Identifying Racism & Discrimination as Contributing Factors in Pregnancy-Related Deaths

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Icahn School of Medicine at Mount Sinai

Please note: webinar is being recorded
Agenda:

• Background
• Goal
• Definitions
• Example of a Tool to Identify Racism
• Recommendations
• Q&A
Background

How Hospitals Are Failing Black Mothers

A ProPublica analysis shows that women who deliver at hospitals that disproportionately serve black mothers are at a higher risk of harm.

by Annie Waldman, Dec. 27, 2017, 8 a.m. EST

Rosa Diaz; Courtesy of Diana Diaz

Nothing Protects Black Women From Dying in Pregnancy and Childbirth

Not education. Not income. Not even being an expert on racial disparities in health care.

by Nina Martin, ProPublica, and Renee Montagne, NPR, Dec. 7, 2017, 8 a.m. EST

Racism Linked to High Maternal and Infant Mortality for Native Women

“We stopped keeping statistics on the number of Native moms and babies that are lost in our region; it was just too upsetting.”

Erica Garner Andrew Burton/ Getty Images

Rosa Diaz; Courtesy of Diana Diaz
Background

What Serena Williams’s scary childbirth story says about medical treatment of black women

Black women are often dismissed or ignored by medical care providers. Williams wasn’t an exception.

By P.R. Lockhart | Jan 11, 2018, 4:40pm EST

ProPublica and NPR story - Nothing Protects Black Women From Dying in Pregnancy and Childbirth
Dec 7, 2017

“In the more than 200 stories of African-American mothers that ProPublica and NPR have collected over the past year, the feeling of being devalued and disrespected by medical providers was a constant theme...Over and over, black women told of medical providers who equated being African American with being poor, uneducated, noncompliant and unworthy. “Sometimes you just know in your bones when someone feels contempt for you based on your race,” said one Brooklyn woman who took to bringing her white husband or in-laws to every prenatal visit.”

Pregnancy-Related Mortality Ratios by Race-Ethnicity, 2007-2016

- Non-Hispanic Black: 40.8
- American Indian: 29.7
- Asian/Pacific Islander: 13.5
- White: 12.7
- Latina: 11.5

Pregnancy-Related Mortality Ratios by Educational Attainment, 2007-2016

- Less than high school:
  - Black non-Latina: 44.6
  - AI/AN non-Latina: 50.8
  - White non-Latina: 25.0

- High school graduate:
  - Black non-Latina: 59.1
  - AI/AN non-Latina: 43.7
  - White non-Latina: 25.2

- Some college:
  - Black non-Latina: 41.0
  - AI/AN non-Latina: 32.0
  - White non-Latina: 11.7

- College graduate or higher:
  - Black non-Latina: 40.2
  - AI/AN non-Latina: >5X
  - White non-Latina: 7.8

### EXHIBIT 2

Likelihood of severe maternal morbidity and mortality in the US, by selected characteristics, 2007–15

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Adjusted odds ratio&lt;sup&gt;a&lt;/sup&gt;</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural (ref: urban)</td>
<td>1.09</td>
<td>1.05, 1.13</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Year (continuous)</td>
<td>1.04</td>
<td>1.03, 1.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age (continuous)</td>
<td>1.00</td>
<td>0.99, 1.00</td>
<td>0.260</td>
</tr>
<tr>
<td>Insurance payer (ref: private)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>1.31</td>
<td>1.28, 1.34</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Uninsured/self-pay/other</td>
<td>1.31</td>
<td>1.26, 1.37</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Race/ethnicity (ref: non-Hispanic white)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>1.79</td>
<td>1.72, 1.84</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.38</td>
<td>1.33, 1.44</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1.34</td>
<td>1.27, 1.42</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>1.61</td>
<td>1.44, 1.80</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Unknown/other</td>
<td>1.21</td>
<td>1.15, 1.27</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Bottom national quartile of income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ref: top three quartiles)</td>
<td>1.11</td>
<td>1.08, 1.14</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Census region of hospital (ref: South)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>1.09</td>
<td>1.03, 1.15</td>
<td>0.003</td>
</tr>
<tr>
<td>Midwest</td>
<td>0.92</td>
<td>0.87, 0.98</td>
<td>0.012</td>
</tr>
<tr>
<td>West</td>
<td>0.90</td>
<td>0.85, 0.96</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Source: Kozhimannil KB. Health Affairs. 2019 Dec; Vol.38, No.12.
How Did We Get Here?
Levels of Racism: A Theoretic Framework and a Gardener’s Tale
Camara Jones, MD, PhD, MPH

- Racism is a system of inequity that exists among other systems of inequity (e.g. sexism)
- Each system of inequity can be categorized by 3 factors:
  - Unfairly disadvantaging some individuals
  - Unfairly advantaging other individuals
  - Saps the strength of the whole society through a waste of human resources
- Racism exists on three levels

Institutionalized racism
- Initial historical insult
- Structural barriers
- Inaction in face of need
- Societal norms
- Biological determinism
- Unearned privilege

Personally mediated racism
- Intentional
- Unintentional
- Acts of commission
- Acts of omission
- Maintains structural barriers
- Condoned by societal norms

Internalized racism
- Reflects systems of privilege
- Reflects societal values
- Erodes individual sense of value
- Undermines collective action

Figure 1: Pathways to Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality

Discrimination in Maternal Healthcare

• