Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

News Release

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Contact: ODH Office of Communications (614) 644-8562

ODH Awarded $12 Million in Federal Grants to Address Maternal Mortality in Ohio

ODH releases first comprehensive report on pregnancy-associated maternal deaths

COLUMBUS – The Ohio Department of Health (ODH) has been awarded $12 million in federal funding to address maternal mortality across the state. The grants coincide with ODH's release of Ohio's first comprehensive report on pregnancy-associated maternal deaths. The report identifies statewide trends in pregnancy-associated and pregnancy-related maternal deaths from 2008-2016 and provides recommendations to prevent maternal mortality.

A pregnancy-"associated" death is defined as the death of a woman while pregnant or anytime within one year of pregnancy regardless of cause. A pregnancy-"related" death is defined as the death of a woman while pregnant or within one year of pregnancy from any cause related to or aggravated by the pregnancy or management, excluding accidental or incidental causes. According to the U.S. Health Resources and Services Administration (HRSA), the rate of pregnancy-related maternal deaths in the U.S. has more than doubled since 1987, and the agency is funding state efforts across the U.S. to address this issue.

HRSA recently announced that ODH will receive approximately $10 million over the next five years to support maternal mortality prevention efforts. The funding will be used to establish a maternal health task force and create and implement a plan to prevent and reduce preventable maternal deaths. It will also fund efforts to support translating findings from maternal mortality review to action by implementing data-driven strategies. In addition, the U.S. Centers for Disease Control and Prevention (CDC) has awarded ODH a $2.2 million grant over five years to continue the work of the agency's Pregnancy-Associated Mortality Review (PAMR) program.

"The ODH PAMR program was developed in 2010 to identify and review pregnancy-associated deaths with the goal of developing interventions to reduce maternal mortality, particularly for preventable pregnancy-related deaths," said ODH Director Amy Acton, MD, MPH. "There is more that we can, and must, do to prevent maternal deaths in Ohio."

The new ODH report summarizes key findings from 186 pregnancy-related deaths of Ohio women that occurred between 2008-2016. Key findings included:

- The leading underlying causes of pregnancy-related deaths included heart conditions, infections, severe bleeding, and pre-eclampsia and eclampsia.
- 57% of the pregnancy-related deaths from 2012-2016 could have been prevented.
- The number of pregnancy-related deaths ranged from a high of 34 deaths in 2009 to 15 deaths in 2014.
- Ohio women died from pregnancy-related causes at a ratio of 14.7 per 100,000 live births during the 2008-2016 timeframe.
- Ohio's pregnancy-related mortality ratio of 11.6 in 2016 (the most recent state data available) was significantly lower than the U.S. ratio of 17.2 in 2015 (the most recent national data available).
- Black women are more than two-and-a-half times more likely to die of a pregnancy-related condition than white women.

“We are very thankful for the volunteer members of our Pregnancy-Associated Mortality Review Committee who represent many disciplines and who have dedicated years of service to produce the data represented in this report,” said Dr. Acton.

Ohio has been an early adopter of strategies being advocated at the national level through CDC and the Association of Maternal & Child Health Programs (AMCHP) while also serving as a resource for other states as they set up their own maternal mortality review committees.

“In the near decade that we’ve partnered with the Ohio Department of Health through the *AMCHP Every Mother Initiative and the Building U.S. Capacity to Review and Prevent Maternal Deaths* program, we’ve come to know them as an early adopter of innovation, dedicated to rigorous data quality, and eager to share their learnings with the community of maternal mortality review committees,” said AMCHP Chief Executive Officer Jonathan Webb, MPH. “All of this is fueled by an ever-present urgency to translate findings from the committee into preventing maternal mortality for Ohio’s women, children, families, and communities.”

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NOTE TO NEWS MEDIA – The complete ODH “Report on Pregnancy-Associated Deaths in Ohio 2008-2016” is available here.