Department of Children & Youth

OHIO COUNCIL TO ADVANCE MATERNAL HEALTH NEWSLETTER

AUGUST 2024

OH-CAMH

Lead Partner Support (LPS) Tool Meetings (OH-CAMH)

Beginning in August we will host monthly meetings designed to assess OH-CAMH's strategic plan progress to date and current activities of OH-CAMH strategies. We will do so by facilitating completion of the Lead, Partner, Support (LPS) Tool shared during the April meeting. This tool will also assist in identifying stakeholders and clarifying the roles of OH-CAMH members.

If you missed April's meeting or are interested in a refresher of the LPS Tool, you can watch a recording of the meeting **here**. LPS Tool content begins at 31:06. A demo of the tool begins at 36:00.

Calendar invites will be sent in response to RSVP responses.

Please RSVP by Friday, August 16th.

Thursday, August 22nd **1:00-2:30PM**	**Strategy 7:** Promote organizational shifts in culture that support a trauma responsive approach to clinical and public health services. **Strategy 8:** Invest in maternal mental health services. **Strategy 9:** Invest in services for maternal substance use and mental health disorders.
Monday, September 16th **1:00-2:30PM**	**Strategy 1:** Implement provider education and accountability. **Strategy 3:** Diversify the racial/ethnic and professional makeup of the perinatal workforce. **Strategy 10:** Increase multidisciplinary communication and collaboration between clinical care providers, community-based organizations, and public health service organizations.
Thursday, October 10th **12:30-2:00PM**	**Strategy 4:** Expand access to post-partum health insurance coverage. **Strategy 6:** Improve data collection and quality measures to further examine the maternal health crisis and inform solutions.
Thursday, November 14th **1:00-2:30PM**	**Strategy 2:** Redesign and prioritize funding for community-based organizations. **Strategy 5:** Institutionalize evidence-based quality improvement interventions to improve maternal safety processes. **Strategy 11:** Improve access to health education for pregnant and parenting individuals to improve health outcomes.

We look forward to your participation and contributions!

Perinatal Mental Health Screening and Protocol: A Culturally Responsive Framework for Screening with Black Women

Black birthing women are at a higher risk for perinatal depression and anxiety and are less likely to have their symptoms addressed with quality, responsive care. However, mental health screening providers have not yet been resourced with mental health screening and referral guidelines that consider the cultural contexts and lived experiences of Black communities in Ohio.

This framework for culturally responsive screening - a project of the Screening and Identification Strategic Area Action Team of the Ohio Perinatal Mental Health Task Force - was created in collaboration with Black birthing women, Black birth workers, perinatal service providers throughout Ohio, Karen Sheffield-Abdullah, PhD, RN, CNM, and the POEM Program of Mental Health America of Ohio. A literature review and primary data from focus groups and interviews with Black birthing women and birth workers/clinicians also informed recommendations.

Resources include the full protocol and briefing and a OPMH Task Force branded one-page and an unbranded one page resource for those who may deliver a mental health screening to Black birthing women. These resources are free, publicly accessible, and can be distributed at your organization.

Please contact Raquel Williams at rwilliams@mhaohio.org with questions or comments about this protocol.

Maternal Health Data and Reports

In the month of May three reports were released detailing national maternal mortality data:

- Data from the National Vital Statistics System
- Data from the Pregnancy Mortality Surveillance System
- Data from Maternal Mortality Review Committees in 38 States

While all three reports use different sources and measures for maternal mortality, the importance of the work to identify, understand, and prevent maternal mortality remains unchanged. Due to the differences between these data systems, we cannot compare rates across sources. The Ohio Pregnancy-Associated Mortality Review (PAMR) Committee is Ohio's Maternal Mortality Review Committee (MMRC), and all Ohio maternal mortality data comes from PAMR. Please see the graphic below as well as the attached resource from the CDC for a breakdown of how each data source measures maternal mortality and what we can learn and interpret from each data source.

