New York State Maternal Mortality and Morbidity Advisory Council Report 2023

Table of Contents

About the New York State Maternal Mortality and Morbidity Advisory Council

In 2019, New York State Public Health Law § 2509 was enacted that allowed for the creation of two Maternal Mortality Review Boards in New York State, the New York State Maternal Mortality Review Board and the New York City Maternal Mortality and Morbidity Review Committee. Together, the Boards review all maternal deaths in NYS; determine cause of death, factors leading to death, and preventability of each maternal death; and develop strategies to reduce the incidence of maternal mortality and disparities in outcomes.

Public Health Law § 2509 also authorized the Commissioner to establish a Maternal Mortality and Morbidity Advisory Council which is comprised of multidisciplinary experts and lay persons knowledgeable in the fields of maternal mortality, women's health, and public health, and includes members who serve and are representative of the racial, ethnic, and socioeconomic diversity of the birthing people of the state. The Council reviews findings from the New York State Maternal Mortality Review Board and New York City Maternal Mortality and Morbidity Review Committee and develops recommendations on policies, best practices, and strategies to prevent maternal mortality and morbidity, using health equity principles to address disparities, social determinants of health, and environmental issues known to impact maternal health outcomes.

About this Report

This report summarizes the activities of the New York State Maternal Mortality and Morbidity Advisory Council, as well as details the Council's key recommendations to prevent maternal mortality, morbidity, and related disparities. These recommendations are designed to improve the experience of care and outcomes for birthing people across New York State. A specific emphasis is placed on recommendations that address racial and ethnic disparities in maternal health outcomes. It is important to note that in the Findings Section of the report, the term 'women' is used, whereas in other sections of the report, the term 'birthing people' is used. The findings were based on review of pregnancy-associated deaths in 2018, and this cohort was restricted to individuals identified as female on the death certificate and/or hospital discharge records. The Department is committed to gender-inclusivity, and therefore, the term 'birthing people' is used throughout the rest of the report, where appropriate.

Maternal Mortality and Morbidity Advisory Council Members

Chair:

- **Cheryl Hunter-Grant, LMSW**, Former Executive Director, Lower Hudson Valley Perinatal Network

Members:

- **Machelle Allen, MD**, Chief Medical Officer, New York City Health + Hospitals Corporation
- **Chinyere Anyaogu, MD**, Vice Chair, Women's Health Services and Assistant Professor of Medicine, New York City Health + Hospitals, North Central Bronx
- **Susan Beane, MD**, Executive Medical Director, Healthfirst
- **Sherita Bullock**, Executive Director, Healthy Baby Network
- **Kenyani Davis, MD, MPH**, Physician, Community Health Center of Buffalo
- **Sherae Gayle**, Community Member, Healthy Baby Network
- **Helena Grant**, **MS, CNM, LM, CICP, FACNM**, Senior Advisor of Midwifery Initiatives, Bureau of Maternal, Infant & Reproductive Health, New York City Department of Health and Mental Hygiene
- **Latisha Harper**, Community Health Worker/Community Member, Catholic Charities
- **Pilar Herrero, JD**, **LLM**, Senior Staff Attorney, US Human Rights, Center for Reproductive Rights
- **Ellen Higgins, LCSW**, Perinatal and Infant Community Health Collaborative Program Director, Suffolk County Health Department
- **Reverend Diann Holt**, Founder and Executive Director, Durham's Maternity Stress Free Zone
- **Elizabeth Igboechi, RN, NEA-BC, FNP, CPPS**, Administrative Director, Quality and Safety, Obstetrics, Gynecology, and Women's Health, Montefiore Medical Center
- **Omari Maynard**, Community Member, Brooklyn Perinatal Network
- **Barbara McFadden, RN, BS, MHSA**, President, Long Island Chapter, National Coalition of 100 Black Women

