leadership by March 31st
- Meet with Dennis for feedback on the TP Charter within the next 2 weeks
- Complete the TP Charter by January 31st

THE **COMMUNITY** COLLABORATIVE

Washington State Department of HEALTH

MATERNAL MORTALITY REVIEW PANEL & AIHC ADDENDUM

Deborah Gardner, Anne McHugh, JanMarie Ward, Cindy Gamble

WASHINGTON STATE MATERNAL MORTALITY REVIEW PANEL

FINDINGS AND RECOMMENDATIONS FROM THE 2025 REPORT

Deborah (Debs) Gardner, MPH, MFA, Washington State Department of Health
Anne (Annie) McHugh, MPH, Washington State Department of Health
Cindy Gamble (Tlingit), MPH, CLC, American Indian Health Commission
JanMarie Ward (Chumash), MPA, American Indian Health Commission

VISION & IMPLICATIONS

Any maternal death is UNACCEPTABLE.

Ultimately, we hope to prevent deaths, address inequities, and improve the wellbeing of adults and children in Washington.

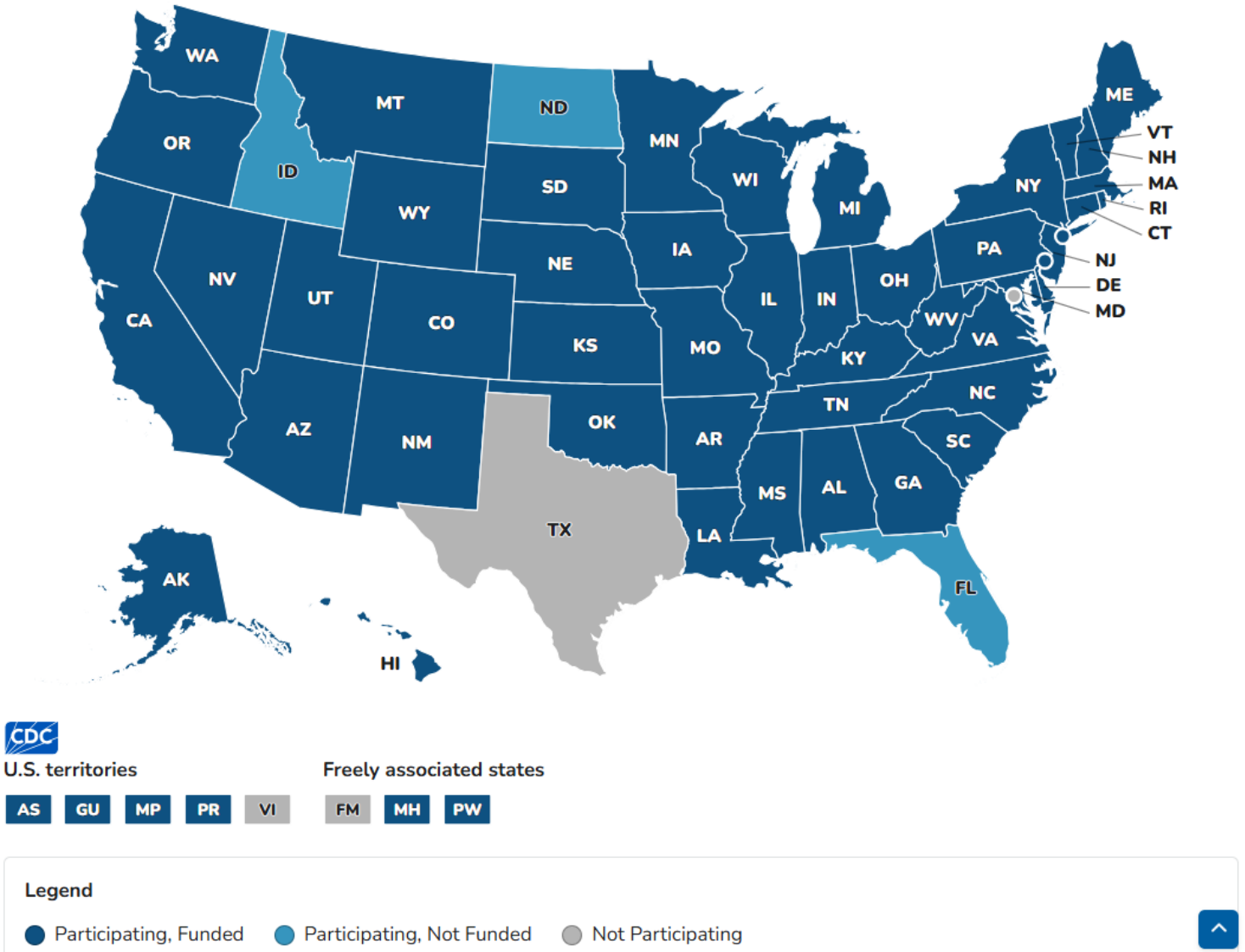
Intersectionality of Maternal Mortality

Maternal mortality connects to most fields and issue areas, including:

- **Public health**
- **Health care** and **support**, including **mental health** and **substance use disorder** treatment and support
- Addressing **racism** and **inequities**
- Support services, including **culturally specific community support** and basic needs (**housing**, **food**, **transportation**, **child care**, etc.)
- **Environmental** issues
- **Violence** prevention
- **Education**

OVERVIEW AND BACKGROUND: Washington State's MMRP

Maternal Mortality Review Nationwide

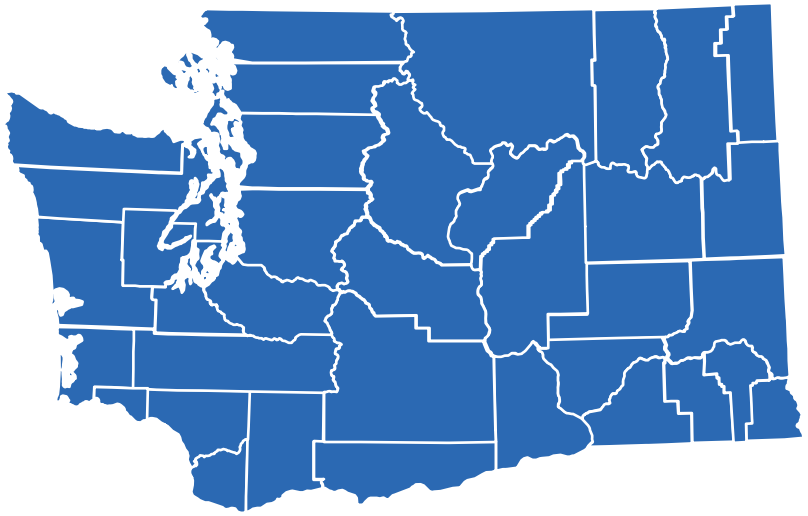


WA's Legislative Mandate for Maternal Mortality Review

- **2016**: Washington State Legislature established the **Maternal Mortality Review Panel through a state law** (RCW 70.54.450).
- **2019:** The Law was **amended** to make the Panel and the maternal mortality review process **permanent** and add details.
- The law directs the Panel to **review maternal deaths** and provide a **legislative report** every three years.

Washington State Maternal Mortality Review Panel (MMRP)

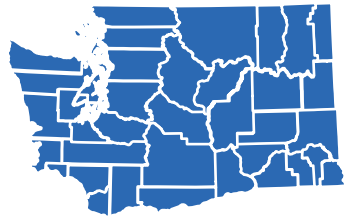
- Reviews deaths of Washington residents **during pregnancy through 1 year after.**
- Provide a report to the legislature every 3 years.
- Convened by the Washington State Department of Health (DOH).
- Had 80+ members last term; has 100+ this new term.
- Has a breadth of expertise and backgrounds, including priority focus on American Indian / Alaska Native communities.