Maternal Mortality Information Systems at a Glance[2]

	NVSS	PMSS	MMRCs
Identifies causes of death during pregnancy and up to **42 days after**	✓	✓	✓
Identifies causes of death during pregnancy and **up to one year after**		✓	✓
Uses **death records**	✓	✓	✓
Uses **fetal death and birth records**		✓	✓
Uses **sources** such as medical records, social service records, autopsies, and informant interviews			✓
Determines if a death was **preventable**			✓
Provides information on maternal mortality at the **national level**	✓	✓	
Provides information on national **maternal mortality disparities**	✓	✓	
Provides information at the **state and local level**	✓		✓
Identifies **nonmedical contributing factors**			✓
Provides specific **recommendations for prevention**			✓

Comparison of Information Systems

Information System	Based on	Purpose
National Vital Statistics System (NVSS)[4, 5]	► **Death records** To assign International Classification of Diseases (ICD) codes, which identify maternal deaths among deaths that occurred **during pregnancy and up to 42 days after**	Provides information about national trends and characteristics of maternal deaths, including maternal mortality rates Cause of death coding that aligns with the World Health Organization definition of a maternal death
Pregnancy Mortality Surveillance System (PMSS)[6]	► **Death records** ► **Any linked birth records or fetal death records** To review and determine pregnancy relatedness among deaths **during pregnancy and up to one year after**	Provides information about national trends and characteristics of pregnancy-related deaths, including pregnancy-related mortality ratios
State and local Maternal Mortality Review Committees (MMRCs)[1]	► **Death records** ► **Any linked birth records or fetal death records** ► **Medical records** ► **Social service records** ► **Autopsies** ► **Informant interviews** To review deaths, determine pregnancy relatedness, and identify prevention recommendations within the state and local context among deaths **during pregnancy and up to one year after**	Provides information about pregnancy-related deaths at the state or local level, and can be combined across jurisdictions Pinpoints specific factors contributing to deaths Determines if deaths are preventable Provides tangible prevention recommendations

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Compelling Clicks

The Maternal Health Learning and Innovation Center (MHLIC) Resource Center

MHLIC serves as a national hub to connect maternal health learners with maternal health “doers” across the country, cataloging and disseminating best practices related to maternal health improvement. To find resources related to maternal health such as webinars, toolkits, and much more visit the MHLIC Resource Center website.

2024 Black Maternal Health Conference Training Institute

Registration for the 2024 Black Maternal Health Conference and Training Institute (BMHC24) is NOW OPEN! Join the Black Mamas Matter Alliance on September 12-14, 2024, at the official global assembly for Black Maternal health, equity, scholarship, innovation, policy, and advocacy work, projects, practice, and initiatives.

About the Information from Maternal Mortality Review Committees

Maternal Mortality Review Committees (MMRCs) identify specific factors contributing to pregnancy-related deaths and determine if the deaths were preventable. MMRCs look at pregnancy-related deaths at the local and state level.[1] There are two main systems of information on maternal mortality at the national level: the National Vital Statistics System (NVSS) and the Pregnancy Mortality Surveillance System (PMSS).

We cannot directly compare NVSS, PMSS, and MMRC information. While they are all trusted resources, they use different information to create their data, and they serve different purposes.[2, 3]

NVSS and PMSS do not uncover the whole story of each death like MMRCs. NVSS solely uses information from death records to identify medical causes of death, which do not include enough detail to understand the circumstances of each death. PMSS uses death records, with additional detail from any birth or fetal death records that link to a death record, to identify medical factors linked to these deaths. PMSS does not provide enough detail to fully understand the circumstances of each death. MMRCs use medical and nonmedical sources to understand the range of factors that contributed to a death. From this information, MMRCs recommend actions that can make a difference.[2]

Because of the depth and breadth of the MMRC process, MMRCs are the gold standard for identifying and describing pregnancy-related deaths.

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Determines if a death was **preventable**			✓
Provides information on maternal mortality at the **national level**	✓	✓	
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Identifies **nonmedical contributing factors**			✓
Provides specific **recommendations for prevention**			✓

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References

[1] Centers for Disease Control and Prevention. Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). Accessed April 30, 2024. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html

[2] St Pierre A, Zaharatos J, Goodman D, Callaghan WM. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. *Obstet Gynecol*. 2018;131(1):138-142.

[3] Trost SL, Beauregard J, Petersen EE, Cox S, Chandra G, St Pierre A, Rodriguez M, Goodman D. Identifying Deaths During and After Pregnancy: New Approaches to a Perennial Challenge. Public Health Rep. 2023 Jul-Aug;138(4):567-572. Epub 2022 Jul 23. PMID: 35872654; PMCID: PMC10291162.

[4] National Center for Health Statistics. Maternal Mortality. Accessed April 30, 2024. https://www.cdc.gov/nchs/maternal-mortality/index.htm

[5] Hoyert DL. Maternal mortality and related concepts. Vital Health Stat 3. 2007 Feb;(33):1-13. PMID: 17460868.

[6] Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. Accessed April 30, 2024. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

For more information on CDC's Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) initiative and MMRCs, visit **cdc.gov/ERASEMM**.

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ERASE MM Enhancing Reviews and Surveillance to Eliminate Maternal Mortality