State Maternal Health Innovation Program
Expanded Maternal Health Annual Report Guidance
OMB Control No. 0906-XXXX

Public Burden Statement: The State Maternal Health Innovation (State MHI) program Maternal Health Annual Report (MHAR) will monitor grantee's progress in accessing, analyzing, and using state-level maternal health data and to summarize the data focused work that grantees accomplish. The purpose of the State MHI program is to reduce maternal mortality and severe maternal morbidity (SMM) by improving access to care that is comprehensive, high-quality, appropriate, and on-going throughout the preconception, prenatal, labor and delivery, and postpartum periods; enhancing state maternal health surveillance and data capacity; and identifying and implementing innovative interventions to improve outcomes for populations disproportionately impacted by maternal mortality and SMM. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0906-XXXX and it is valid until XX/XX/202X. This information collection is required to obtain or retain a benefit (42 U.S.C. § 701(a)(2) (Title V, § 501(a)(2) of the Social Security Act), Data will be private to the extent permitted by the law. Public reporting burden for this collection of information is estimated to average 12 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Information Collection Clearance Officer, 5600 Fishers Lane, Room 14NWH04, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please see https://www.hrsa.gov/about/508-resources for the HRSA digital accessibility statement.

<u>Maternal Health Annual Report Introduction:</u>

The State Maternal Health Innovation Program (State MHI) launched in 2019 to reduce maternal mortality and severe maternal morbidity (SMM) by supporting state-led demonstrations focused on improving maternal health and addressing maternal health disparities through quality services, a skilled workforce, enhanced data quality and capacity, and innovative programming. This program also engages public health professionals, providers, payers, and consumers through state-led Maternal Health Task Forces (MHTF). These Task Forces review state-specific maternal health data then implement evidence-based interventions and innovations that address critical gaps in service delivery.

The purpose of the Maternal Health Annual Report (MHAR), otherwise referred to as the Annual Report on Maternal Health in the Notice of Funding Opportunity (NOFO), is to document and report state-level data on maternal health indicators, evaluate existing disparities in the data, and link data to innovation activities.

In accordance with the requirements of the NOFO, a MHAR is collected every year of the grant either through an Expanded MHAR or through an Interim MHAR. The Interim MHAR will be included in the NCC Progress Report. The following guidance details the requirements of the Expanded MHAR.

Instructions for submission:

- The MHAR is due ***(due date)*** and must be uploaded in HRSA's Electronic Handbooks (EHBs). Project Officers will create a placeholder in the EHBs prior to the due date.
- Narrative information can be uploaded as a Word document or PDF. <u>We recommend using the headings below and clearly labeling all sections. If your MHAR does not use the headings below, we suggest providing a crosswalk to compare the required elements with your MHAR sections.</u>
- Data requested in Section 5 must be submitted (and uploaded in the EHBs) as an Excel document using the MHAR Data Table provided.

Narrative Information

1) **Key Data Findings and Contributing Factors (include a note about the timeframe of data used for each component)**
   a) Describe the leading causes of pregnancy-related deaths in the state. Describe how you obtained this information (for example, through the state's Maternal Mortality Review Committee (MMRC) or another mechanism that conducts maternal health data surveillance).
   b) Describe the State MHI program's relationship with the state MMRC.
   c) Report on key contributing factors that may be associated with the leading causes of pregnancy-related deaths in the state. Potential categories for consideration include workforce shortages, social determinants of health, access to maternity care, lack of education (providers, birthing people, families), and existing policies. The Maternal Mortality Review Information Application (MMRIA) contributing factor classes[1] can be used for the narrative in this section.
   d) Describe factors that contribute to SMM within the state, including the SMM rate, the SMM definition used (and specifically whether the state includes blood transfusions alone in the SMM definition), and how the state has approached identification and analysis of SMM.
   e) Please describe populations in the state disproportionately affected by maternal mortality or other maternal health factors. Examples may include race, geographic residence (e.g., rural, urban), or any other population characteristic that is relevant in your state's context.
   f) Describe what measures have been most important in evaluating your innovations for State MHI and what data sources you use.