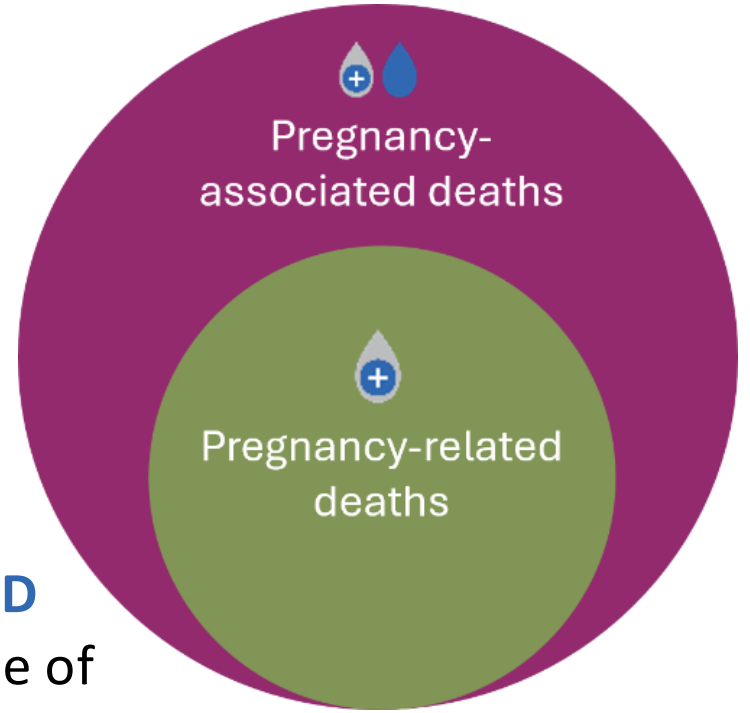
Washington's MMRP: A Wealth of Expertise

Washington's Maternal Mortality Review Process

1. DOH **identifies and confirms** deaths.
2. DOH requests medical and other records, then **writes a de-identified summary**.
3. MMRP **meets to review** the death and make recommendations for prevention.
4. MMRP and DOH **consolidates and narrows down recommendations** after 3 years.
5. MMRP and DOH compile **data and recommendations** into a report.



Maternal Mortality Review Definitions



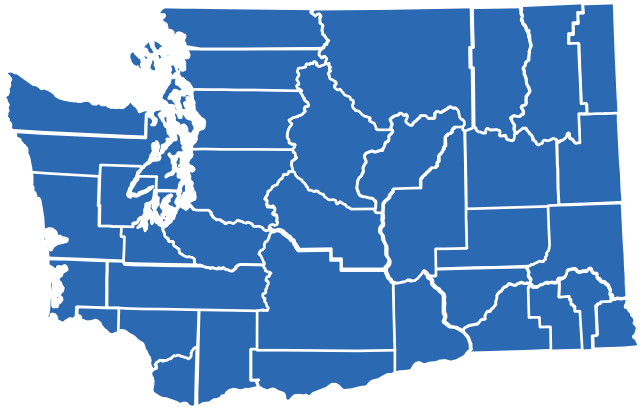
PREGNANCY-ASSOCIATED DEATHS: *all maternal deaths from any cause* during pregnancy or up to 1 year after.

Some pregnancy-associated deaths are **PREGNANCY-RELATED** (**caused or worsened by pregnancy).** They happened because of a pregnancy complication, a chain of events initiated by pregnancy, or an unrelated condition aggravated by pregnancy.

Some pregnancy-associated deaths are NOT pregnancy-related—the cause had no connection to pregnancy. For some deaths, the Panel doesn't have enough information to determine if the death was related to pregnancy.

How MMRP Cases are Reviewed

- A **respectful review** of each potentially pregnancy related death, using an anonymized, de-identified case narrative summary**:**
  - Was the death **pregnancy-related**?
  - If it was pregnancy-related, was it **preventable**?
    - From a **clinical** perspective and/or from an **equity and social determinants of health** perspective?
  - Did **racism, discrimination, and bias play a role**?
  - What **factors contributed** to these deaths?
  - **Recommendations**: What might help prevent such a death, at the time or even years before? (These are the basis for our legislative report every three years.)



KEY FINDINGS FROM THE 2025 MMRP REPORT

2025 Maternal Mortality Review Panel Report

- Submitted to the Washington State Legislature December 2025 (fourth MMRP report in WA)
- **Aims:**
  - **Prevent** maternal deaths
  - Raise **awareness**
  - Increase **health equity**
  - Improve **perinatal care**
- **Data** from **2021–2022** maternal deaths; some from 2014–2022
- **Recommendations: legislature** and **other audiences**
- **Addendum: American Indian Health Commission**

Report to the Legislature

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

RCW 70.54.450

Prepared by the Prevention and Community Health Division

Washington State Department of HEALTH

What's new with this report format?

- **Shorter**, more **focused**.
- Stronger focus on **legislative audience**.
- **Stories from community members:**
  Voices from Washington stories about pregnancy, birth, or postpartum experiences and challenges in Washington.
- **Success stories** from people around Washington about implementing recommendations from the 2023 MMRP report.

www.doh.wa.gov/maternalmortality

Report to the Legislature

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

RCW 70.54.450

Prepared by the
Prevention and Community
Health Division

Washington State Department of HEALTH

Key findings from the report (2021–2022 deaths)

- **Maternal mortality INCREASED in 2021–2022.** This is the first increase in WA MMRP reports.
- Pregnancy-related maternal mortality rates were **30.5 per 100,000 live births.**
    - **Statistically significantly** higher than the state's rate in 2017–2020, of 19.0 per 100,000 live births.

MATERNAL MORTALITY INCREASED IN WASHINGTON

Key findings from the report (2021–2022 deaths)

- **Behavioral health** related conditions were the **leading cause**, accounting for **nearly half (45%)** of all pregnancy-related deaths.
    - The majority of these were **overdose deaths**, most of which involved **fentanyl**.

BEHAVIORAL HEALTH conditions were the **leading cause**

Preventability of Pregnancy-Related Deaths

The Panel found **82% of pregnancy-related deaths were preventable**, meaning there was at least some chance of the death being averted if a factor that contributed to the death had been different.

This reflects:

- **A broader understanding of preventability:**
  Clinical, equity, and social-determinants-of-health factors, including upstream factors earlier in life.
- **An opportunity to take action:**
  Better understanding of what's behind maternal deaths.

82% of **pregnancy-related** deaths were **PREVENTABLE**

Racism, Discrimination, Bias, and Inequities

- MMRP identified **discrimination, bias, interpersonal racism,** or **structural racism** in **76%** of preventable pregnancy-related deaths. (2021–2022)

- **Disparities** and **inequities** persist: (2014–2022)
  - Age
  - Race/ethnicity
    - Particularly American Indian / Alaska Native
  - Rural
  - Medicaid coverage, reflecting socioeconomic status

- Communities most burdened by perinatal health inequities have **expertise** and **cultural knowledge** to **lead solutions** to **reduce maternal mortality.**

Disparities and inequities persist

RECOMMENDATIONS

MMRP Report Recommendations

3 priority recommendations, which include:

- **12 recommendations** for the Washington State **Legislature** (page #s 16–23)
- **75 recommendations** for **other audiences** (page #s 32–49)
  - Health systems and facilities
  - Health care and support providers
  - State and local agencies
  - Academic institutions
  - Organizations
  - Communities

Report to the Legislature

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

RCW 70.54.450

Prepared by the Prevention and Community Health Division

Washington State Department of HEALTH

MMRP Priority Recommendations

Improve health care quality and access.

Strengthen community support services.

Provide equitable, culturally responsive care.

Recommendation 1. Improve Health Care Quality and Access

Ensure Washingtonians have **access** to **high-quality health care**—including **mental health care, substance use disorder** treatment, and **preventive** care—throughout pregnancy, birth, and postpartum by strengthening and funding **care coordination**, improving **communication** and **protocols**, and ensuring providers have the **skills**, **training**, and **professional support** they need to provide high-quality care**.**

Voices from Washington

"Five days after giving birth, ***I went to the ER with clear symptoms of preeclampsia****.* ***I was sent home with a few pills.*** *Just hours later, I had* ***uncontrollable seizures*** *and was admitted to the ICU, where I spent a week—time I should have had with my newborn.* ***Years later, after another pregnancy, I was again at risk. But this time, I wore a blue rubber wristband from the Blue Band Initiative,*** *designed to alert health care providers that a patient is at risk for preeclampsia. The nurse recognized the band right away and brought me to the OB, where I was admitted and treated with magnesium."*

"Originally, I was interested in birthing at a birthing center, but our ***insurance plan didn't cover one****. I would like to see* ***more options for pregnant people*** *to choose the kind of birthing environment* ***that feels best to them****."*

Sample Recommendations: Health Care Quality and Access

1.2 The legislature should protect and increase **funding and access for family-friendly, judgment-free substance use disorder (SUD) and opioid use disorder (OUD) treatment and support for pregnant and postpartum patients** across Washington, including in rural areas with limited access to community services.

1.6 The legislature should support policies and provide financial support to address the **shortage of maternity care and emergency obstetric care in rural areas** through 3 approaches

- Preserving rural and critical access hospitals
- Increasing the **number of rural perinatal care providers**
- **I**ncreasing the resources and knowledge needed to prevent and respond to **obstetric emergencies** in rural areas.