- **Erin McKee, MAS, BSN, RNC-OB, C-EFM**, Regional Perinatal Quality Specialist, Perinatal Outreach Program, Albany Medical Center
- **Ngozi Moses**, **MSc**, Executive Director, Brooklyn Perinatal Network
- **Sonia Murdock**, Executive Director, Postpartum Resource Center of Long Island
- **Esther Patterson**, Doula and Board Member, BirthNet
- **Monica Richardson**, Healthy Start Program Coordinator, Onondaga County Health Department
- **Lynn Roberts, PhD**, Associate Dean of Student Affairs and Alumni Relations, City University of New York Graduate School of Public Health and Health Policy
- **Hannah Searing, MA-MHS**, Director of Research and Evaluation, Bureau of Maternal, Infant, and Reproductive Health, New York City Department of Health and Mental Hygiene
- **Lee Stetzer, MD, MPH**, Medical Director, Upper Hudson Planned Parenthood, Assistant Professor, Department of Family and Community Medicine, Albany Medical College
- **Elizabeth Stiles**, M-WRAP Program Manager, St. Lawrence Health System - Canton OB/GYN, Potsdam OB/GYN, Gouverneur OB/GYN
- **Colette Sturgis**, **BS, IBCLC**, Program Director, Perinatal and Infant Community Health Collaborative, Urban Health Plan
- **Amanda J. Victory, MD**, Obstetrician and Gynecologist, Highland Hospital
- **Kevin D. Watkins, MD, MPH**, Public Health Director, Cattaraugus County Health Department

Maternal Mortality in New York State

Maternal mortality and severe maternal morbidity rates are key indicators of the health of a society and are of major public health importance. Maternal death and severe maternal morbidity can happen at any time during pregnancy, childbirth, or in the postpartum period.

The United States has the highest maternal mortality rate among developed countries and is one of the only countries in the world with a worsening maternal mortality rate since 2000.[1] In 2018-2020, Black women in the United States died at more than double the rate of White women (40.9 vs. 16.0 deaths per 100,000 live births).[2,3] During the same period, New York State had an overall maternal mortality rate that was lower than the national rate (19.3 vs. 20.4 deaths per 100,000 live births) but with larger racial disparities: Black women in New York State died at over four times the rate of White women (55.8 vs. 13.2 deaths per 100,000 live births).[4]

Severe maternal morbidity, which encompasses the most severe, non-fatal complications of pregnancy, affects an estimated 50,000-65,000 pregnant persons in the United States every year.[5] Severe maternal morbidity includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a birthing person's health. Using the most recent list of indicators, severe maternal morbidity has been steadily increasing in recent years.

Powerful stories from mainstream media outlets have brought increased attention to the persistent racial disparities in maternal mortality rates in New York State and the country, especially for Black birthing people, as well as to the high overall rate of maternal mortality.

By better understanding the unique circumstances that lead to death during the perinatal period, strategies to improve access to care and outcomes can be developed and employed by the many partners who work with or care for this population.

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[1] Roosa Tikkanen et al., Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries (Commonwealth Fund, Nov. 2020)
[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2021.
[3] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database.
[4] Vital Statistics of New York State (https://www.health.ny.gov/statistics/vital_statistics/vs_reports_tables_list.htm)
[5] Hawkins, S., Harper S., and Baum C. Associations Between State Level Changes in Reproductive Health Services and Indicators of Severe Maternal Morbidity. JAMA Pediatrics. 2022.

Key Findings from the NYS Maternal Mortality Review Board's Review of NYS Pregnancy-Associated Deaths, 2018[6]

Pregnancy-Associated Deaths*

- In 2018, 117 pregnancy-associated deaths were identified among New York State residents.
- Of the 117 pregnancy-associated deaths, 41 were found to be pregnancy-related, 56 were found to be pregnancy-associated but not related, and 20 were found to be pregnancy-associated but unable to determine relatedness.
- In 2018, the percent of pregnancy-associated deaths by race/ethnicity was 50% for White, non-Hispanic women, 32% for Black, non-Hispanic women, 11% for Hispanic women, and 7% for Other, non-Hispanic women in New York State.
- Substance use disorder was a factor in 86.5% of other pregnancy-associated deaths (which include pregnancy-associated, but not related deaths and pregnancy-associated, but unable to determine relatedness deaths) due to mental health conditions.

Pregnancy-Related Deaths*

- Racial disparities in maternal deaths remain significant. In 2018, the pregnancy-related mortality ratio, which is the number of pregnancy-related deaths per 100,000 live births, was 65.4 for Black, non-Hispanic women, 12.9 for White, non-Hispanic women, 5.8 for Hispanic women, and 9.3 for Other, non-Hispanic women in New York State.
- The pregnancy-related mortality ratio for Black, non-Hispanic women was 5x the rate of White, non-Hispanic women in 2018.
- The top three leading causes of pregnancy-related deaths in 2018 were embolism, hemorrhage, and mental health conditions.
- The New York State Maternal Mortality Review Board determined that 76% of pregnancy-related deaths were preventable.
- All pregnancy-related deaths due to hemorrhage, mental health conditions, and cardiomyopathy were determined to be preventable.
- Discrimination was a probable or definite circumstance surrounding 46% of pregnancy-related deaths.