2) **Linking Data to Action**
   a) Describe how your State MHI activities are aligned with recommendations from your state MMRC (if applicable) and Title V programs (for example, outcome measures, State Action Plan, etc.)
      i) Where applicable, please highlight MMRC recommendations that are being implemented to reach and/or consider the needs of populations disproportionately affected by pregnancy-related mortality in your state.
   b) Describe the action(s) the Task Force has taken to review state-specific maternal health data and implement evidence-based interventions or innovations.
   c) Describe how you use state-level maternal health data to inform your State MHI innovation activities.

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[1] See Page 6 (Appendix B. Contributing Factor Descriptions) of the MMRIA MMRC Decisions Form for Contributing Factor Descriptions: https://reviewtoaction.org/sites/default/files/2024-02/mmria-form-v23-fillable.pdf

3) **Improvements to Maternal Health Data Collection & Analysis**
   a) Highlight any improvements to the collection, access, analysis, and use of state-level data on pregnancy-related mortality and SMM within the reporting period ==*(reporting period start date – reporting period end date*==).
   b) Describe any improvements in data quality and analysis of social determinants of health and race and ethnicity data.

4) **Sharing Data**
   a) Briefly describe how the program has shared the results of the state's maternal health data analyses during the reporting period ==*(reporting period start date – reporting period end date)*== such as publications, presentations, and other activities, including those in partnership with the state Perinatal Quality Collaborative (PQC), MMRC, or other entities, if applicable. Include the types of audiences it has been shared with and whether it has been shared publicly or internally.

MHAR Data Table

5) **State Maternal Health Data**
   a) Report on maternal health measures at the state level to include the total number of live births, total number of pregnancy-related deaths, percent of live births where the mother had health insurance, rate of low-risk cesarean birth, percent of women who received a postpartum visit, and percent of women screened for postpartum depression. A table is provided at the end of this document (Table A) with additional information (data definitions and sources), where applicable.
      i) Please use calendar year (CY) ==(reporting year)== data for live birth data and the PRAMS measures and CY ==(PRAMS year)== data for pregnancy-related deaths. If the data are not available for the requested timeframe for a measure, include the most recently available data and a note explaining why a different time period was used. Be sure to indicate the data source and calendar year for each measure. Additional notes can be provided where necessary.
      ii) All data should be presented as a total number and/or percentages, including numerators and denominators where applicable. Data should reflect **state of residence**, if possible. Data should be disaggregated by maternal age, race/ethnicity, level of education, and geography, as appropriate. Please note if you are unable to disaggregate the data by any of the requested categories.
      iii) Use the MHAR Data Table as the format for reporting the data. Upload the completed MHAR Data Table in the EHBs.

Table A: *The information in this table is also included as a worksheet in the MHAR Data Table Excel document for ease of reference.*

Measure	Definition	Source	Numerator	Denominator
Total number of live births	Total number of live births	Live birth certificate	Total number of live births	N/A
Total number of pregnancy-related deaths	A death during or within **one year** of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the	MMRIA[ii]/MMRC (if MMRIA/MMRC not available, use PMSS[iii])	Total number of pregnancy-related deaths	N/A

	physiologic effects of pregnancy[i]			
Percent of live births where the mother had health insurance	Source of payment at delivery other than self-pay	Live birth certificate	Total number of live births with a source of payment at the time of delivery that is not self-pay	Total number of live births
Rate of low-risk cesarean birth	Cesarean birth among nulliparous (no prior births), term (37 or more completed weeks based on obstetric estimate), singleton (not a multiple birth), and cephalic or vertex (head-first) births[iv]. Also referred to as NTSV (nulliparous, term, singleton, vertex) births. This measure is sometimes also reported as the rate of low-risk cesarean delivery.	Live birth certificate	Number of cesarean births among term (≥37 weeks gestation), singleton, vertex births to nulliparous women	Number of term (≥37 weeks gestation), singleton, vertex births to nulliparous women
Percent of women with a recent live birth who received a postpartum visit	Percent of women with a recent live birth who reported receiving a postpartum checkup. *Please indicate whether the data are from the Phase 8 or Phase 9 Questionnaire, or, if your state does not have PRAMS, whether the postpartum checkup definition is within 4-6 weeks after giving birth or up to 12 weeks after giving birth.*	Pregnancy Risk Assessment Monitoring System (PRAMS, Core Question 46 of the Phase 8 Questionnaire or Core Question 44 of the Phase 9 Questionnaire) or similar	*For reference (numerator does not need to be reported): Number of women with a recent live birth receiving a postpartum checkup (defined as a regular checkup about 4-6 weeks after giving birth in the Phase 8 Questionnaire and up to 12 weeks after giving birth in the Phase 9 Questionnaire)*	*For reference (denominator does not need to be reported): Number of women with a recent live birth.*
Percent of women with a recent live birth screened for postpartum depression OR Percent of women screened for depression or anxiety following a recent live birth	Percent of women with a recent live birth who were asked during a postpartum checkup if they were feeling down or depressed (PRAMS Phase 8 Questionnaire) OR Percent of women who reported that a healthcare provider asked a series of questions, in person or on a form, about whether they were feeling down, depressed, anxious, or irritable following a recent live birth (PRAMS Phase 9 Questionnaire). *Please indicate whether the data are from the*	PRAMS (Core Question 47 of the Phase 8 Questionnaire or Core Question 50 of the Phase 9 Questionnaire) or similar	*For reference (numerator does not need to be reported): If using Phase 8 Questionnaire: Number of women with a recent live birth screened for postpartum depression by the 4-6 week checkup If using the Phase 9 Questionnaire: Number of women with a recent live birth who were asked by a healthcare provider about feeling down, depressed, or*	*For reference (denominator does not need to be reported): Number of women with a recent live birth Note: for PRAMS Phase 8 Questionnaire, women without a postpartum checkup are classified as "no screening"*