Recommendation 2. Strengthen Community Support Services

Invest in, develop, and expand comprehensive **community support services** that address **essential needs** during pregnancy and postpartum. This includes strengthened **home visiting** programs, **social work** services, **doula** support, and wraparound support for **mental health and substance use disorder.**

Voices from Washington

"My first pregnancy was very trying. I couldn't eat, I lost weight, and I couldn't take care of myself. ***No one's ready for the first trimester****. The father left when I was 2 months pregnant.* ***I became homeless****. I started my prenatal care in one city and then continued in another, but they wouldn't listen to me, no matter how much I would tell them my concerns.* ***It would have been helpful to have more safety nets****."*

"Connecting with others who had experienced severe maternal complications was profoundly healing. I ***wish I'd known*** *about those* ***resources*** *earlier.* ***Providers*** *should* ***routinely share them—it can make all the difference*** *in not feeling alone."*

Sample Recommendations: Community Support Services

2.2 The legislature should expand support for **universal access to wraparound services** through pregnancy and at least 1 year postpartum, including **home visiting, doula support, and peer support workers**.

2.3 The legislature should prioritize both **protecting existing and funding new** programs that **meet people's basic needs during pregnancy and postpartum**. Ideally, access to transportation, housing, income, and child care would be universally available.

2.16 Funders and state and local agencies should **increase funding and capacity** for **community-based organizations** to support people during pregnancy and postpartum.

- Services may include **culturally relevant parenting classes**, **community-led support groups**, family reconciliation services, and trauma-informed therapy.

Recommendation 3. Provide Equitable, Culturally Responsive Care

Ensure **care and services** throughout pregnancy, birth, and postpartum are **culturally responsive**, **free from bias**, grounded in **trauma-informed** practices, and actively address **racial injustice.**

Voices from Washington

*"I'm of African descent and it's **really hard to find a provider of color in Washington**. It is also hard to find any practitioner that even inquired about LGBTQ patients or that was **knowledgeable about the queer community**. The understanding and language was not there."*

*"**I experienced a miscarriage due to systemic racism.** My pregnancy could have been viable had **they listened to my requests** and not ignored me or told me what I was experiencing was normal, even though I knew it was not. **I have to live with the loss of my baby** the rest of my life, and with knowing my miscarriage could have been prevented."*

Sample Recommendations: Equitable, Culturally Responsive Care

3.3 Health care systems, state agencies, and academic institutions should work together to **build and sustain a diverse maternal health workforce** that **reflects the communities it serves**.

- This means promoting, recruiting, integrating, and supporting people across all health and allied professions, including doulas, patient navigators, and community health workers (CHWs).
- Efforts should begin **upstream** through intentional **outreach, education, training, mentorship, and career** pipeline programs for **Black, Indigenous, and people of color (BIPOC) communities, people with disabilities, and 2SLGBTQIA+ students and professionals**.

Sample Recommendations: Equitable, Culturally Responsive Care

3.11 State and local agencies, along with **community-based organizations**, should deliver ongoing, culturally relevant messaging about **how to safely access perinatal care**, including for **immigrant and refugee communities**.

- This includes language-specific messages about **health insurance access, privacy protections, and opportunities to receive perinatal care and support regardless of insurance or immigration status**.

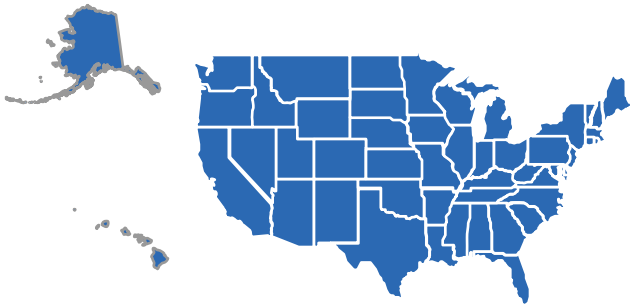
3.14 DOH and other state agencies should **fund community-based organizations** to increase **access to cultural and traditional healing practices and foods.**

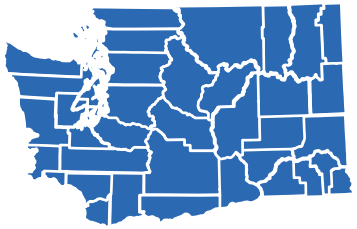
- These efforts can help reduce historical and systemic barriers that disproportionately affect Indigenous birthing people and their families.

Current Context and Emerging Challenges

Current and emerging issues may make recommendations more **challenging** and **important:**

- **Medicaid cuts (**Medicaid covers 45% of WA births; 70% in rural areas)
- **Rural** maternity care shortages
- **Perinatal** and **reproductive care** access challenges and fears
- **Mental health care** access
- State **budget** limitations
- **Misinformation** and **disinformation**
- Threats to **immigrant**, **BIPOC**, and **LGBTQ+** communities
- **Uncertainty** about health, environment, and society in the future





The report includes recommendations to both **protect existing services** and **take new steps.**

Connecting 2025 MMRP Report Recommendations to Your Priorities

- Are you **involved in efforts** to implement one or more of the recommendations **at the community level**? Or **hope to start soon**?
- **With whom** do you hope to **collaborate**? Others on this call? How can you **connect**?
- What recommendations are **most relevant** in your region, profession, or **community**?
- How can the report's findings and recommendations **support your work and priorities**?
- Are there **other efforts you are aware of** that you want to share?

Questions?

We are also available to present to other groups. Please contact us.

Deborah (Debs) Gardner, MPH, MFA
Maternal Mortality Review Coordinator
Washington State Department of Health
deborah.gardner@doh.wa.gov

Anne (Annie) McHugh, MPH
Epidemiologist III
Washington State Department of Health
anne.mchugh@doh.wa.gov

Report to the Legislature

Maternal Mortality Review Panel: Maternal Deaths 2021–2022

December 2025

RCW 70.54.450

Prepared by the
Prevention and Community
Health Division

Washington State Department of HEALTH

DEPARTMENT OF HEALTH COMMUNITY COLLABORATIVE
January 14, 2026

Washington State's New
2025 Maternal Mortality Review Panel Report to the Legislature

AMERICAN INDIAN HEALTH COMMISSION ADDENDUM TO THE WASHINGTON STATE DEPARTMENT OF HEALTH MATERNAL MORTALITY REVIEW PANEL REPORT TO THE LEGISLATURE

ABOUT US

We are a Tribally-driven, non-profit organization providing a forum for the twenty-nine tribal governments and two urban Indian health programs in Washington State to work together to improve health outcomes for American Indians and Alaska Natives.

PULLING TOGETHER FOR WELLNESS

MATERNAL INFANT CHILD HEALTH

The development of a comprehensive, long-term, Tribally-driven Maternal and Infant Health (MIH) strategy relies on the wisdom and knowledge held by leadership and communities, integrates healing and trauma informed practices, acknowledges the impact of historical, genocidal and ongoing racism experiences, and applies Tribally developed tools such as the 7 Generation principle and the Pulling Together for Wellness (PTW) vision, values, principles, and framework.

AIHC Maternal Infant Health Continuum

AIHC PRIORITIZES MATERNAL, INFANT, AND CHILD HEALTH

PULLING TOGETHER FOR WELLNESS

2008

Tribal Leaders respond to the disproportionate rates of adverse MIH outcomes. Research to develop 2010 AIHC Maternal Infant Health Strategic Plan.

2010

Initial Funding to 3 MIH Strategic Plan Recommendations

- MIH Workgroup – foundation to creating healthy communities.
  - TA to Tribes and UIHOs-supporting Tribes/UIHOs where they are at.
- **COLLABORTION WITH WIC AS A VITAL PROGRAM IN T/U COMMUNITIES.**
- Engage in collaboration to raise awareness, develop, and support culturally relevant home visiting.

2015

2015 AIHC adopts PTW by Resolution

The Pulling Together for Wellness is a Tribally-driven, culturally grounded PSE approach – requires we meet and listen to Native leaders, Elders, youth, cultural knowledge keepers, and community to inform MIH strategy.

Understanding MIH Status and Community Needs

- **Continuation of Community Conversations-PBP needs Erase Maternal Mortality.**
- Tribal Maternal, Infant, Child, and Adolescent Health (MICAH) Needs Assessment . (MCHBG).
- Feasibility of Tribally-led Maternal Mortality Review Committees (MMRC). Convening Community Conversations.
- Assessing needs to support Breastfeeding in Tribal/Urban Indian Communities.

2022 – 2025

May 2025 Affiliated Tribes of Northwest Indians adopts the PTW by Resolution as the policy of ATNI.

