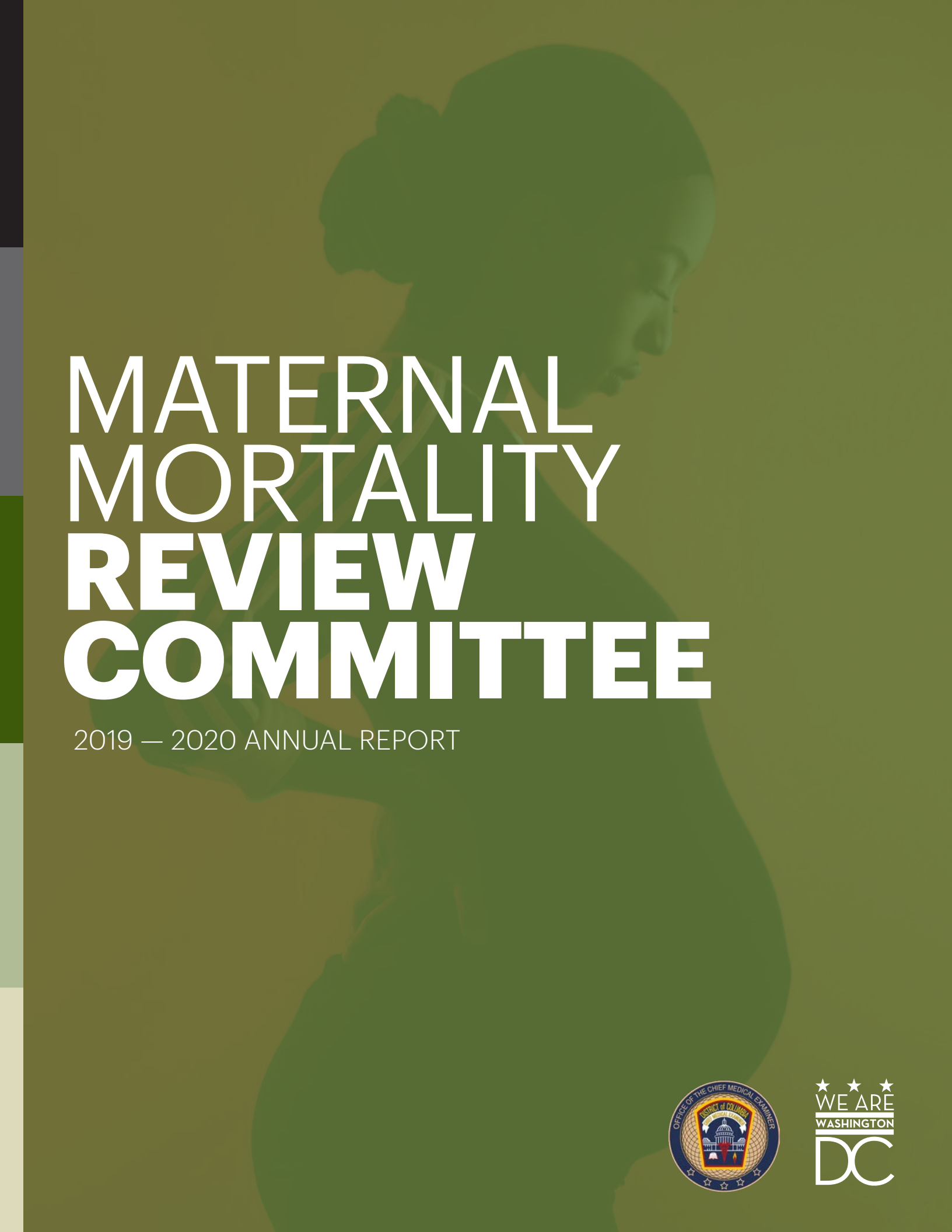

MATERNAL MORTALITY **REVIEW COMMITTEE**

2019 — 2020 ANNUAL REPORT

WE ARE WASHINGTON DC

MATERNAL MORTALITY REVIEW COMMITTEE

2019-2020 ANNUAL REPORT

MISSION STATEMENT:

Presented To

The Honorable Muriel Bowser, Mayor, District of Columbia
The Council of the District of Columbia
The Residents of the District of Columbia

MATERNAL MORTALITY REVIEW COMMITTEE CO-CHAIRS

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DECEMBER 2021

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GREETINGS FROM
MMRC CO-CHAIRS

The establishment of the District of Columbia's Maternal Mortality Review Committee (DC MMRC) in 2018 presented the unique opportunity to address systemic factors impacting maternal mortality by evaluating services, care delivery, and referrals provided to birthing persons who died during pregnancy, childbirth, or within 365 days of the end of a pregnancy. Such barriers – including racism, discrimination, and bias - adversely affect pregnancy-related health outcomes.

Aza Nedhari
LM, CPM, MS

Christina X. Marea,
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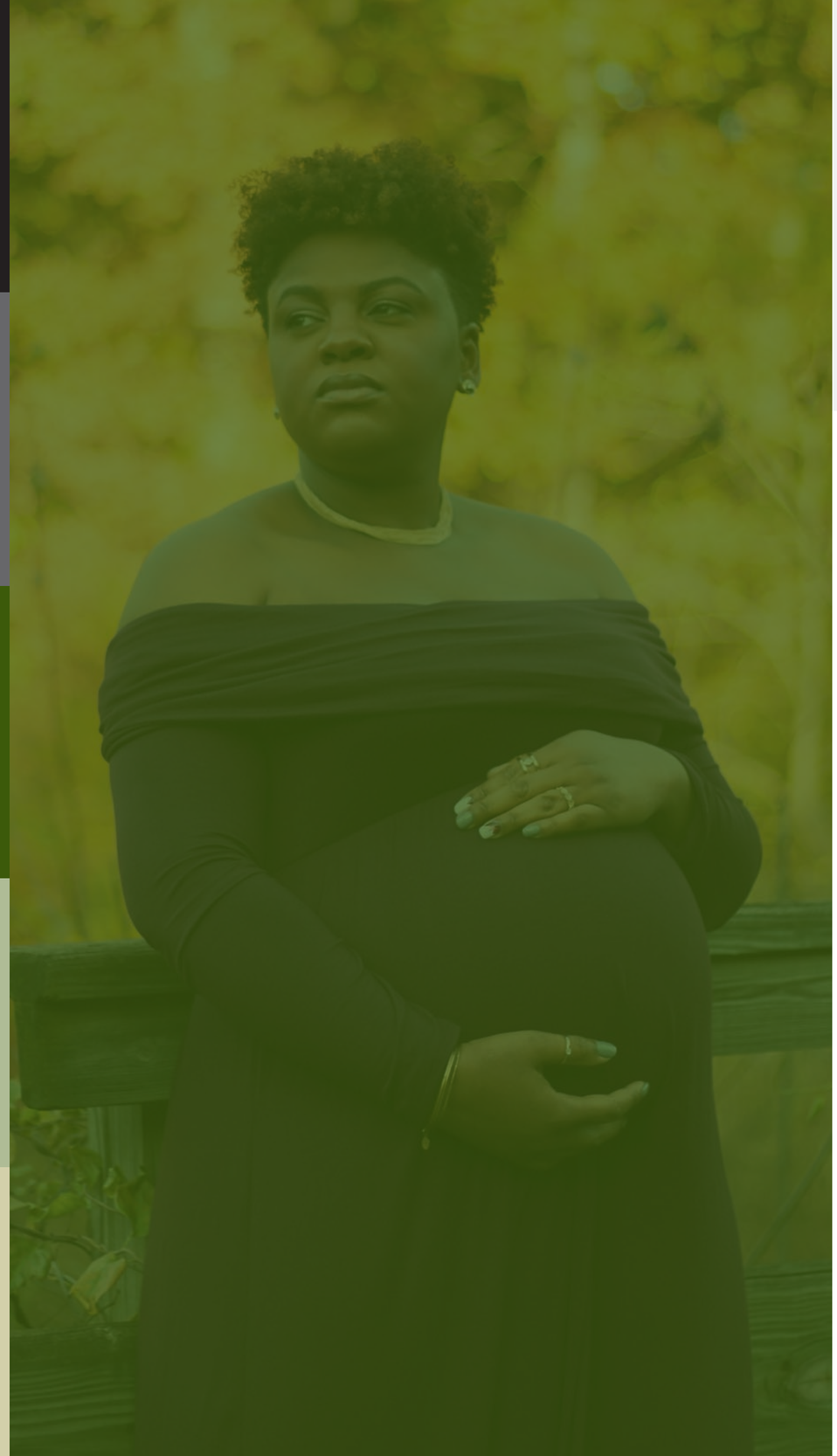

We present to you the first Maternal Mortality Review Committee Annual Report.