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* See Glossary

[6] New York State Department of Health. New York State Maternal Mortality Review Report on Pregnancy-Associated Deaths in 2018. Albany, NY: New York State Department of Health. 2022.

Key Recommendations

The Maternal Mortality and Morbidity Advisory Council made 12 recommendations to reduce maternal mortality and morbidity and address disparities in maternal health outcomes. The recommendations were developed using health equity principles. They call on individuals, institutions, organizations, and government bodies to take action to improve maternal health outcomes in New York State. The recommendations are organized into three domains – policy change, best practices, and strategies.

Policy Change:

- The New York State Department of Health's Office of Health Equity and Human Rights as well as the Office of Primary Care and Health Systems Management should ensure completion of evidence-based racial equity training for all staff working in health care delivery systems within 6 months of start and annually thereafter, preferably in-person.

- The New York State Education Department should require documentation of racial equity training of all licensed health care providers upon licensure and/or renewal.

- Policymakers and health care partners should strategically create, support, sponsor, and sustain a diversified multidisciplinary workforce (including doulas, midwives, obstetricians, psychologists, etc.) to ensure culturally matched care that facilitates effective communication between health care teams, patients, and caregivers.

- The American College of Emergency Physicians (ACEP) and American College of Obstetricians and Gynecologists (ACOG) should establish both clinical care and patient experience guidelines for the emergency department that prioritize pregnancy and the postpartum period to establish equitable and respectful care, in collaboration with the American College of Nurse-Midwives (ACNM); Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); Academy of Family Physicians (AAFP); American Academy of Emergency Medicine (AAEM); etc.

Best Practices:

- The New York State Legislature should require birthing facility participation in New York State Perinatal Quality Collaborative (NYSPQC) quality improvement projects, and this should be reported as part of the New York State Maternity Information Scorecard (Hospital Maternity-Related Procedures and Practices Statistics (ny.gov)).

New or Enhanced Strategies:

- New York State should provide funding to partners to create, establish, evaluate and ensure sustainability for a network of maternal medical homes that are widely accessible to pregnant people in the perinatal period, and designed to improve perinatal health outcomes through the provision of comprehensive clinical care along with coordination of referrals to multiple specialty providers and psychosocial support services, with an emphasis on chronic conditions, behavioral health needs, and socioeconomic challenges. Program development should include input from persons with lived experience, and should utilize principles of trauma informed care, shared decision-making, and social determinants of health.

- New York State should increase funding for perinatal health home visiting programs (such as Healthy Families New York, Perinatal and Infant Community Health Collaboratives, Nurse-Family Partnerships, etc.) and perinatal networks to expand existing programs and establish new ones where they are needed, ensuring universal access throughout New York State, and the New York State Department of Health should issue advisories to health care delivery partners about available home visiting services, including program directories and pathways to connect perinatal health care patients with local resources.

- The New York State Office of Mental Health and partners should develop and fund a parental mental health peer specialist model/pilot program with standardized competencies and training to support those at high risk for experiencing a Perinatal Mood and Anxiety Disorder and ensure hospitals/birthing facilities make these services available during the perinatal period (as early as preconception and up to 365 days postpartum).

- The New York State Department of Health's Office of Primary Care and Health Systems Management should increase awareness of the Facility Complaint Form which allows individuals and families, including those who have experienced a morbidity/mortality, to express concerns and provide feedback on the care they received. An annual report on perinatal-related complaints should be developed and published.

- The New York State Department of Health should provide education and guidance to New York State birthing facilities and emergency departments on shared decision-making to ensure effective patient/family/provider dialogue.

- New York State should develop and implement a mechanism to provide compensation to community partners for their participation in workgroups, committees, boards, councils, and projects.

- The New York State Office of Mental Health should expand funding to the Association of Black Psychologists to conduct Healing Circles for providers and

communities regarding hospitals' maternal deaths or severe maternal morbidities.

The Maternal Mortality and Morbidity Advisory Council also recommended that the New York State Department of Health's Office of Health Equity and Human Rights, as well as the Office of Primary Care and Health Systems Management, incorporate an assessment of racial equity, health equity, social justice, and respectful care into the operating standards of hospital/birthing facility Certificate of Need) applications for approval by the Public Health and Health Planning Council (PHHPC). On June 22, 2023, a new Health Equity Impact Assessment law went into effect. Under the statute, certain Certificate of Need applications now require a Health Equity Impact Assessment to be filed with the application. The Health Equity Impact Assessment Law applies to general hospitals, birthing centers, nursing homes, and ambulatory surgery centers. *As this statutory requirement has been enacted, the recommendation was removed from the final list of key recommendations.*

Call to Action: Implementation of Recommendations

The Maternal Mortality and Morbidity Advisory Council recognizes that to make a sustainable impact on maternal mortality and morbidity and reduce racial and ethnic disparities in New York State, further actions are needed by a wide range of partners working together at the system, facility, provider, community, and individual levels. These partners include, but are not limited to, state and local governments, professional organizations, insurers, hospital systems, individual providers, and community-based organizations. Each are in a unique position to help improve patients' birthing experiences and maternal outcomes by making impactful change where birthing people live, work, and seek health care. The Council sought to make recommendations that are actionable, in which partners could see their roles in improving the experience of care, as well as outcomes for birthing people in New York State. The voices of individuals with lived experience and their support systems are also integral in calling partners to act.

Recognize and Reduce Racism and Discrimination

Racism exists within our society and in health systems in many different forms, all of which create barriers to maternal health. Racism can be overt and explicit, or unconscious and less visible. Often it is systemic and structural. Systemic and structural racism are forms of racism that are pervasively and deeply embedded in systems, laws, written or unwritten policies, and entrenched practices and beliefs that produce, condone, and perpetuate widespread unfair treatment and oppression of people of color, with adverse health consequences.[7] Examples include residential segregation, unfair lending practices and other barriers to home ownership and accumulating wealth, schools' dependence on local property taxes, environmental injustice, etc. Systemic and structural racism permeate all sectors and areas of New York State. Addressing these inequities will require mutually reinforcing actions by multiple partners. A crucial first step is acknowledging their existence.

This is a call to action for all levels of government, health care facilities, health care providers, community-based organizations, and professional associations to acknowledge and address the legacy and persistence of systemic racism, review and revise long-standing policies and practices to ensure all birthing persons are treated equally, embed fairness and inclusivity in decision-making processes, and redress inequities in policies that serve as barriers to equal opportunity.[8]

Addressing structural racism is necessary to mitigate racial and ethnic disparities in maternal health care. State and local public health agencies can advance health equity by focusing on racism and discrimination as public health issues and allocating more resources towards improving the health and well-being of Black birthing people, using a data driven approach. State agencies can lead quality improvement initiatives

[7] Braverman PA, Arkin E, Proctor D, et al. Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling. *Health Affairs*. 2022; Vol. 40. Number 2.
[8] The White House. Fact Sheet: U.S. Efforts to Combat Systemic Racism. March 21, 2021.

with health care facilities and providers, aimed at advancing policies and best practices to reduce racism and discrimination and improving the experience of care and perinatal health outcomes for Black birthing people. Likewise, state and local health agencies can advance health equity by making it less onerous for community-based organizations, representing diverse communities, to be competitive in applying for grants.

The Advisory Council is strongly urging all health care delivery systems to provide racial equity training for all staff, not just perinatal providers. With assistance from the New York State Department of Health Offices of Health Equity and Human Rights and Primary Care and Health Systems Management in developing this racial equity training, all health care facilities in New York State can provide and ensure that their staff complete the training annually. Birthing facilities can support staff participation in quality improvement projects that address maternal mortality, maternal morbidity, and birth equity through education and training, as well as policy and practice changes. Birthing facilities can facilitate access to a full range of culturally aware and linguistically competent, multidisciplinary providers that support patient-centered decision-making throughout the birthing experience. To help ensure that health care delivery systems are advancing health equity, they should complete, as required by the New York State Department of Health, the Health Equity Impact Assessment when filing certain Certificate of Need applications.