2025-26

Assessments and Surveys

- AI/AN Pregnancy Risk Assessment Monitoring System - Tribal-led
- Continuation of Feasibility of Tribally-led Maternal Mortality Review Committees (MMRC).
- Community/Patient Surveys and Staff Surveys- Phase 1
- Continuation of WIC assessment and listening sessions.

OUR APPROACH TO

Pulling Together for Wellness (PTW) Framework
IMPORTANCE OF ADDRESSING ROOT CAUSES

- PTW, a culturally grounded policy, systems, and environmental change approach, serves as our guidance in strategic development and engagement practices.
- PTW focuses on restoring holistic health, symbolized by the medicine wheel and a reflection that our physical, mental, emotional, and spiritual health are interwoven in culture and central to all parts of whole person, community, and environmental wellness.
- Is inclusive of both leadership and community engagement.
- Embraces the Seven Generation Principle as a way of life.
- Values the balance of Native Way of Knowing and western science.
- Stresses the importance of engaging with partners that understand and honor Tribal Sovereignty and self-determination as foundational principles and values.

PULLING TOGETHER FOR WELLNESS

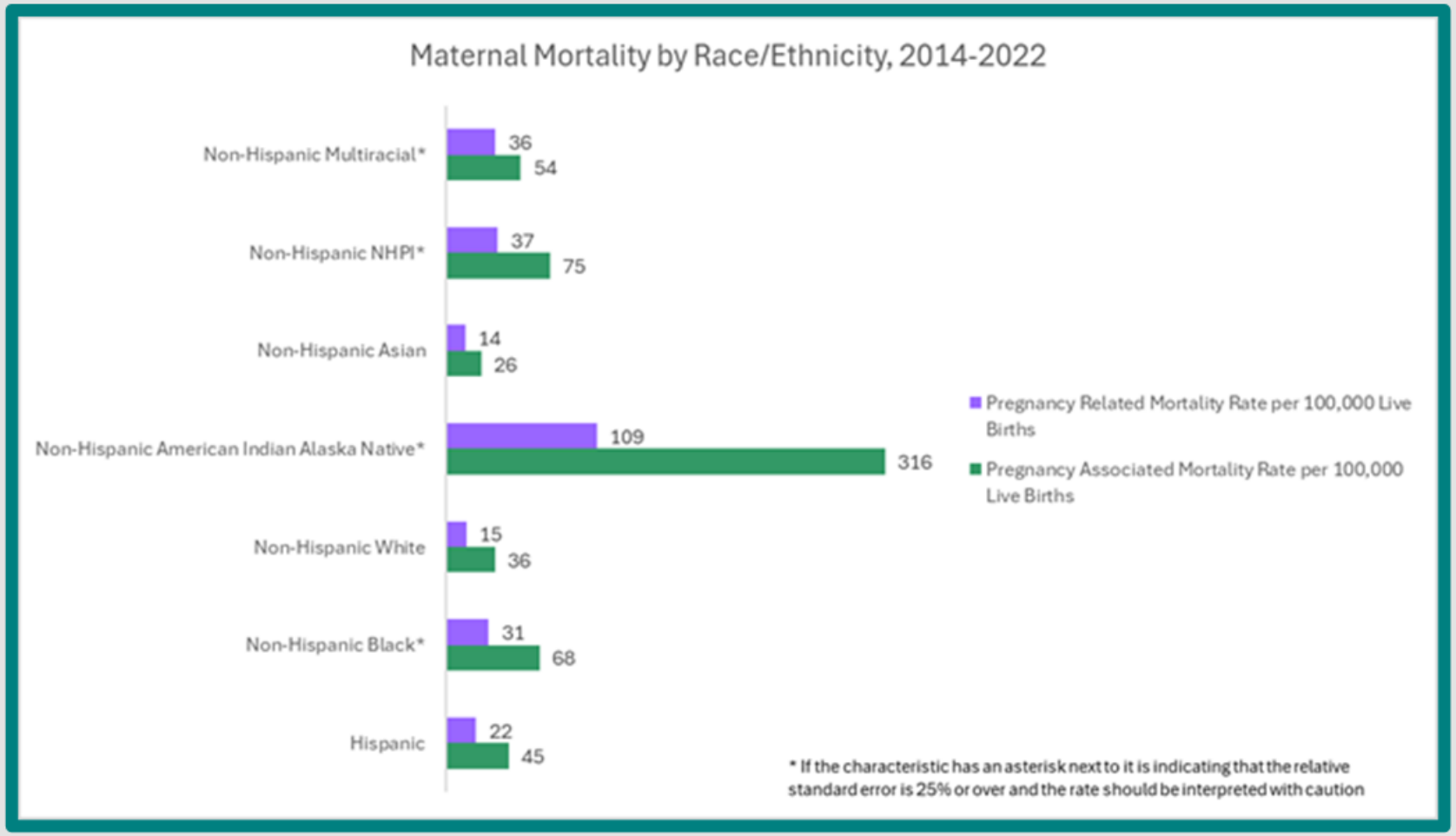
The Current Sense of Urgency for AI/AN MIH in Washington State

What the last 3 Maternal Mortality Review Panel Reports to the Legislature Tell Us:

- In the 2019 Report, American Indians and Alaska Natives (AI/AN) had the highest rate of maternal mortality compared to any other race or ethnicity. **"The highest risk factor for maternal mortality is to be American Indian or Alaska Native."**
- In the 2023 Report, AI/ANs have the highest rate of pregnancy associated and pregnancy related deaths.
- In the 2025 Report, AI/ANs have the highest rate of pregnancy associated and pregnancy related deaths.

PULLING TOGETHER FOR WELLNESS

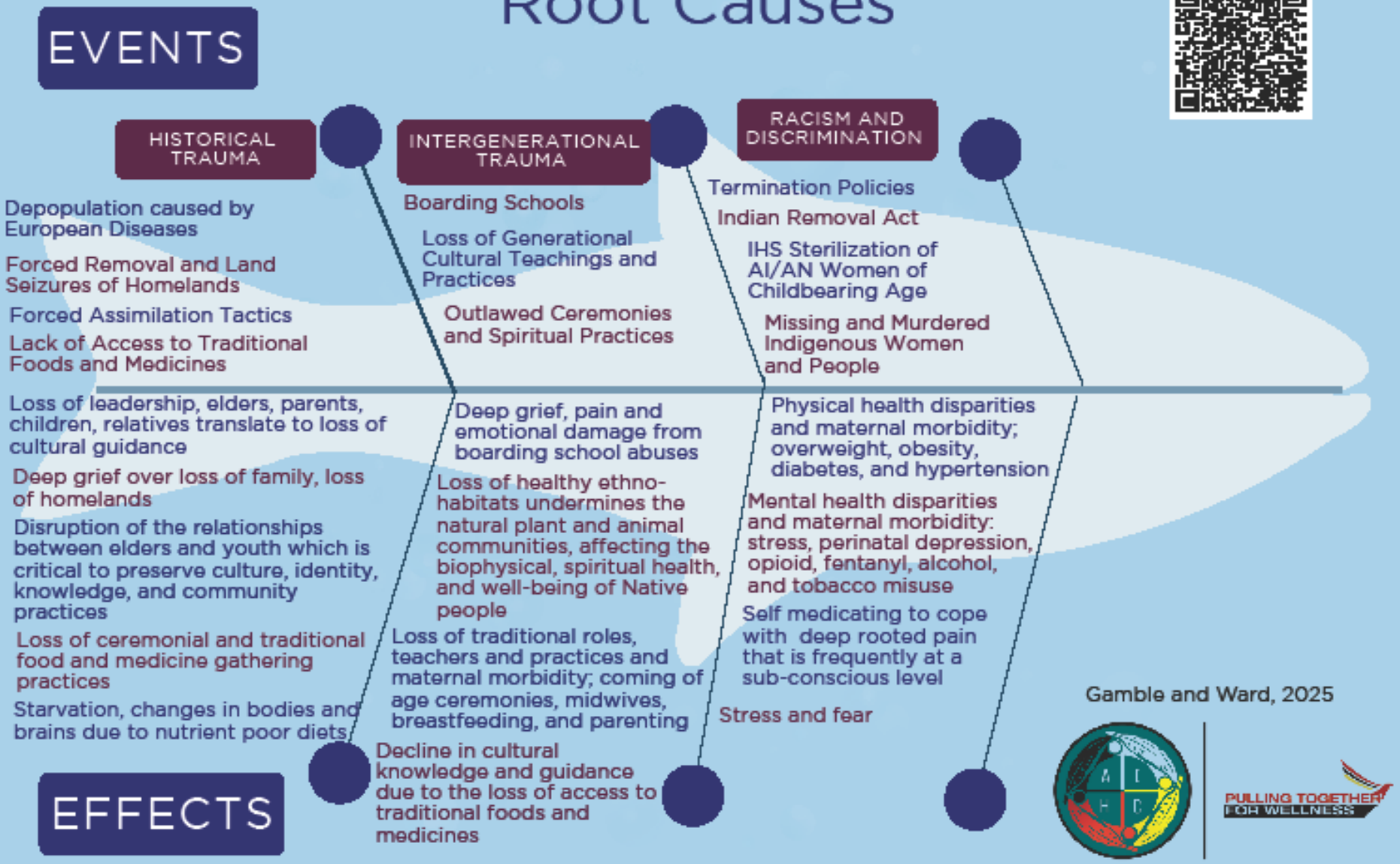
2025 Demographic Maternal Mortality Ratios and Counts for Pregnancy-Associated and Pregnancy-Related Deaths, Washington State 2014-2022, Washington State DOH