As the inaugural co-chairs of the DC MMRC, we express our gratitude for being elected to represent a group of 25 multi-disciplinary experts in the field of maternal health. Committee members volunteer their time to retrospectively evaluate medical, social, and behavioral services provided to birthing persons during the pregnancy, birth, and the postpartum period depending on the circumstances of the case. We use a life-course approach for our reviews, looking beyond the immediate pregnancy and postpartum periods, to better understand how social, community, and environmental factors may have accumulated over a person's life. Through our collective experiences in our respective fields, we recognize the complex needs of birthing persons while navigating the healthcare system – noting that some birthing people face structural disadvantages that make accessing care even more challenging. The conversations surrounding disparities in healthcare coupled with adverse life experiences are difficult; however, the appointed members of the DC MMRC accept the challenge.

We present to you the first Maternal Mortality Review Committee Annual Report. We hope that this report will be used throughout our maternal health community, in both public and private practices, to break systemic and structural barriers that affect the lives of birthing persons, their families, and the surrounding community. We thank and appreciate the DC MMRC members, meeting participants, and the OCME Fatality Review Division for their commitment to the work of the DC MMRC.

ESTABLISHMENT OF THE **MMRC**

Authority: The MMRC was established and became effective on June 5, 2018, through DC Law 22-11. This law formally established the Maternal Mortality Review Committee (MMRC) for the District of Columbia. The Office of the Chief Medical Examiner provides facilities, staffing and other administrative support for the MMRC.

PURPOSE AND FUNCTIONS OF THE MATERNAL MORTALITY REVIEW COMMITTEE

The MMRC's purpose is to determine the causes associated with maternal mortalities of District residents and those that occur in the District. Responsibilities also include describing and recording any trends, data, or patterns that are observed surrounding maternal mortalities and to create a strategic framework for improving maternal health outcomes, including addressing the disparities experienced by people from marginalized racial and ethnic groups in the District. The committee makes recommendations to improve the identification, investigation, and prevention of maternal mortalities. The committee writes a publicly available annual report of its findings, recommendations, and steps taken to evaluate the implementation of past recommendations.

The MMRC's implementation was a strategic process that began in July 2018 and was coordinated in collaboration between the Office of the Chief Medical Examiner (OCME), DC Health (DOH), and the Mayor's Office of Talent and Appointments (MOTA). Potential members were identified and recruitment included both public solicitation of interest and targeted outreach to stakeholders. Candidates underwent formal interviews and were vetted by MOTA. Recommendations for member candidate were presented to the DC Council on March 14, 2019, during the Judiciary and Public Safety Roundtable. Thereafter, final confirmations were approved.

Figure 1. **2019-2020 MMRC Implementation Timeline**

2018
Effective June 5, 2018, DC Law 22: 111 Maternal Mortality Review Committee Establishes Act of 2018

2018
July 2018
Joint recruitment efforts of MMRC candidates by the Mayor's Office of Talent and Appointments (MOTA), Office of the Chief Medical Examiner (OCME) and DC Health

2019
March 14, 2019
Judiciary and Public Safety Roundtable (Confirmation of Member nominations)

2019
May 9, 2019
First official MMRC Meeting and Swearing in of new member appointments

2019
July 16, 2019
Co-chair selections, quorum meeting schedules and rules and procedures and formalized protocols adopted

2019
September 24, 2019
First case review meeting

COMMITTEE COMPOSITION

Members and meeting participants comprise the following District government agencies, community-based service providers, and District resident members affected by a maternal mortality.

The MMRC Composition includes:

- The Office of the Chief Medical Examiner;
- The Department of Health;
- The Department of Behavioral Health;
- The Department of Health Care Finance;
- The Department of Human Services;
- One person with experience in obstetrics and gynecology from each of the District's hospitals and birthing centers;
- One representative from the American Congress of Obstetricians and Gynecologists;
- One representative from the American College of Nurse-Midwives;
- One registered obstetric nurse;
- One certified nurse-midwife;
- One representative from a pediatric hospital;
- Three representatives from community organizations specializing in women's health, teen pregnancy, or public health;
- One social worker specializing in women's health or maternal health;
- One person who has been directly impacted by a maternal mortality; and
- One doula.

ROLE OF THE MMRC

The Committee shall evaluate maternal mortalities, including associated factors, by:

1. Identifying and characterizing the scope and nature of maternal mortalities in the District and of District residents;
2. Describing and recording any data or patterns that are observed surrounding maternal mortalities;
3. Examining past events and circumstances surrounding maternal mortalities by reviewing records and other pertinent documents of public agencies and private entities responsible for investigating maternal mortalities or treating pregnant people;
4. Developing and revising, as necessary, operating rules and procedures for the review of maternal mortalities, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and record-keeping of the causes of maternal mortalities;
5. Recommending systemic improvements to promote improved and integrated public and private systems serving pregnant people in the District;
6. Recommending components for prevention and education programs;
7. Creating a strategic framework for improving maternal health outcomes for racial and ethnic minorities in the District, including reducing disparities in maternal mortality rates for racial and ethnic minorities, incorporating a system of review that looks at the Social Determinants of Health (SDH), Adverse Childhood Experiences (ACEs) and Risk and Protective Factors; and
8. Recommending training for maternal health providers to improve the identification, investigation, and prevention of maternal mortalities.
9. Presenting an Annual Report on July 1 of each year of cases reviewed from the previous calendar year to the Council and Mayor with the findings, recommendations, and steps taken to implement past recommendations.

THE CASE REVIEW PROCESS

The MMRC conducts a systematic, multi-agency, multi-disciplinary review of pregnancy-related or pregnancy-associated deaths within the District using a non-judgmental life course approach.

FACT GATHERING

The case review process is retrospective and begins after data has been reconciled by various organizations (hospitals, government agencies, community service providers). These records often contain hundreds of pages of information for each system, agency, or service provider involved. The analysis of each case includes an overview of past events and circumstances by reviewing records and other pertinent documents from public and private agencies to include the following:

- Demographic information of the mother/ pregnant or birthing person, child, and father (if known) such as race, ethnicity, educational attainment
- Hospital or medical center where the mother/ pregnant or birthing person sought prenatal care, Emergency Department visits, or ongoing specialty care (ex. cardiology)
- Location and circumstances leading to the death
- Health characteristics of the mother/ pregnant or birthing person including complications developed in pregnancy, health conditions before pregnancy
- Fetal and neonatal health characteristics such as birth weight, abnormalities, etc.
- Use of public benefits (i.e., SNAP, housing voucher, and Medicaid)
- Involvement in the criminal justice system, or child welfare programs

The full case review process models a systems framework. All systems that the decedent interfaced with are analyzed to determine how that system contributed to the decedent's outcome. Then recommendations are made by the committee to strengthen those systems. System-specific documents analyzed include:

Hospital/Midwife/Doula Services:
obstetrical care, labor, and delivery, postpartum, and continued general wellness care

DC Courts/Metropolitan Police Department
i.e., civil and or criminal matters

Office of the Chief Medical Examiner:
autopsy, toxicology, scene

DC Department of Health:
vital records or additional services information

DC Department of Human Services:
emergency housing, childcare, medical assistance, counseling, etc.

DC Fire & EMS:
emergency transport services and records

DC Department of Behavioral Health:
mental health care, pre-existing conditions or emergency psychiatric services, hospitalizations, substance abuse disorders (i.e., treatment and recovery)

DC Department of Health Care Finance:
insurance status, claims information, and continuity of coverage

Other:
Child Welfare, Employment, Financial and community services

The MMRC uses a methodological approach to examine the interaction of the complex systems of District residents informed by the CDC's Maternal Mortality Review Information Application (MMRIA) that guides committees to consider contributing factors at the level of the patient/ their family, the health care provider, the healthcare facility, the healthcare system, and the community. In instances where a decedent had limited interaction with government systems and community service providers, or the decedent died in the District but was a resident of another jurisdiction, a statistical case review is conducted.

DC CASE OUTLINE

Summary of Documents Utilized for Review

1. Maternal history to include basic demographic information (i.e., age, race[1], height, weight, ward of residence), gravidity and parity, a summary of pre-existing medical conditions, a summary of prenatal care received, medications prescribed.
2. Summary of hospitalizations including Labor and Delivery, and any emergency department visits
3. Circumstances surrounding death
4. CME/MPD scene investigation if applicable
5. Autopsy report with final diagnosis and toxicology results to include cause and manner of death
6. Maternal risk and protective factors including family constellation, social history, and community indicators- to include social determinants of health, ACEs, employment, education level, housing location, community supports/ available resources.
7. District Government agency system involvement

[1] In keeping with Centers for Disease Control and Prevention (CDC) fatality review framework, the decedent's race is added at the end of the report to reduce potential bias.

SOCIAL DETERMINANTS OF HEALTH

The MMRC addresses social determinants of health (SDOH) in each case reviewed. The CDC defines the SDOH as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. As part of the fatality review process, this includes analyzing access to medical treatment, social support, safety, socio-economic conditions, food deserts, access to quality education, transportation, and job opportunities in the District.

The MMRC also looks to identify whether there were opportunities in existence to alter outcomes (Good Chance, Some Chance, No Chance, Unsure/Unable to Determine). If opportunities are identified, the committee enumerates and makes specific recommendations. In addition, the MMRC notes things that went well throughout the case with a focus on highlighting the strengths of the decedent.

KEY DECISIONS FOR MMRC[2]

There are six key decisions the MMRC makes for each death reviewed:

1. Was the death pregnancy-related?
2. What was the underlying cause of death?
3. Was the death preventable?
4. What were the factors that contributed to the death?
5. What are the recommendations and actions that address those contributing factors?
6. What is the anticipated impact of those actions if implemented?

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[2]The MMRC completes the CDC Committee Decisions form available at the following source: https://reviewtoaction.org

PREGNANCY-ASSOCIATED MORTALITY AND SEVERE MATERNAL MORBIDITY: EXAMINATION OF YEARS 2014-2018

Background

This section provides an overview of pregnancy-associated mortality (which includes maternal mortality, pregnancy-related mortality, and pregnancy-associated but not related mortality) and severe maternal morbidity in the District. Table 1 provides standard definitions for the indicators presented. Note that the mortality indicators presented here are based on DC Vital Records data. While Vital Records data are a valuable data source for assessing pregnancy-related mortality, the Maternal Mortality Review Committee's (MMRC's) determination of pregnancy-relatedness is based on an extensive case review that includes contextual and medical information beyond the death certificate. MMRC findings are considered the gold standard data source for pregnancy-related mortality.

Table 1. **Definitions of key indicators of mortality and morbidity around pregnancy**

Indicator	Definition
Maternal Death	A 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.[3,4] This definition is used by the National Center for Health Statistics and the World Health Organization.
Maternal Mortality Ratio (Rate)	The number of maternal deaths (using the above definition) per 100,000 live births.[3] The maternal mortality ratio is also colloquially called the maternal mortality rate.
Pregnancy-Related Death	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 physiologic effects of pregnancy.[3,4] (Includes maternal deaths within 42 days and pregnancy-related deaths 43 days to one year following the termination of pregnancy.)
Pregnancy-Related Mortality Ratio (Rate)	The number of pregnancy-related deaths (using the above definition) per 100,000 live births.[3] The pregnancy-related mortality ratio is also colloquially called the pregnancy-related mortality rate.
Pregnancy-Associated Death	A death during or within one year of pregnancy, regardless of the cause.[3,4] (Includes maternal deaths and pregnancy-related deaths.)
Pregnancy-Associated, but not related Death	A death during or within one year of pregnancy, from a cause that is not related to pregnancy.[3]
Severe Maternal Morbidity	The CDC defines severe maternal morbidity as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.[5]

[3] Association of Maternal and Child Health Programs and the Centers for Disease Control and Prevention, (n.d.). Review to Action—Working Together to Prevent Maternal Mortality: Definitions. Retrieved from https://reviewtoaction.org/learn/definitions.

[4] In Vital Records mortality data, a maternal death is defined as a death occurring during pregnancy or within 42 days of termination of pregnancy with the underlying cause of death assigned to International Statistical Classification of Diseases, 10th Revision (ICD–10) codes A34, O00–O95, and O98–O99 (Source: Hoyert DL. 2021. Maternal mortality rates in the United States, 2019. NCHS Health E-Stats. Retrieved from https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/E-Stat-Maternal-Mortality-Rates-H.pdf). A pregnancy-related death is defined in the Vital Records data as a death occurring during or within one year of pregnancy, with the underlying cause of death assigned to ICD–10 codes A34, O00–O95, and O98–O99. A pregnancy-associated death is defined in the Vital Records data as a death during or within one year of pregnancy with any underlying cause of death ICD-10 code.

[5] See the CDC SMM web page for a complete listing of the International Classification of Diseases (ICD) diagnosis and procedure codes included in the definition (Centers for Disease Control and Prevention, (n.d.). Severe Maternal Morbidity in the United States. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html).

OVERVIEW OF PREGNANCY-ASSOCIATED DEATHS

During 2014-2018, 36 District-resident lives were lost during pregnancy or within one year following the end of pregnancy from any cause.[6] Of the 36 pregnancy-associated deaths, 11 were maternal deaths, 10 were pregnancy-related deaths occurring 43 days to one year following the termination of pregnancy, and 15 were deaths occurring within one year of the termination of pregnancy due to accidental or incidental causes. Figure 2 shows the number of maternal deaths, pregnancy-related deaths occurring 43 days to one year following the end of pregnancy and pregnancy-associated, non-related deaths that occurred each year during 2014-2018 (see Figure 2).

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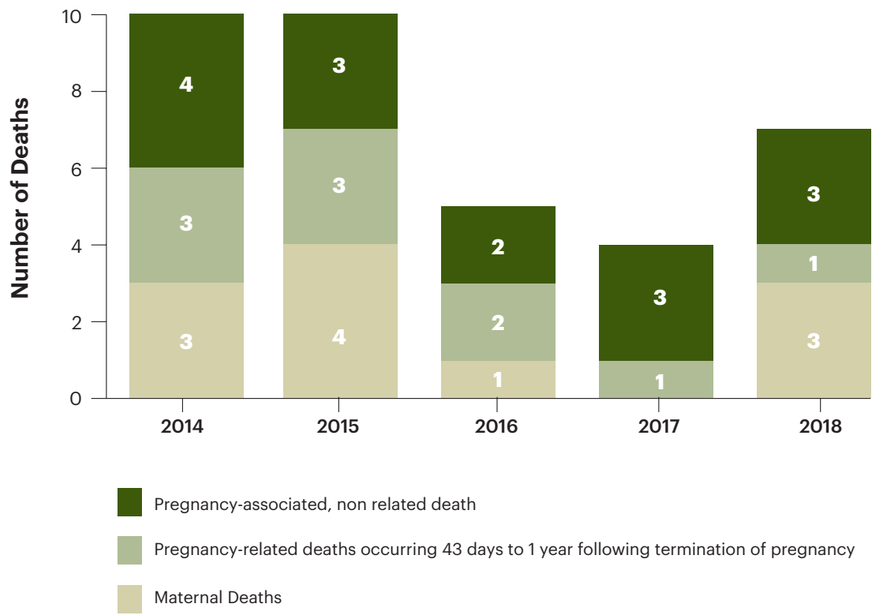
[6] This summary presents deaths to district residents, including deaths that occurred in other states, but does not include deaths to residents of other states that occurred in the district. During 2014-2018, 10 pregnancy-associated deaths occurred in the district to residents of other states.

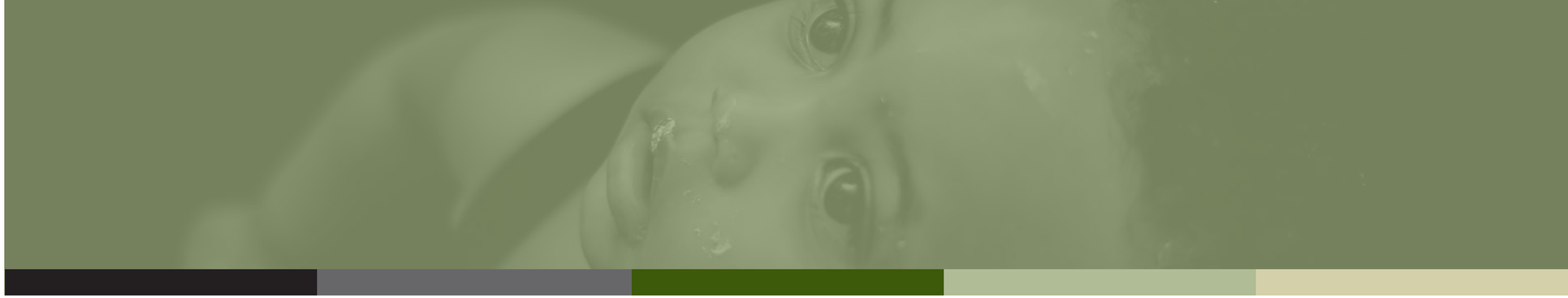
"... CDC defines severe maternal morbidity as unexpected outcomes of labor and delivery ...

Figure 2. **District Resident Pregnancy-Associated Deaths by Year, 2014-2018**



Data source: 2014-2018 DC Mortality Files; Vital Records Division, Center for Policy Planning and Evaluation, D.C. Department of Health. Includes DC-resident deaths that occurred either in DC or in another state or country. Refer to Table 1 for definitions of maternal, pregnancy-related, and pregnancy-associated, non-related deaths.

MATERNAL MORTALITY RATE



The DC maternal mortality rate (MMR) for 2014-2018 is the number of DC-resident maternal deaths divided by the total number of DC-resident live births during these years, multiplied by 100,000. The five-year DC maternal mortality rate for 2014-2018 is 23.1 deaths per 100,000 live births. Figure 3 compares DC's five-year maternal mortality rate to the United States' five-year maternal mortality rate for the same period.

The rates shown in Figure 3 are surrounded by confidence interval bars showing the lower and upper limits of the 95% confidence intervals for the estimates. For example, the five-year DC MMR is estimated to be 23.1 deaths per 100,000 live births. Due to the small number of births and maternal deaths in DC, caution should be exercised when interpreting this DC rate. However, we can be 95% confident that the true value of DC's five-year MMR falls between 11.5 and 41.2 deaths per 100,000 live births.

In the US, the maternal mortality rate during the years 2014-2018 is 20.7 per 100,000 live births. We can be 95% confident that the true value of US's five-year MMR falls between 20.0 and 21.3 deaths per 100,000 live births. While the DC maternal mortality rate is higher than the US maternal mortality rate, because the 95% confidence intervals overlap, the difference is not statistically significant. We do affirm that both the DC and US maternal mortality rates are too high and must be urgently addressed.

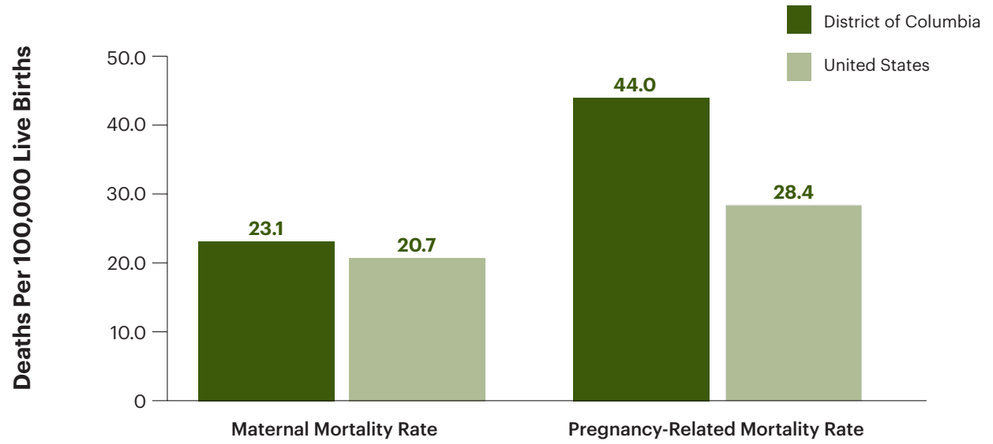
PREGNANCY-RELATED MORTALITY RATE

The DC pregnancy-related mortality rate for 2014-2018 is the number of DC-resident pregnancy-related deaths divided by the total number of DC-resident live births during these years, multiplied by 100,000. The five-year DC pregnancy-related mortality rate for 2014-2018 is 44.0 deaths per 100,000 live births (Figure 3).

In the United States overall, the five-year pregnancy-related mortality rate during 2014-2018 is 28.4 deaths per 100,000 live births. While the DC pregnancy-related mortality rate is higher than the US rate, the difference is not statistically significant because of the wide confidence intervals for the DC rate.

> **In the US, the maternal mortality rate during the years 2014-2018 is 20.7 per 100,000 live births.**

Figure 3. **Maternal and Pregnancy-Related Mortality Rates among District of Columbia Residents and US Total Population, 2014-2018**



Data Sources: 2014-2018 DC Natality and Mortality Data, Vital Records Division, Center for Policy Planning and Evaluation, DC Department of Health; the United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS), Division of Vital Statistics Natality public-use data 2007-2018, on CDC WONDER Online Database; US Mortality Data: CDC, NCHS. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, released in December 2019. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Refer to Table 1 for definitions of the maternal and pregnancy-related mortality rates. The vertical bars in the figure correspond to the lower and upper limit of the 95% confidence interval for each estimate.

PREGNANCY-ASSOCIATED DEATHS BY MATERNAL CHARACTERISTICS

Maternal Age

Among the 36 pregnancy-associated deaths during 2014-2018, 19% were aged 15-24 years, 36% were aged 25-34 years, 36% were aged 35-44 years, and 8% were aged 45-54 years. Figure 4 shows the breakdown of these lives lost by maternal age and whether the death was a maternal, pregnancy-related, or non-related pregnancy-associated death.

Figure 4. **District Resident Pregnancy-Associated Deaths by Age at Death, 2014-2018**

Data source: 2014-2018 DC Mortality Files; Vital Records Division, Center for Policy Planning and Evaluation, DC Department of Health. This includes DC-resident deaths that occurred either in DC or in another state or country. Refer to Table 1 for definitions of maternal, pregnancy-related, and pregnancy-associated, non-related deaths.

DISPARITIES BY RACE

Pregnancy-associated deaths in the District are disproportionately concentrated among Non-Hispanic Black birthing people (Figure 5). While Black birthing people constitute roughly half of all births in DC, they account for 90% of all pregnancy-related deaths and 93% of pregnancy-associated, non-related deaths.[7] This is in stark contrast with White birthing person, who comprise about 30% of births but experienced no pregnancy-related deaths, and one pregnancy-associated, non-related death during 2014-2018.[8] During the five-year period, one maternal death was to a Hispanic birthing person, and one maternal death was to a birthing person with race classified as Other and ethnicity non-Hispanic (Figure 5).

[7] Data source: 2014-2018 Natality and Mortality Files; Vital Records Division, Center for Policy Planning and Evaluation, DC Department of Health.
[8] ibid.

“Pregnancy-associated deaths in the District are disproportionately concentrated among Non-Hispanic Black birthing people.