Address the Impact of Social Determinants of Health

Inequities in the distribution of resources, resulting in poverty, unstable housing/homelessness, and unsafe neighborhoods, can have a negative impact on an individual's health and safety throughout life and contribute to disparities in health outcomes. Multiple partners' efforts to address these inequities are needed to impact systemic change in maternal mortality and morbidity. State and local agencies can focus their efforts on the more structural, social determinants of health, (i.e., lack of housing, transportation, affordable healthy foods, and accessible health care), as these factors all impact health. Facilities can train their providers to identify the social determinants of health that may impact their patients' pre-existing health status, ability to attend medical appointments, access to nutritional foods, etc., and address those factors that are within their sphere of influence (e.g., transportation assistance, evening hours, telehealth visits, etc.). Structural barriers impacting health and health care, that are not within the purview of the health care system, will need to be addressed by all levels of government, health insurers, and communities through interventions and legislative and policy changes.

Support Mental Health

Maternal mortality and morbidity have far reaching impacts on families, providers, and communities. Facilities can provide families and providers time and space to grieve following a tragic loss. Professional organizations can offer their members education and "healing circles" to share their experiences and support one another. Providers can utilize the education and consultation services of Project TEACH to guide the optimal

management of mental health conditions in pregnant and postpartum patients. Individuals experiencing perinatal mood and anxiety disorders can be identified and referred to support services such as the Postpartum Resource Center of New York.

Find New Partners and Explore Ways to Drive Action

Individuals and communities can expand advocacy efforts by creating and leveraging new partnerships. Community-based organizations can encourage pregnant and postpartum people to lend their voices to this effort, to affect change and improve the experience of care for all birthing people, especially Black birthing people who have experienced racism and discrimination in the health care system, as well as adverse birth outcomes. Community-based organizations can elevate the voices of pregnant and postpartum people by inviting them to participate in state and local workgroups, councils and boards, as well as focus groups and community listening sessions. Legislators can learn from and respond to the voices of pregnant and postpartum people and providers of maternal health care by allocating funding for community-based, perinatal home visiting programs, maternity medical homes, and perinatal quality improvement projects.

Improve Care Coordination and Optimize Postpartum Care

For birthing people experiencing chronic medical or behavioral health conditions during pregnancy and postpartum, the importance of timely follow-up cannot be overstated. Scheduling, traveling to, and attending multiple medical appointments may be difficult for healthy birthing people to complete, and much more so for those experiencing pregnancy or postpartum complications or illness. Seeking follow-up care becomes more challenging when caring for an infant or other children. Some pregnant and postpartum people, especially those adversely impacted by social determinants of health, may need care coordination supports and community services to enable them to schedule and keep their appointments. This coordination involves all partners (statewide, regionally, and locally), to determine the best approach. The expansion of Medicaid coverage to include one-year postpartum will improve the continuity of care for pregnant and postpartum people by coordinating care past delivery, with the goal of improving the care and experience of care for birthing people, their newborns, and their family.

Maternal Mortality and Morbidity Advisory Council Activities (2020 – 2023)

The Maternal Mortality and Morbidity Advisory Council held its first meeting in December 2020. This was a kick-off meeting. The Council met again in Spring 2021. During the meeting, the Department shared the New York State Maternal Mortality Review Board's 2018 key recommendations to reduce maternal mortality and morbidity. Due to the COVID-19 pandemic, the Council did not meet again until June 2022. This was a joint meeting of the New York State Maternal Mortality Review Board and Maternal Mortality and Morbidity Advisory Council. During the meeting, the two groups discussed how they could work together to develop recommendations to achieve their shared goals of reducing maternal mortality and morbidity and eliminating racial disparities. From June 2022 – June 2023, the Maternal Mortality and Morbidity Advisory Council convened eight times to develop their recommendations, and a smaller ad hoc committee of Advisory Council members met five times to refine the recommendations. The members voted unanimously on the final set of 12 recommendations.

Throughout the process of developing the recommendations, Advisory Council members expressed the importance of addressing the impact of racism and discrimination on maternal health outcomes. Above all, the Advisory Council stressed the need to center this work on making systemic and/or institution level changes, as they contribute to the inequitable distribution of resources, gaps in services, and continued disparities experienced by many birthing people. Council members indicated that birthing people continue to feel disrespected and/or experience discrimination when accessing care, a barrier which can make obtaining care and/or following provider advice even more challenging. Continuing to proactively address the impact of racism and bias on birth outcomes, as well as focusing on the patient's experience of care, were seen as ongoing needs. Council members suggested that the use of doulas during labor and delivery may improve the experience of care by supporting and empowering birthing people.