PULLING TOGETHER FOR WELLNESS

Maternal Mortality and Morbidity

Root Causes



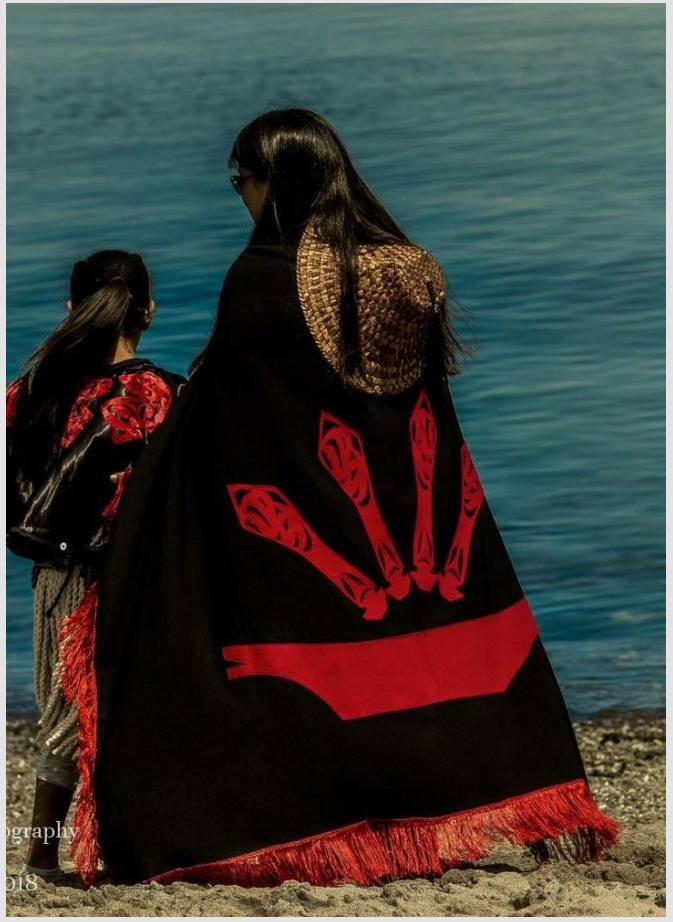
Gamble and Ward, 2025

PULLING TOGETHER FOR WELLNESS

COMMUNITY CONVERSATIONS - 2022 Initial Work

Listening Sessions To Address AI/AN Maternal Mortality Disparities In The State Of Washington

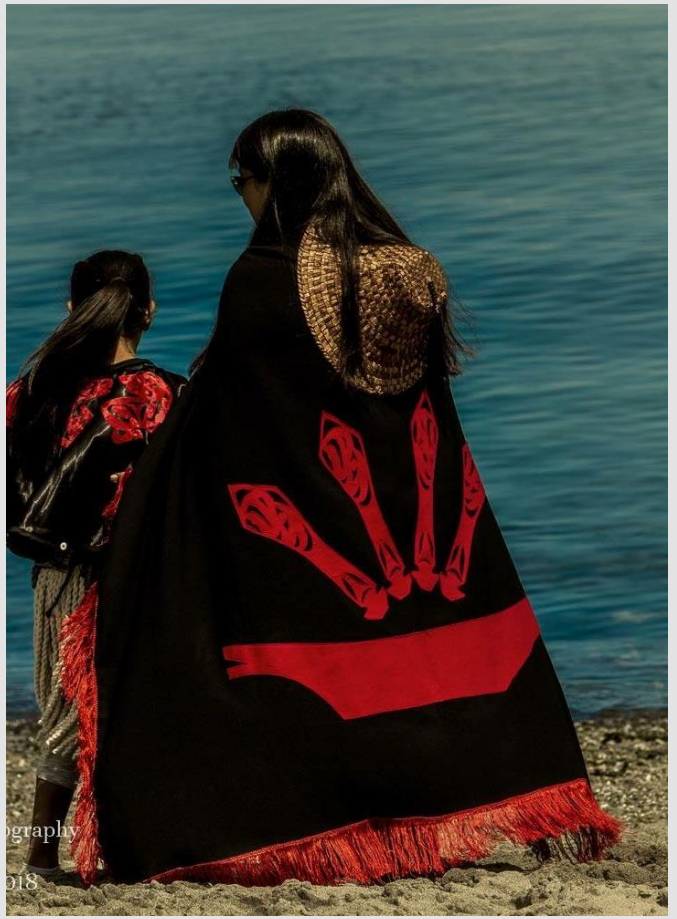
- We were able to schedule five (5) statewide virtual gatherings - Conversations About the Health of Native Pregnant, Birthing and Postpartum Women and People.
- We also convened five (5) statewide virtual meetings with Tribal and Urban Indian Health leadership for their input.
- **This resulted in Seven (7) leadership recommendations which informed the 2023 MMRP Report to the Legislature.**



PULLING TOGETHER FOR WELLNESS

COMMUNITY CONVERSATIONS - 2024-2025 Continuation

- We were able to schedule Community Conversations in person, resulting in **6 Tribal and Urban Indian gatherings**. Although the virtual gatherings were informative, the in-community gatherings are a culmination of a long-standing goal.
- The act of facilitating conversations in a participant's community is not only about gathering information, but also about **building relationships and trust that demonstrates and affirms the importance of community wisdom and values.**



PULLING TOGETHER FOR WELLNESS

COMMUNITY CONVERSATIONS
2024-25 CONVENINGS

- Participants were invited to share their insights and wisdom around 9 questions/issues regarding the full spectrum of maternal health, including maternal morbidity and mortality.
- It was humbling to hear very personal stories from participants about the most concerning obstacles, challenges, and injustices Tribal community members are dealing with.
- It was uplifting and inspiring to hear their brilliant insights about their home communities, community members, and families, as well as their ideas about ways to make their lives and the lives of people in their communities better.

PULLING TOGETHER FOR WELLNESS

FOCUSED ON COMMUNITY CONVERSATION RESULTS AND RECOMMENDATIONS

TRIBAL AND URBAN INDIAN LEADERSHIP RECOMMENDATIONS TO DOH AND THE LEGISLATURE

JULY 2025

PULLING TOGETHER FOR WELLNESS

2025 AIHC Maternal Mortality Recommendations to DOH and The Legislature

1. **Uphold Tribal Sovereignty** – this is fundamental for all issues related to Tribes, as it is the law of the land.
2. Prioritize elimination of Native Maternal Mortality until the disparity is eliminated.
3. Acknowledge that the Maternal Mortality of AI/AN birthing people is a crisis.
4. Work with DOH to change the review process to include pregnancy associated deaths for full examination in the review process by State MMRP.

PULLING TOGETHER FOR WELLNESS

2025 AIHC Maternal Mortality Recommendations to DOH and The Legislature

5. Continue efforts to facilitate discussions regarding MMR in each Tribal community and urban Indian community.
6. Align with Opioid/Fentanyl Response Taskforce efforts as they relate to maternal mortality and morbidity.
7. Explore development of Maternal Mental Health Behavior Health Aide provider type and a Maternal Health Support hotline.
8. Continue investment in the people who experience the highest level of impact of social determinants of health, the highest mortality rates, and are most affected by discrimination.

PULLING TOGETHER FOR WELLNESS

2025 AIHC Maternal Mortality Recommendations to DOH and The Legislature

9. Support the implementation of the Pulling Together for Wellness framework at the Tribal/UIHO level.
10. Support sustainable long-term implementation of the AI/AN PRAMS-like survey, State PRAMS survey, and ACEs questionnaire.
11. Assess provider training and education within state systems to understand gaps in knowledge base in working with Tribes and AI/AN people.
12. Utilize AIHC's MCHBG assessment data, Community Conversations data, other Tribally developed and led data sets for planning and policy development, in combination with the addendum recommendations.