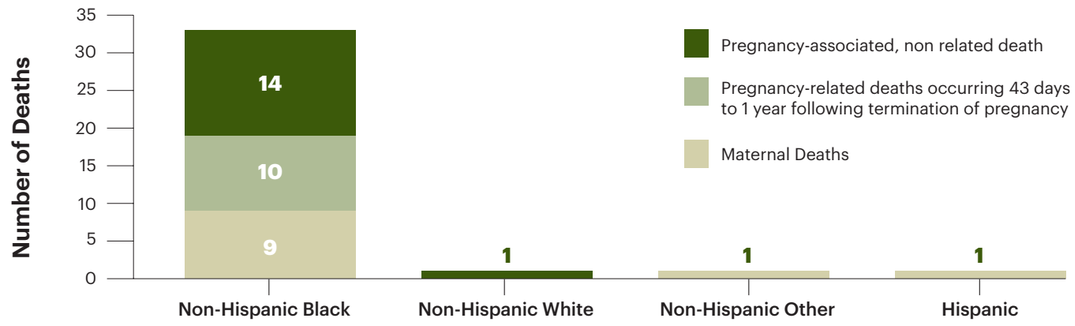
DISPARITIES BY GEOGRAPHY

Pregnancy-associated deaths are overrepresented in certain geographic areas in the city, with 70% of pregnancy-associated deaths occurring to women residing in Wards 7 and 8 (Figure 6). By contrast, residents of Wards 2 and 3 did not experience any pregnancy-associated deaths during 2014-2018.

70%

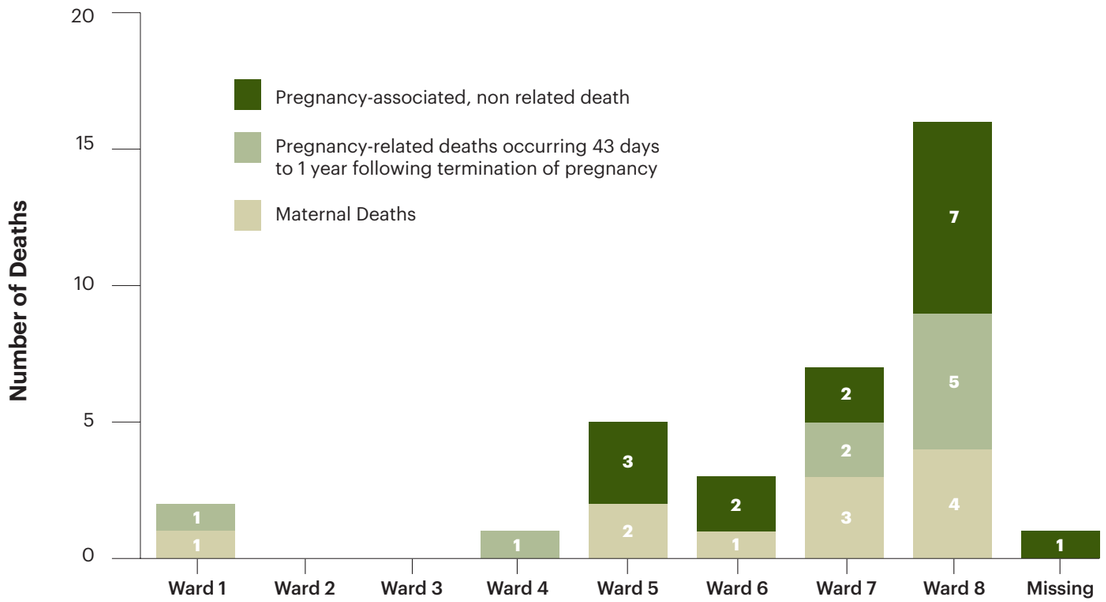
of pregnancy-associated deaths occurring to birthing people residing in Wards 7 and 8.

Figure. 5. **District Resident Pregnancy-Associated Deaths by Race and Ethnicity, 2014-2018**



Data source: 2014-2018 DC Mortality Files; Vital Records Division, Center for Policy Planning and Evaluation, DC Department of Health. This includes DC-resident deaths that occurred either in DC or in another state or country. Refer to Table 1 for definitions of maternal, pregnancy-related, and pregnancy-associated, non-related deaths.

Figure 6. **District-Resident Pregnancy-Associated Deaths by Ward of Residence, 2014-2018**



Data source: 2014-2018 DC Mortality Files; Vital Records Division, Center for Policy Planning and Evaluation, DC Department of Health. This includes DC-resident deaths that occurred either in DC or in another state or country. Refer to Table 1 for definitions of maternal, pregnancy-related, and pregnancy-associated, non-related deaths.

LEADING CAUSES OF PREGNANCY-RELATED DEATH, DISTRICT OF COLUMBIA 2014-2018

Roughly 24% of the 21 pregnancy-related deaths in 2014-2018 were due to **cardiovascular diseases or conditions such as stroke,** 19% were due to **heart diseases or conditions, such as cardiomyopathy,** and 19% were due to **pregnancy or delivery-related injuries or complications such as hemorrhage or uterine rupture during pregnancy** (19%). The remaining pregnancy-related deaths were due to other conditions complicating the pregnancy, childbirth, and puerperium (38%).[9]

The 15 pregnancy-associated, non-related deaths were due to accidental or incidental causes, such as automobile accidents and homicide.[10]

SEVERE MATERNAL MORBIDITY

Birthing people in the District also experience high rates of severe maternal morbidity (SMM), defined as unexpected outcomes of labor and delivery that result in significant short-or long-term consequences to their health[11] The definition includes twenty-one specific morbidities; sixteen of these are based on diagnoses, and five are based on procedures that were performed during the hospital stay. In 2016-2017, 392 DC-resident women experienced one or more SMM during a DC-hospital-based delivery, amounting to a two-year rate of 222 SMM per 10,000 deliveries.

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[9] Data source: 2014-2018 Mortality Files; Vital Records Division, Center for Policy Planning and Evaluation, DC Department of Health.

[10] ibid.

[11] Centers for Disease Control and Prevention, (n.d.). Severe Maternal Morbidity in the United States. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

The **leading SMM diagnoses or procedures in the District are blood transfusion, eclampsia, acute renal failure, disseminated intravascular coagulation, shock, adult respiratory distress syndrome, pulmonary edema/acute heart failure, ventilation, hysterectomy, and sepsis.** Many of these leading SMM—such as blood transfusion, emergency hysterectomy, and shock—often result from uncontrolled bleeding or uterine rupture.[12]

Like mortality, severe maternal morbidity disproportionately affects Black women in DC. In 2016-2017, the rate of SMM among Black DC-residents was 2.6 times greater than the rate among White DC-residents (302 SMM cases per 10,000 deliveries among Black women, compared with 118 SMM cases per 10,000 deliveries among White women).[13]

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[12] Hospital Discharge Data for 2016-2017, DC Hospital Association. Compiled by State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health. International Classification of Diseases (ICD) diagnosis and procedure codes were used to identify severe maternal morbidities occurring during delivery hospital stays.

[13] ibid.

SELECTION OF CASES FOR MMRC REVIEW

The DC Vital Records Division conducts a thorough process to identify all potential pregnancy-associated deaths that occurred in the District or to District residents. Potential pregnancy-associated deaths are identified by the following pathways:

1. Indication of pregnancy via the pregnancy checkbox on the death certificate,
2. Indication of pregnancy via a string search of the literal cause of death fields on the death certificate,
3. CD-10 codes indicating a pregnancy-related death,
4. Record linkage to a birth or fetal death record, indicating that a decedent experienced a pregnancy within the preceding year.

A team of Vital Records and DC Health staff meet quarterly to review all potential pregnancy-associated deaths, document whether the pregnancy checkbox is confirmed via record linkage, and identify concerns that require follow-up with the cause of death certifiers. Listings of all potential pregnancy-associated deaths are shared with the Office of the Chief Medical Examiner quarterly for the MMRC.

“Birthing people in the District also experience high rates of severe maternal morbidity (SMM) ...