	PRAMS Phase 8 or Phase 9 Questionnaire, or, if your state does not have PRAMS, which definition you are using.		*anxious since their new baby was born.*	

The following breakdown should be used to report disaggregated data for each of the measures above, where available and appropriate	
Data by age	Use the following age ranges: ≤24 25-39 40+
Data by race/ethnicity[v]	American Indian or Alaska Native Asian Black or African American Hispanic or Latino Middle Eastern or North African (e.g., Egyptian, Israeli) Native Hawaiian or Pacific Islander White Multiracial and Multiethnic[vi] If data is stratified and examined by different categories of race/ethnicity within your state, please indicate in your submission
Data by education	Less than a High School graduate High School graduate or GED completed Some college or Associate's degree Bachelor's or advanced degree

Data by geography	Indicate geographical breakdown of <u>urban</u> versus <u>rural</u> using the following definitions:
	
	The National Center for Health Statistics has an urban-rural classification scheme for counties that includes six urbanization levels (four metropolitan and two nonmetropolitan) on a continuum ranging from most urban to most rural. [vii]
	Metropolitan classifications (to be used when referring to <u>urban</u> areas for the purposes of this report):
	  1) Large metro metropolitan statistical area (MSA) population of 1 million or more which is broken down into large central metro and large fringe metro
	  2) Medium metro MSA population less than 250,000
	  3) Small metro MSA population less than 250,000
	Nonmetropolitan classifications (to be used when referring to <u>rural</u> areas for the purposes of this report):
	  1) Micropolitan urban cluster population of 10,000 – 49,999
	  2) Noncore
	
	When indicating the geographic breakdown of urban versus rural for the maternal health outcomes data based on the

	NCHS Urban-Rural Classification Scheme, please use the county of residence rather than the county of occurrence. It may also be important to examine your data by regions that make sense for your state (North/South/East/West; North/Central/Southern, etc.)
Use the MHAR Data Table as the format for reporting the data. Upload the data in the EHBs as an Excel spreadsheet.	

[i] Pregnancy-related death: Preventing Pregnancy-Related Deaths | Maternal Mortality Prevention | CDC

[ii] MMRIA – Maternal Mortality Review Information Application: Maternal Mortality Review Information App (MMRIA) | CDC - Login

[iii] PMSS – Pregnancy Mortality Surveillance System: Pregnancy Mortality Surveillance System | Maternal Mortality Prevention | CDC

[iv] Low-risk cesarean definition (Page 6): Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2021. National Vital Statistics Reports; vol 72, no 1. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://dx.doi. org/10.15620/cdc:122047.

[v] Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. Federal Register :: Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity

[vi] "Multiracial and Multiethnic" checkbox is not recommended for use during data collection. This recommendation applies to the use of data tabulations, where ensuring respectful and commonly understood terminology is used to describe the population which identifies with multiple racial and/or ethnicity groups. Annex 1. Content Team Final Report (census.gov)

[vii] National Center for Health Statistics (NCHS) Urban-Rural Classification Scheme for Counties: National Center for Health Statistics | National Center for Health Statistics | CDC