PULLING TOGETHER FOR WELLNESS

2025 AIHC Maternal Mortality Recommendations to DOH and The Legislature

13. Continuously monitor the implications of recent federal actions and policy changes that impact State and Tribal funding, affecting AIAN health and wellness systems, structures, and supports.

14. Support the Washington State-administered Pregnancy Risk Assessment Monitoring Survey and Surveillance System (PRAMS), as well as the AIAN Pregnancy Resilience and Risk Assessment and Action Monitoring Surveillance System (AI/AN PRRAAMSS).

PULLING TOGETHER FOR WELLNESS

Seven Original Tribal/Urban Indian Leader Standing Recommendations from 2023 Addendum

1. Reduce Native Maternal Mortality until the disparity is eliminated
2. Culturally appropriate engagement and building trust is critical
3. Tribal-led data needs assessments, planning, administration and analysis, including PRAMS to address root causes and harm reduction
4. Address historical inequities and create trust in health transformation system change through policy, inclusion, and allocation of funds
5. Improve and expand access for culturally relevant services and resources
6. Funding, focus and prioritize support of Tribal-led workforce planning and development
7. Support and fund Tribal-led nutrition planning and development, such as Food Sovereignty and First Foods (breast-feeding

PULLING TOGETHER FOR WELLNESS

2025 AIHC Maternal Mortality Recommendations to DOH and The Legislature

- These recommendations are strong and important strategies in the work of improving AI/AN maternal, infant, and family health.
- It is important to note that although most of the Tribal/Urban Indian leader recommendations for the 2025 Addendum are new, **the original recommendations still stand as foundational recommendations and strategies, which need to be reviewed and considered when actions and projects are suggested**.
- The 14 new leadership recommendations reflect the rich detail of working face-to-face in the community, the work that has occurred in the last 2 years and the impacts of the current state and federal environment.
- The one original recommendation that is consistent in both is the 2023 and the 2025 AI/AN Addendum is “Prioritize reducing Native Maternal Mortality until the disparity is eliminated” with the addition of “as well as maintain this priority until it is achieved” in the 2025 report.

PULLING TOGETHER FOR WELLNESS

UPDATES ON 2023- 25 PROGRESS TO ADDRESS AI/AN MATERNAL MORTALITY

1. Reduce Native Maternal Mortality until the disparity is eliminated

1. There are several Tribal and Urban Indian grass roots organizations (versus Tribal Nations) who are conducting significant birth justice work in their communities.
2. AIHC is working on the AI/AN PRAMS Project to administer a unique AI/AN PRRAAMS survey. This is a Tribal-led project to address root causes.
3. AIHC Maternal Child Health Block Grant (MCHBG) needs assessment; was designed and implemented as a Tribal led project.
4. AIHC Community Conversations Project is gathering data on the health of Native PBP people.
5. AIHC MIH workgroup survey is gathering data on the needs/resources gap in Tribal and Urban Indian communities.
6. AIHC is gathering data about the feasibility of Tribal MMRP/C models and raising awareness of this effort to leadership and elders.
7. AIHC is conducting a study regarding the needs of AI/AN families utilizing WIC.

PULLING TOGETHER FOR WELLNESS

UPDATES ON 2023- 25 PROGRESS TO ADDRESS AI/AN MATERNAL MORTALITY

2. Culturally appropriate engagement and building trust

1. **AIHC is working on the AI/AN PRAMS Project to administer a unique AI/AN PRRAAMS survey. This is a Tribal-led project to address root causes.**
2. **AIHC is applying appropriate comprehensive strategies in engagement and trust building.**

PULLING TOGETHER FOR WELLNESS

UPDATES ON 2023- 25 PROGRESS TO ADDRESS AI/AN MATERNAL MORTALITY

3. Tribal-led data needs assessments, planning, administration, and analysis, including Tribal PRAMS and harm reduction strategies.

1. **AIHC is working on the AI/AN PRAMS Project to administer a unique AI/AN PRRAAMS survey. This is a Tribal-led project to address root causes.**
2. **AIHC MCHBG needs assessment; was designed and implemented as a Tribal led project.**
3. **AIHC Community Conversations Project is gathering data on the health of Native PBP people.**
4. **AIHC MIH workgroup survey is gathering data on the needs/resources gap in Tribal and Urban Indian communities.**

PULLING TOGETHER FOR WELLNESS

UPDATES ON 2023- 25 PROGRESS TO ADDRESS AI/AN MATERNAL MORTALITY

4. Address historical inequities and create trust in health transformation system change through policy, inclusion, and allocation of funds

1. **Tribes, Urban Indian Health leaders, AIHC, and legislative/state agency partners worked together to successfully pass the Traditional Indian Medicine Bill.**

PULLING TOGETHER FOR WELLNESS

UPDATES ON 2023- 25 PROGRESS TO ADDRESS AI/AN MATERNAL MORTALITY

5. Improve and expand access for culturally relevant services and resource

1. **Affiliated Tribes of Northwest Indians (ATNI) adopted the PTW framework and its 21 competencies by resolution as the policy of ATNI Conference in May.**
2. **AIHC's PTW framework is a culturally grounded policy, systems, or environmental change approach and introduces the concept of the Seven Generational Principle in Tribal and non-Tribal training.**
3. **Generational Clarity training is available through AIHC. The training addresses the impact of historical trauma and adverse childhood experiences on the health and well-being of AI/AN people. It includes the importance of both our authentic stories and the acknowledgment of the strength of our ancestors.**

PULLING TOGETHER FOR WELLNESS

UPDATES ON 2023- 25 PROGRESS TO ADDRESS AI/AN MATERNAL MORTALITY

6. Funding, focus and prioritize support of Tribal-led workforce planning and development

1. **Tribal, Urban Indian, and Indigenous Grass Roots organizations such as the Northwest Portland Area Indian Health Board, Hummingbird Indigenous Family Services, and the Center for Indigenous Midwifery are working on training.**
2. **AI/AN Community Health Aides and Behavioral Health Aides, Indigenous Doulas and Lactation Consultants, and Community Midwives and Childbirth Educators respectively.**

PULLING TOGETHER FOR WELLNESS

UPDATES ON 2023- 25 PROGRESS TO ADDRESS AI/AN MATERNAL MORTALITY

7. Support and fund Tribal-led nutrition planning and development, such as Food Sovereignty and First Foods (breast-feeding

1. **AIHC has sponsored a Food Sovereignty Speaker Series for two years based on feedback from Tribal communities. The series has had inspirational and captivating AI/AN experts to address topics like kinship and reciprocity with our environmental and cultural resources, first foods, access to traditional foods and medicines, nutrition, sacred tobacco, addressing hunger in tribal settings, cultivating gardens, harvesting, meal preparation, and more.**

PULLING TOGETHER FOR WELLNESS

2025 AIHC Maternal Mortality Recommendations to DOH and The Legislature

See the full 2025 American Indian Health Commission Addendum, including:

- Twenty (20) updates and actions in response to the 2023 AI/AN Leadership
- Tribal Program Highlight: Suquamish Tribe Changing Tides, Helping Hands Home Visiting Program
- Tribal/Urban Indian Leaders' Recommendations to improve the health of Native pregnant, birthing and postpartum women and people

JanMarie Ward, MPA
Sr Public Health Policy and Program Advisor
janolmstead@gmail.com

Cindy Gamble, MPH
Public Health Consultant
csgamble5@gmail.com

Visit our website for more info on our public health programs, including Maternal and Family Health:

PULLING TOGETHER FOR WELLNESS

Gunalcheesh, Kaqinalin, Thank you!

For more information:

AIHC Website: aihc-wa.com

JanMarie Ward, MPA
Sr Public Health Policy and Program Advisor
janolmstead@gmail.com

Cindy Gamble, MPH
Public Health Consultant
csgamble5@gmail.com

Visit our website for more info on our public health programs, including Maternal and Family Health:

PULLING TOGETHER FOR WELLNESS

CHANGES TO IMMUNIZATION & Q/A

Jamilia Sherls, Office of Immunization

Office of Immunization

Washington State Department of HEALTH

Washington State Department of HEALTH

DOH Office of Immunization Updates

January 14, 2026

Agenda

- Washington DOH Hepatitis B recommendations following ACIP December vote
- January 5, 2026 HHS/CDC Childhood Immunization Schedule revisions
    - What changed: a closer look
- What this means
- Washington DOH and West Coast Health Alliance (WCHA) recommendations
- Public Health resources and support

DOH and Partner Alliances

The Washington State Department of Health (DOH) and the West Coast Health Alliance (WCHA) are closely monitoring rapidly evolving federal developments and are committed to transparency as updates arise. DOH will continue to keep Tribes and partners informed.