2019-2020

MMRC MEETING DISCUSSIONS

MAY 2019

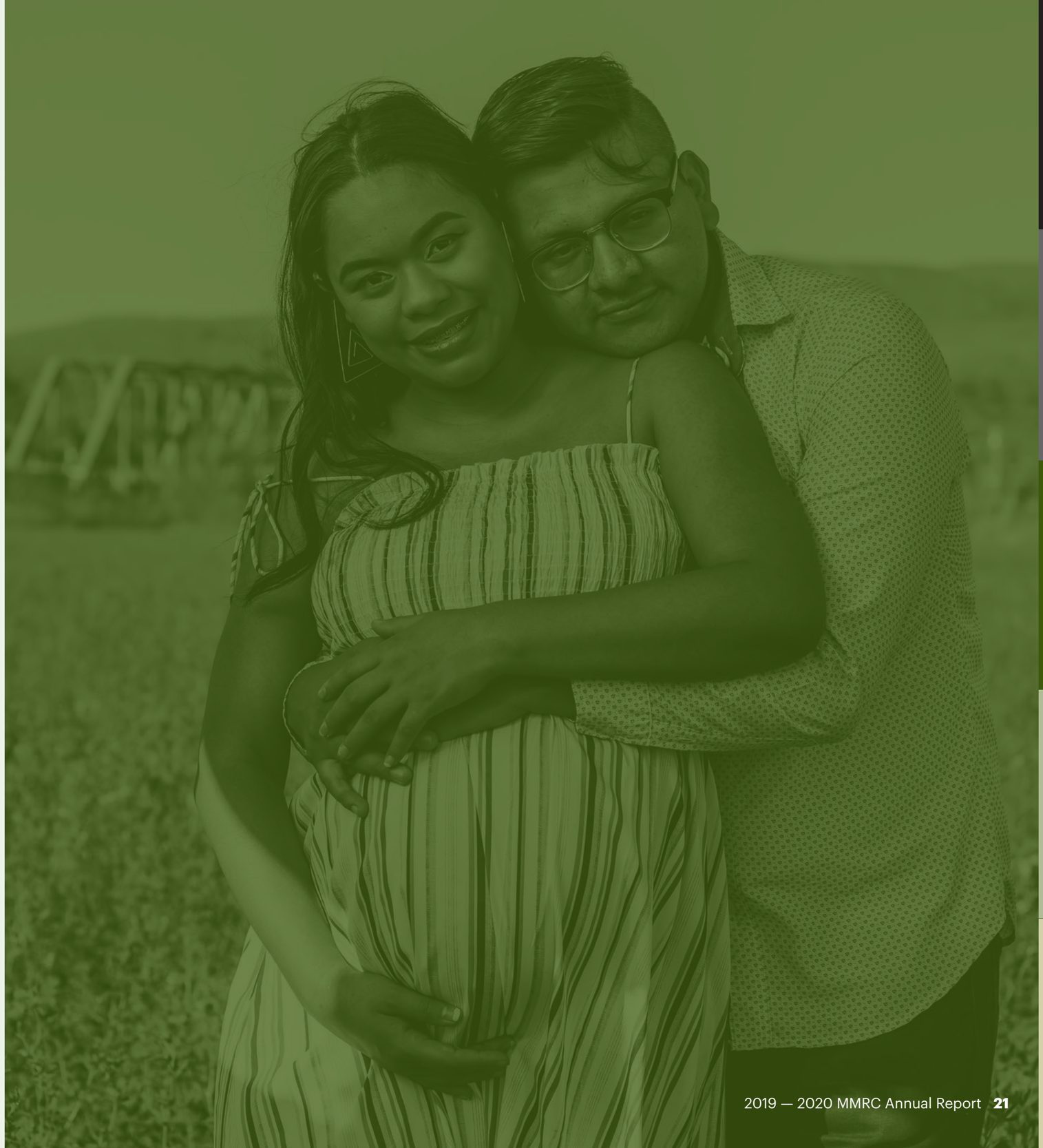
The first formal MMRC meeting was on May 9, 2019, with officials from MOTA present to provide the official swearing-in and presentment of appointment documents to members. Formal introductions of the committee members took place and provided an opportunity for members to share their professional background and experiences, personal viewpoints, and their professional affiliation and motivation for participating on the committee. Several themes emerged from this discussion to include:

- A desire to know "why" women are dying
- A closer look at the accuracy of records and available data
- Addressing the need to improve communication and accountability within the medical system
- Identifying missed opportunities for engagement among providers, community based organizations and government entities
- Addressing the needs of birthing people and provisions for innovative services

There was recognition of all the longstanding efforts in bringing this committee together and the realization and appreciation that the hard work was about to begin.

Members were encouraged not to point fingers or assign blame to any one provider or health care facility during the meetings. If the committee requires additional case information, although it has subpoena power, efforts will be made as a standard of good practice, first to send a "friendly letter' to bring the committee's concerns to the individual provider or institution's attention and request their assessment of the issues and feedback on any corrective action or system improvements that they may have made. If these efforts do not yield the desired results, then the subpoena process can be initiated.

Additional discussion about the meeting schedule, process, rules, and procedures, required forms, confidentiality provisions, and requirements for case reviews took place, with an in-depth discussion of these areas to be covered over the course of the next few meetings.



“The committee discussed the importants of patient choice and autonomy in the development of the plan of care.

JULY 2019

At the July 16, 2019 meeting, July 16, 2019, members reviewed and discussed the MMRC legislation, rules, and procedures, established the meeting frequency and duration of meetings, and voted for co-chairs. There was also a discussion about the process of data linkages between DC, Maryland, and Virginia and whether there was a notification process for cross-jurisdictional deaths. It was shared that the DC Vital Records Division receives information for all deaths that occurred to District residents, including deaths that occurred in other states, as part of a cooperative agreement between all 50 states, five territories, New York City, and the District of Columbia. DC Vital Records Division’s ability to share detailed information on deaths that occurred out-of-state with the MMRC depends on the state where the death occurred.

During this meeting, members discussed the MMRC objectives, functions, and purpose. Roles and current committee vacant seats were discussed where it was shared that movement on the finalization of one of the hospital members was forthcoming. However, it was realized that the seat for a community member affected by a maternal death would be difficult to fill.

The OCME Chief Information Officer spoke to the members about the confidentiality of the Web Portal,[14] not sharing credentials, and secure access to the meeting materials. The OCME General Counsel discussed confidentiality and the importance of non-disclosure of cases or information discussed during closed meeting proceedings. The Chief Medical Examiner highlighted that because of the collaboration of the OCME and DC Health, there may be a future amendment to the DC Code whereby mandatory reporting of maternal mortalities would be made to the OCME. (This legislation was formally established in 2020.)

The MMRC members voted to establish a formal meeting schedule with meetings taking place the fourth Tuesday of every other month, beginning September 2019 from 10:00 am – 12 noon. Quarterly recommendation subcommittee meetings will be scheduled to discuss and vote on the MMRC's proposed recommendations.

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[14] A dedicated SharePoint site (a web-based collaboration system with security features) used to provide access to MMRC case summaries and other confidential meeting materials.

SEPTEMBER 2019

During the public portion of the September 24, 2010 meeting, undergraduate students presented an overview of their maternal health project to the committee.

During the closed portion of this meeting, members reviewed their first case, the members reviewed their first case. Members engaged in detailed and complex discussions about the case, specifically as it related to reviewing the vast range of services that were provided to the decedent. It was also discussed that in addition to the numerous medical services being provided to pregnant people, that the mental health needs and support offered should also be documented to provide the most comprehensive care possible. This may be especially important for those patients who may not have a strong system of supports or who reside alone.

Additionally, it was discussed that there should be no assumptions about a patient’s level of comprehension and that their mental health should be considered when discussing their plan of care. The committee discussed the importance of patient choice and autonomy in th development of the plan of care. Members also discussed their role as being advocates for patients in future MMRC recommendations, especially in relation to discussions externally about legislation and policies that would put a cap on resources and services.

During this meeting, the members also discussed review frameworks such as the resilience model, which were of interest for incorporation into the case summary template. The committee agreed to pursue group training in the operation of an MMRC from experts at CDC.

NOVEMBER 2019

The November 26, 2019 meeting included a member of the public in the open meeting session who expressed an interest in the work of the MMRC. David Goodman, MS, Ph.D., and Julie Zaharatos, MPH, Partnerships and Resources, Maternal Mortality Prevention Team Leads, Division of Reproductive Health, National Centers for Chronic Disease Prevention and Health Promotion from the Centers for Disease Control and Prevention (CDC) conducted a virtual training and technical assistance session to MMRC members during this meeting to increase their skill and capacity for effective case review.

The meeting discussion included a member question about who was responsible for the accountability of committee recommendations. It was shared that there is a local DC framework of accountability through the DC agency performance plans, DC Health oversight of hospitals, and DC Council via performance hearings. The CDC representatives indicated they too were available to provide information and technical assistance on how to act on recommendations and lessons learned from other jurisdictions.