Advisory Council members emphasized the need to support and develop recommendations aimed at improving systems of care. They pointed out that individual and/or family level recommendations can often fail to account for system and other external factors that impact an individual's ability to access necessary care. Council members also expressed that recommendations focusing primarily on patient education and awareness are not sufficient to address the real barriers pregnant and birthing people face in accessing high quality care. Instead, members wanted to focus on practical steps to improve people's ability to access prenatal or postpartum care (e.g., transportation assistance, evening hours, telehealth visits, etc.).

Maternal Mortality and Morbidity Advisory Council members recommended finding ways to ensure that more providers and birthing facilities take advantage of existing resources and supports, including the New York State Perinatal Quality Collaborative quality improvement projects. Council members believe that all health care facilities will benefit from participating in learning collaboratives and quality improvement initiatives,

and suggested ways to hold facilities accountable for staff participation. Members suggested the use of "scorecards" to track facility participation in New York State Perinatal Quality Collaborative quality improvement projects, or the use of incentives.

Moving forward, Maternal Mortality and Morbidity Advisory Council members will continue to work in collaboration with the New York State Maternal Mortality Review Board to share their insights on the development of recommendations. Future plans include increased opportunities for Maternal Mortality and Morbidity Advisory Council members and Maternal Mortality Review Board members to work collaboratively in meetings and on the development of recommendations and/or strategies to prevent maternal deaths and disparities in maternal health outcomes.

Glossary of Terms

Best Practice – an intervention that has shown evidence of effectiveness in a particular setting and is likely to be replicable to other situations

B.R.A.I.N. Technique – a useful technique that can help you weigh the pros and cons of any decision during pregnancy, birth, and beyond

Benefit – What is the benefit to me as a patient?
Risks – What are the risks associated?
Alternatives – What is the alternative to what you are offering?
Instinct – What is my gut telling me?
Nothing – What happens if I do nothing or wait it out?

Healing Circles – welcoming, safe, accepting places that promote wellness and guide a person through deep, supportive intentional healing

Health Equity – achieving the highest level of health for all people which entails focused efforts to address avoidable inequalities by equalizing conditions for health for those who have experienced injustices, socioeconomic disadvantages, and systemic disadvantages

Maternal Morbidity – includes the unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.[9]

Maternal Mortality – the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.[10]

Maternal Medical Home – program designed to improve high-risk obstetric outcomes by providing referrals to necessary specialty care, mental health services, and enhanced wraparound services to address socioeconomic challenges, as well as parenting support and education

Parental Mental Health Peer Specialist – offers hope, guidance, advocacy, and camaraderie for parents and caregivers of children and youth receiving mental health, substance use, or related services

Partners – refer to health care delivery systems, providers, practices, and organizations that have contact with birthing people (e.g., hospitals, community-based organizations, managed care organizations, payors, etc.) and people who are responsible for or affected by health- and health-care-related decisions

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[9] American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine, Kilpatrick SK, Ecker JL. Severe maternal morbidity: screening and review external icon. Am J Obstet Gynecol. external icon2016;215(3):B17–B22.

[10] World Health Organization. International statistical classification of diseases and related health problems, 10th revision (ICD–10). 2008 ed. Geneva, Switzerland. 2009.

Perinatal or Postpartum Mood and Anxiety Disorders (PMAD) – term used to describe distressing feelings that occur during pregnancy (perinatal) and throughout the first year after pregnancy (postpartum)

Perinatal Period – starts as early as preconception and extends up to 365 days postpartum (as defined by the Maternal Mortality and Morbidity Advisory Council)

Pregnancy-Associated Death – a death during pregnancy or within one year of the end of pregnancy

Pregnancy-Related Death – a death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy

Public Health Policy – laws, regulations, plans, and actions that are undertaken to achieve public health goals in a society

Racial Equity – a situation in which people of all races are treated fairly and in the same way; it is achieved when everyone can attain their full potential for health and well-being

Shared Decision-Making – a model of patient-centered care that enables and encourages people to play a role in the medical decisions that affect their health

Social Determinants of Health – the non-medical factors that influence health outcomes (i.e., the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life)

> ***Examples:*** income and social protection; education; unemployment and job security; working life conditions; food insecurity; housing; early childhood development; social inclusion and non-discrimination; and access to affordable, quality health services

Social Justice – justice in terms of the distribution of wealth, opportunities, and privileges within a society

Strategy – a general plan to achieve one or more long-term or overall goals under conditions of uncertainty