DOH is actively collaborating with immunization-related alliances, committees, and boards at both the regional and national levels to align strategy and response.

Office of Immunization

Washington State Department of HEALTH

WA DOH Hepatitis B Vaccine Recommendation

The Washington State Department of Health (DOH) continues to recommend:

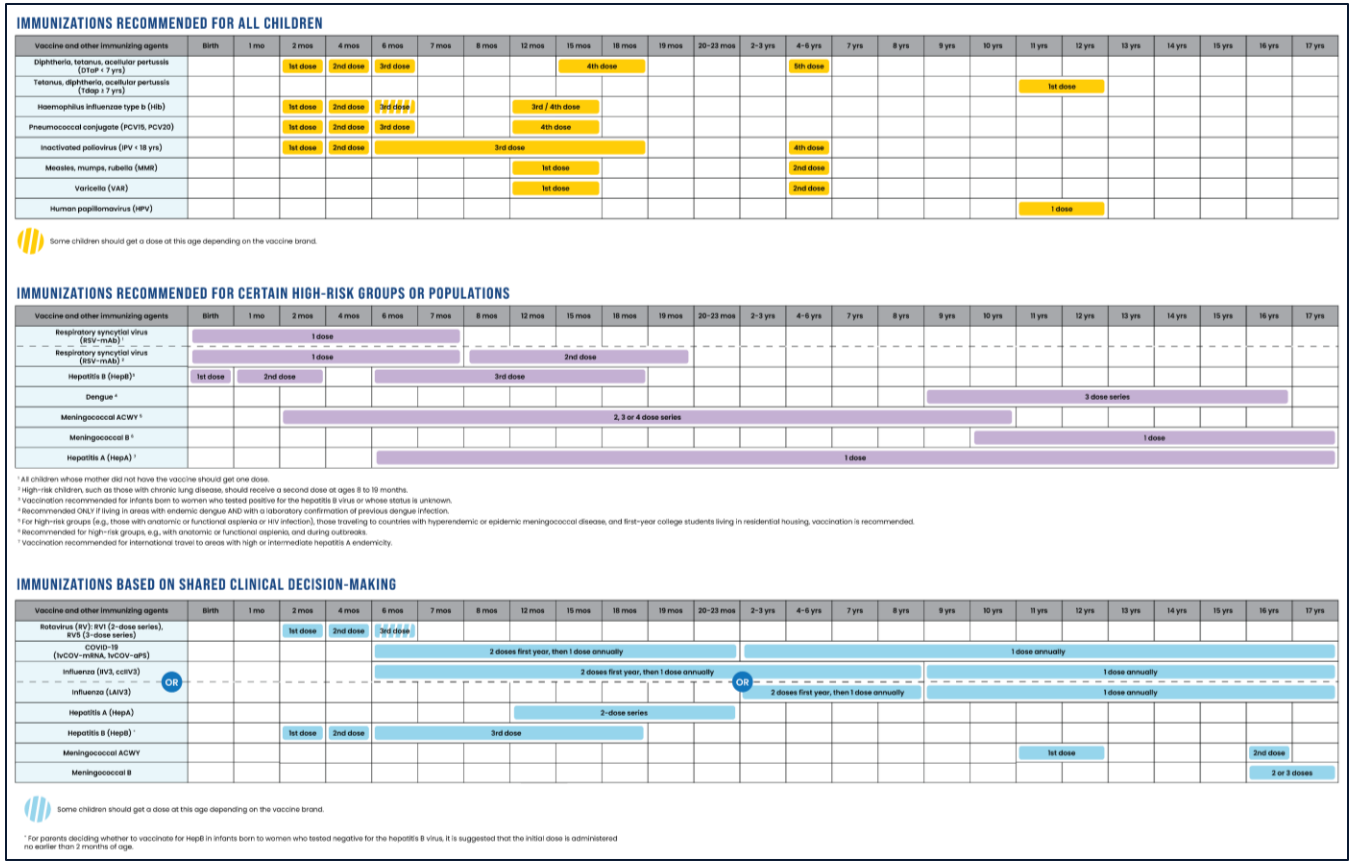
- All newborns receive the hepatitis B vaccine within 24 hours of birth, with completion of the 3 to 4 dose series by 18 months of age, regardless of the birth parents' hepatitis B infection status.
- Newborns of birth parents who test positive for hepatitis B infection or have an unknown status receive hepatitis B vaccine and hepatitis B immunoglobulin within 12 hours of birth.
- For infants born to a parent who is hepatitis B-positive, perform perinatal post-vaccination serologic testing 1-2 months after vaccine series completion, but not before 9 months of age.

This recommendation aligns with recommendations from the West Coast Health Alliance and leading national organizations, including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Infectious Diseases Society of America.

Routine birth-dose vaccination, recommended since 1991, has contributed to a 99% reduction in annual hepatitis B infections and has prevented more than 500,000 childhood infections and an estimated 90,100 childhood deaths.

Read our blog: Why the Hepatitis B Vaccine Birth Dose Matters on Public Health Connection (Spanish version available).

HHS Changes to the Childhood Immunization Schedule



IMMUNIZATIONS RECOMMENDED FOR ALL CHILDREN

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	7 mos	8 mos	12 mos	15 mos	18 mos	19 mos	20–23 mos	2–3 yrs	4–6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Diphtheria, tetanus, acellular pertussis (DTaP < 7 yrs)			1st dose	2nd dose	3rd dose				4th dose					5th dose											
Tetanus, diphtheria, acellular pertussis (Tdap ≥ 7 yrs)																			1st dose						
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	3rd dose			3rd / 4th dose																	
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose			4th dose																	
Inactivated poliovirus (IPV < 18 yrs)			1st dose	2nd dose	3rd dose									4th dose											
Measles, mumps, rubella (MMR)								1st dose						2nd dose											
Varicella (VAR)								1st dose						2nd dose											
Human papillomavirus (HPV)																			1 dose						

Some children should get a dose at this age depending on the vaccine brand.

IMMUNIZATIONS RECOMMENDED FOR CERTAIN HIGH-RISK GROUPS OR POPULATIONS

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	7 mos	8 mos	12 mos	15 mos	18 mos	19 mos	20–23 mos	2–3 yrs	4–6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Respiratory syncytial virus (RSV–mAb) [1]	1 dose																								
Respiratory syncytial virus (RSV–mAb) [2]		1 dose						2nd dose																	
Hepatitis B (HepB) [3]	1st dose		2nd dose		3rd dose																				
Dengue [4]																	3 dose series								
Meningococcal ACWY [5]			2, 3 or 4 dose series																						
Meningococcal B [5]																			1 dose						
Hepatitis A (HepA) [7]					1 dose																				

[1] All children whose mother did not have the vaccine should get one dose.
[2] High-risk children, such as those with chronic lung disease, should receive a second dose at ages 8 to 19 months.
[3] Vaccination recommended for infants born to women who tested positive for the hepatitis B virus or whose status is unknown.
[4] Recommended ONLY if living in areas with endemic dengue AND with a laboratory confirmation of previous dengue infection.
[5] For high-risk groups (e.g., those with anatomic or functional asplenia or HIV infection), those traveling to countries with hyperendemic or epidemic meningococcal disease, and first-year college students living in residential housing, vaccination is recommended.
[6] Recommended for high-risk groups, e.g., with anatomic or functional asplenia, and during outbreaks.
[7] Vaccination recommended for international travel to areas with high or intermediate hepatitis A endemicity.

IMMUNIZATIONS BASED ON SHARED CLINICAL DECISION-MAKING

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	7 mos	8 mos	12 mos	15 mos	18 mos	19 mos	20–23 mos	2–3 yrs	4–6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	3rd dose																				
COVID-19 (tvCOV-mRNA, tvCOV-aPS)					2 doses first year, then 1 dose annually									1 dose annually											
Influenza (IIV3, ccIIV3) OR Influenza (LAIV3)					2 doses first year, then 1 dose annually								OR	2 doses first year, then 1 dose annually			1 dose annually								
Hepatitis A (HepA)								2-dose series																	
Hepatitis B (HepB) [1]			1st dose	2nd dose	3rd dose																				
Meningococcal ACWY																			1st dose					2nd dose	
Meningococcal B																								2 or 3 doses	

Some children should get a dose at this age depending on the vaccine brand.

[1] For parents deciding whether to vaccinate for HepB in infants born to women who tested negative for the hepatitis B virus, it is suggested that the initial dose is administered no earlier than 2 months of age.