HIGHLIGHTS OF THE **CDC'S PRESENTATION AND FOCUS:**

- Statistics and information about the work of other MMRCs nationally and ways in which other committees have documented their final case decisions in a consistent and standardized way, especially recommendations and implemented actions (through the utilization of the committee decisions form which DC adapted).
- The MMRC is not a mechanism for assigning blame, conducting peer reviews or research.
- Criteria and questions to determine whether the death is pregnancy-related: If she had not been pregnant, would she have died? This also holds true for suicide and overdose deaths. A decision tree was discussed.
- Discussed preventability and contributing factors (it was noted that these definitions continue to be further refined in working groups at CDC).
- Discussed including racism and discrimination as contributing factors in case reviews.
- Discussed, when available, geocoding demographics of decedents and identifying health indicators based on zip codes.

JANUARY 2020

The January 28, 2020, open portion of the meeting included an undergraduate student from the University of the District of Columbia who was to be a panelist member at the National Conference of Black Political Scientists. He requested interviews with any interested MMRC members to further shape his understanding and research on the demographics of maternal mortality in the District of Columbia. Three MMRC members shared their interest in being interviewed and agreed to work outside of the meeting to support the student in this endeavor. Following this dialogue, the Committee went into closed session and continued their review and discussion of the case from the September meeting with a focus on how to best implement lessons learned the training hosted at the previous meeting.

MARCH – JUNE 2020

Meetings were suspended during this period due to the COVID public health emergency.

OCME STAFF DIVERSION DURING COVID - VIRTUAL FAMILY ASSISTANCE CENTER (VFAC)

During the onset of the COVID-19 pandemic, in addition to the normal duties of the fatality review division staff, the Fatality Review Division Manager and Fatality Review Program Specialists were detailed to support the development and implementation of the Virtual Family Assistance Center (VFAC) alongside the leadership of the Department of Behavioral Health, (DBH), Department of Human Services (DHS), DC Public Schools (DCPS), School-Based Mental Health, and the Mayor's Office of Community Relations (MOCRS). Staff from each of these areas were the first Navigators to engage with COVID-19 decedent Next of Kin and their families to provide support and resources to them.

WHAT IS THE VFAC?

The Bowser Administration established the Virtual Family Assistance Center (VFAC) to serve as a collaborative, streamlined system to engage with and assist individuals and families who lost loved ones to COVID-19. Trained professionals provided support in a multitude of areas and ensured individuals received the resources available to them during this difficult time.

WHAT SERVICES WERE PROVIDED?

VFAC Navigators provided a listening ear, responded to, and connected individuals to needed District services and resources. These services included, but were not limited to:

- Burial and funeral assistance
- Delivery of food and other essential items
- Connection to vital records and other documents
- Connection to public benefits for food, employment/ unemployment, health insurance, and cash assistance
- Rental, utility, and house cleaning/disinfecting assistance and support
- Mental health and grief support
- Support for seniors
- Support for students

INFORMAL MMRC MEETINGS

During the public health emergency declaration, the fatality review division continued to coordinate and plan meetings, offering members and participants a platform for engagement. Unofficial meetings were held, offering participants an opportunity to present real-time information about the services or programs they were providing to support District residents during these challenging times.

VIRTUAL FATALITY REVIEW FRAMEWORK

During the COVID public health emergency declaration, the Fatality Review Division Manager and Fatality Review Program Specialists developed and implemented a virtual fatality review platform utilizing Web-Ex software. All meetings complied with the Open Meetings Act and provided opportunities for ongoing participation of members during and the public meetings, thus allowing the committee to resume regular committee business.

JULY 2020

The first official virtual MMRC meeting took place on July 28, 2020. An orientation to the virtual platform was presented, and technical support was provided accordingly. A new Co-Chair was voted upon, as well as the extension of the meeting calendar and frequency through the end of the year. As such, the MMRC Rules and Procedures were amended and updated.

During this meeting, the Committee went into closed session and continued the review of the case from the meeting before the public health emergency declaration, utilizing the CDC's Maternal Mortality Review Information Application (MMRIA) Committee Decisions form.[15] Highlights of the case discussion included a finding that the decedent was served in multiple facilities and that a communication breakdown occurred between facilities compromising the quality of care during the prenatal period. Committee members discussed how health care providers and systems can address the needs of patients complex high social needs including the provision of appropriate social referrals and increased outreach earlier in the pregnancy as components of high quality prenatal care. This outreach should include earlier referrals to social services and/or doula services. It was determined that decedent social needs should be given the same level of clinical skill and quality attention as physical/medical needs and that the definition of quality of care should be modified to include social aspects in addition to clinical care.

It was also noted that there are often challenges when caring for medically complex patients. There is a balance between continued maternal health issues and preterm delivery and the challenging decisions associated. The MMRC highlighted that decision-making is a shared responsibility between the patient and all care providers involved in the patient's care and not just one discipline.

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[15] Source: https://reviewtoaction.org/national-resource/maternal-mortality-review-committee-decisions-form

AUGUST 2020

The August 25, 2020, meeting commenced with the members acknowledging how difficult and challenging the summer was and how dedicated the members have been in continuing to engage in the committee's work despite experiencing general pandemic fatigue.

Members reviewed the concept, definition and examples of structural racism. Structural racism includes historical exposure to racism built into systems. The decedent whose case was reviewed, revealed a disparity in terms of access to several different resources. The decedent experienced housing instability that created challenges with access to care and resources. Housing instability also occured at the community and system levels due to the lack of affordable of housing in the District, and the complexity inherent in trying to access affordable housing and housing support in her area. Structural racism was identified in the provider

relationships beyond interpersonal racism, as it played out as power dynamics at the system level. Members agreed this is a place where recommendations to ensure resources that are culturally and economically feasible and appropriate to meet the needs of District residents are so important.

Members also made reflections...

1. Why are we here?
2. Why do we move through the cases in the way we have to date? Members highlighted the strengths of the MMRC being intentional in reviewing cases and that they will continue to review cases from a holistic perspective.
3. To honor the whole person in how we look at the cases and not strictly from a single system perspective.
4. Recognizing that because DC is such a small jurisdiction, there may be individuals at the table who either knew the decedent or served the decedent in some capacity.
5. Members wanted to honor the decedents whose cases were presented for review and be mindful of how comments were presented, to lead with empathy, and recognize the grief process for all involved.
6. The MMRC members realized additional time was needed to continue cultivating relationships and establish trust among all members. As members continue to do the committee's work, they were reminded to also do the work on themselves and continue to challenge their own assumptions, biases, and sometimes fears. Committee members acknowleged that they will have to sit with the uncomfortable truths about the health care system, our society, and the roles members play within those settings. Members recognized this is what is necessary to create a better, equitable, and more just maternal health system in the District.

SEPTEMBER 2020

During the September 22, 2020 meeting the committee reviewed of two new cases of Maryland residents who died in the District. The two decedent's medical histories were reviewed. However, they did not have any system involvement with District agencies. No additional findings or recommendations were made.

NOVEMBER 2020

A student from Georgetown University participated in the open portion of the November 24, 2020 meeting and inquired about several aspects of maternal mortality in the District. Members addressed the questions, provided information about their respective professional backgrounds, and shared additional online resources such as those associated with the CDC on Maternal Mortality[16] and the DC Health's 2018 Perinatal Health and Infant Mortality Report.[17]

Members continued their review of a case from the previous meeting. There was a rich discussion about the receipt of medical records being requested on behalf of the MMRC. It was realized that different hospitals maintain records in different places. The hospital medical records are not always provided in their entirety (pathology, prenatal care, and delivery records are often not provided or are incomplete). MMRC physician representatives from the hospitals where a decedent received services agreed to work with fatality review staff to map out the different services and providers within their respective systems where records were created and stored to ensure all supplemental information could easily be requested and received. Additionally, MMRC physician members agreed to collaborate with fatality review staff to conduct a preliminary review of the cases in advance of the full MMRC meeting to ensure all information was received and reflected the necessary medical information to determine whether the death was preventable from a medical perspective.

Additionally in closed session, the MMRC reviewed a case stemming from domestic violence. The MMRC collaborated with the DC Domestic Violence Fatality Review Board (DVFRB) Coordinator on this case. Further discussion of the case required additional agency provider participation (i.e., child welfare, courts), which would be coordinated in preparation for the January 2021 meeting.