U.S. childhood immunization schedule overhauled

The Trump administration is overhauling long-standing vaccine recommendations to align with other countries. Several vaccines that are now broadly recommended for children are limited to high-risk groups or in consultation with doctors.

VACCINE	REVISED RECOMMENDATION
MMR	Still routinely recommended
Polio	Still routinely recommended
Chicken pox	Still routinely recommended
DtAP	Still routinely recommended
Tdap	Still routinely recommended
Hib	Still routinely recommended
PCV	Still routinely recommended
HPV	Still routinely recommended
RSV	High risk groups only
Hepatitis A	High risk groups only
Hepatitis B	High risk groups only
Meningococcal ACWY	High risk groups only
Dengue	Still for high risk groups only
Influenza	No longer routinely recommended
Covid	No longer routinely recommended
Rotavirus	No longer routinely recommended

Covid vaccine recommendation was previously changed in the fall. Officials are also recommending one HPV vaccine dose instead of two.

Source: Department of Health and Human Services

FENIT NIRAPPIL / THE WASHINGTON POST

HHS Press Releases issued January 5, 2026

- CDC Acts on Presidential Memorandum to Update Childhood Immunization Schedule | HHS.gov
- Fact Sheet: CDC Childhood Immunization Recommendations | HHS.gov

What Changed: A Closer Look

Vaccine-Preventable Disease	AAP Recommendations	Changes in Recommendation
HPV (Human papillomavirus) Contagious viral infection spread by close skin-to-skin touching, including during sex	For all adolescents, 2 doses • dose one: starting at age 9 • dose two: 6 months later	1 Dose instead of 2, but still recommended for all children
RSV (Respiratory syncytial virus) Contagious viral infection of the nose, throat, and sometimes lungs; spread through air and direct contact	Recommended for all babies under 8 months of age	High Risk Groups Only
Hepatitis A Contagious viral infection of the liver; spread by contaminated food or drink or close contact with an infected person	2-dose series: 12–23 months of age	High Risk Groups Only
Hepatitis B Contagious viral infection of the liver; spread through contact with infected body fluids such as blood or semen	Birth	High Risk Groups Only *suggested to be given starting at 2 months of age
Meningococcal ACWY Contagious bacterial infection of the lining of the brain and spinal cord or the bloodstream; spread through air and direct contact	For all adolescents, 2 doses • dose one: starting at age 9 • dose two: 6 months later	High Risk Groups Only

What Changed: A Closer Look

Vaccine-Preventable Disease	AAP Recommendations	Changes in Recommendation
Influenza (Flu) Contagious viral infection of the nose, throat, and sometimes lungs; spread through air and direct contact	6 months of age, minimum	No longer routinely recommended / Shared Clinical Decision-Making
COVID-19 Contagious viral infection of the nose, throat, or lungs; may feel like a cold or flu. Spread through air and direct contact	6 months of age, minimum	No longer routinely recommended / Shared Clinical Decision-Making
Rotavirus Contagious viral infection of the gut; spread through the mouth from hands and food contaminated with stool	6 weeks of age, minimum	No longer routinely recommended / Shared Clinical Decision-Making

Sources:

- American Academy of Pediatrics (AAP) Recommended Child and Adolescent Immunization Schedule
- Childhood Immunization Schedule by Recommendation Group | HHS.gov

What Does This Mean?

- Changes in the newly released recommended immunization schedule are not based on new evidence about vaccine safety or effectiveness.
  - The revisions were driven by a comparison of the number of routine vaccines recommended in the U.S. versus select other countries, without accounting for differing health systems, disease burden, or access to care.
  - The changes were not reviewed by medical or public health experts, health care providers, or the public prior to release.
- **Insurance coverage is not expected to change this plan year.**
  All child and adolescent vaccines recommended as of December 31, 2025, will continue to be available and covered by public and private insurers.

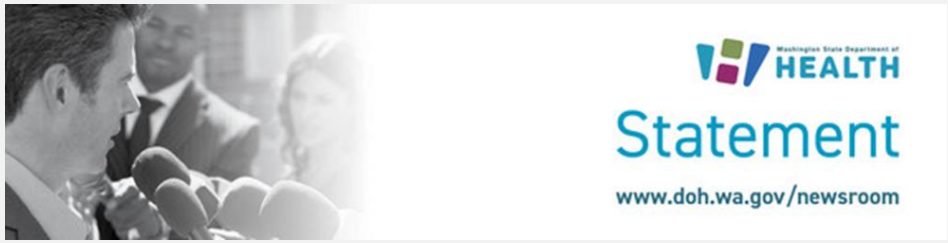
WA DOH and WCHA Reaffirm Alignment with AAP Child and Adolescent Immunization Schedule

Vaccines save lives.

The WCHA and WA DOH reaffirm alignment with the American Academy of Pediatrics (AAP) Recommended Child and Adolescent Immunization Schedule.

Read:

- The WCHA Press Release, January 5, 2026
- The WA DOH Press Release, January 5, 2026



American Academy of Pediatrics

Child and Adolescent Immunization Schedule

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

These recommendations must be read with the Notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the outlined purple bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine and other immunizing agents	Birth	1 mos	2 mos	4 mos	6 mos	8 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Respiratory syncytial virus (RSV-mAb [nirsevimab, clesrovimab])	1 dose during RSV season depending on maternal RSV vaccination status (See Notes)					1 dose nirsevimab during RSV season (See Notes)												
Hepatitis B (HepB)	1st dose	2nd dose			3rd dose													
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes													
Diphtheria, tetanus, and acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose				4th dose				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes			3rd or 4th dose (See Notes)										
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose			4th dose										
Inactivated poliovirus (IPV)			1st dose	2nd dose	3rd dose								4th dose					See Notes
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)					1 or more doses of 2025–2026 vaccine (See Notes)							1 dose of 2025–2026 vaccine (See Notes)						
												1 dose of 2025–2026 vaccine (See Notes)						
Influenza					1 or 2 doses annually (See Notes)										1 dose annually (See Notes)			
Measles, mumps, and rubella (MMR)					See Notes			1st dose					2nd dose					
Varicella (VAR)								1st dose					2nd dose					
Hepatitis A (HepA)					See Notes			2-dose series (See Notes)										
Tetanus, diphtheria, and acellular pertussis (Tdap ≥7 yrs)															1st dose			
Human papillomavirus (HPV)															2-dose series	See Notes		
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes												1st dose		2nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)															See Notes			
Respiratory syncytial virus vaccine (RSV [Abrysvo])															Seasonal administration during pregnancy if not previously vaccinated			
Dengue (DEN4CYD: 9–16 yrs)															Seropositive in areas with endemic dengue (See Notes)			
Mpox																		

Range of recommended ages for all children

Range of recommended ages for catch-up vaccination

Range of recommended ages for certain high-risk groups or populations

Recommended vaccination for those who desire protection

Recommended vaccination based on shared clinical decision-making

Washington DOH Respiratory Virus Immunization Recommendations

Age/Condition	COVID-19	Influenza	RSV
Children	• All 6-23 months • All 2-18 years with risk factors or never vaccinated against COVID-19 • All who are in close contact with others with risk factors[1] • All who choose protection[1]	• All 6 months and older	• All younger than 8 months[2] • All 8-19 months with risk factors
Pregnancy	• All who are planning pregnancy, pregnant, postpartum or lactating	• All who are planning pregnancy, pregnant, postpartum or lactating	• 32-36 weeks gestational age[2]
Adults	• All 65 years and older • All younger than 65 years with risk factors • All who are in close contact with others with risk factors • All who choose protection	• All	• All 75 years and older • All 50-74 years with risk factors

Read: West Coast Health Alliance announces vaccine recommendations for COVID-19, flu, and RSV | Washington State Department of Health

Need Public Health Information or Support?

- Visit the Washington State Department of Health (DOH) website for trusted public health information.
- Sign up for WA DOH newsletters for timely updates.
- Follow WA DOH on social media: Facebook, Threads, Instagram, Bluesky, and TikTok.
- Contact your Local Health Jurisdiction (LHJ) for public health information and resources in your community.
- For immunization-related questions, email OI@doh.wa.gov
- Explore immunization tools and materials in the Vaccine Confidence Resource Library on the DOH website.

NEXT MEETING: Feb. 11

FOCUS:
Sec. Dennis Worsham will share his 100-day listening session and plans for the year

VISIT:
https://waportal.org/partners/community-collaborative

"Only when it is dark enough can you see the stars."

—Martin Luther King, Jr.

THE **COMMUNITY** COLLABORATIVE

Washington State Department of HEALTH

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.