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[16] Source: https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html

[17] Source: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/Perinatal%20Health%20Report%202018_FINAL.pdf

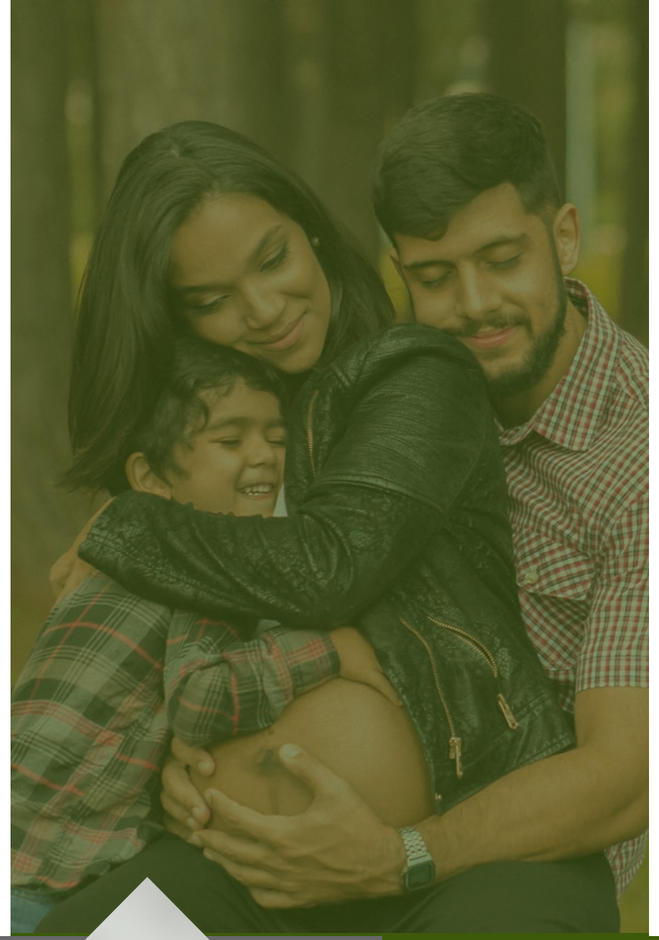
2019/2020 ACCOMPLISHMENTS AND HIGHLIGHTS

IN 2019-2020, THE MMRC ACCOMPLISHED THE FOLLOWING:

- Members were identified and officially sworn-in by Mayor's Office of Talent and Appointments. Members were oriented by the Fatality Review Division Staff
- Produced Final Rules and Procedures
- Established quorum and meeting frequency
- Reviewed the MMRC Legislation
- Reviewed Robert's Rules of Order
- Received training from CDC experts on committee conduct and case review protocols
- Held the first case review in November 2019
- Implemented a virtual meeting framework in July 2020
- March – June 2020 Members provided presentations on COVID-19 related services affecting labor and deliveries in DC
- Successfully conducted first official virtual MMRC meeting July 2020

A LOOK INTO **2021 MMRC OBJECTIVES**

- The development of a robust framework for the identification of findings and recommendations.
- Continued use of the CDC Maternal Mortality Review Committee Decisions Form MMRIA.
- Conducting quarterly recommendation sub-committee meetings for the formal adoption of recommendations.
- Continued research and submission of applications for grants or other financial resources to support the work of the MMRC.



A PREVIEW OF **RECOMMENDATIONS**

IN 2019-2020, THE MMRC ACCOMPLISHED THE FOLLOWING:

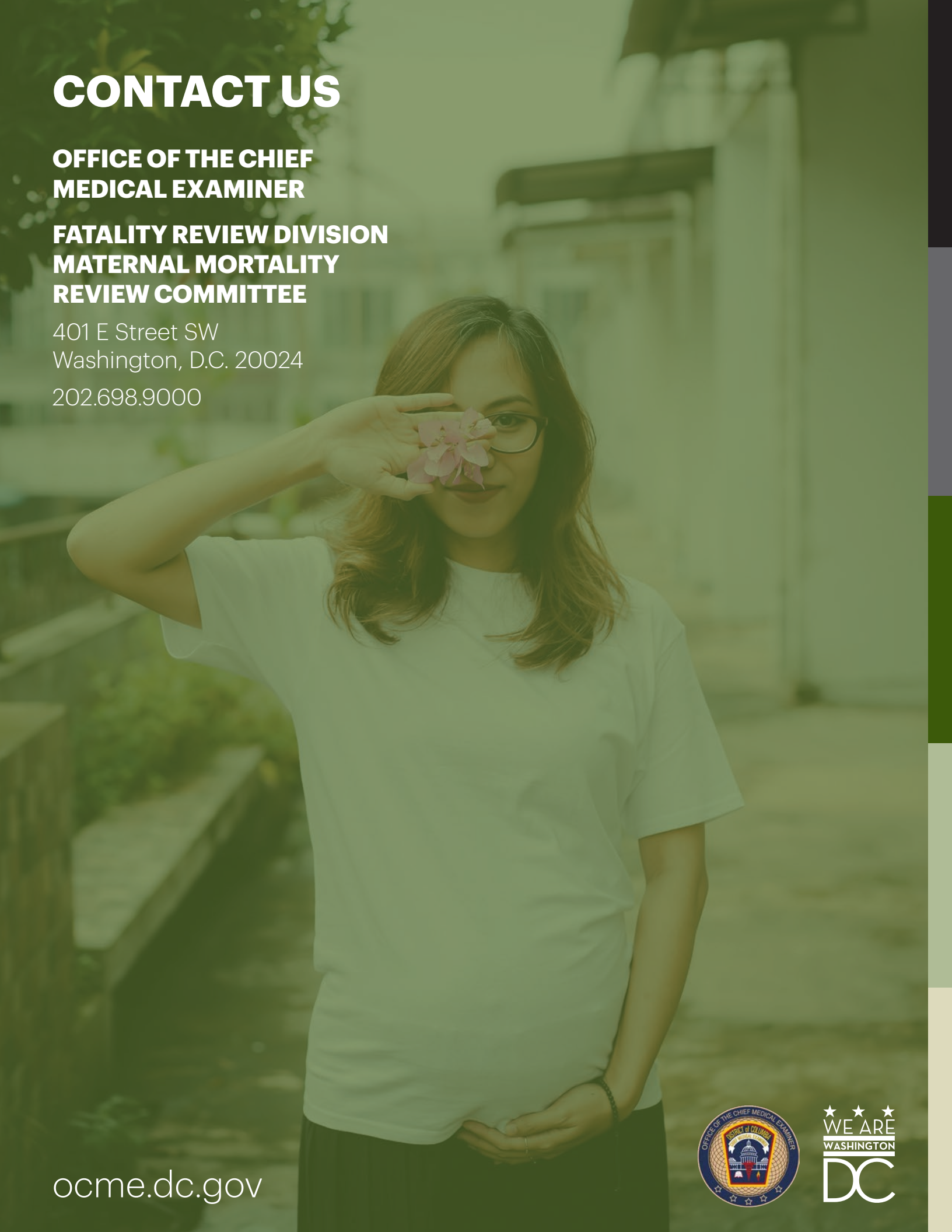
1. DC Hospitals and other inpatient care facilities should increase the availability of inpatient social workers who have the capacity to engage with the patient during hospitalization and provide companionship in addition to information gathering to increase the level of support the patient receives.
2. System improvements need to be made in the transition from in-hospital to home care by increasing same-day home nursing services, same-day telephone calls, and connections, and same-day provision of medications.

"DC Hospitals and other inpatient care facilities should increase the availability of inpatient social workers who have the capacity to engage with the patient during hospitalization ..."

ACKNOWLEDGEMENT

The Office of the Chief Medical Examiner's Fatality Review Division expresses their deep appreciation for the work of the members of the Maternal Mortality Review Committee. Their tireless volunteerism will help the District of Columbia to improve outcomes for all residents of the District of Columbia. We recognize that with this group of dedicated individuals, the work of the MMRC will not be in vain. Your work speaks truth to power, and we thank you for your service.

We also thank DC Health's Center for Policy, Planning, and Evaluation for providing contextual data to the MMRC in 2019. This information was included in this annual report.



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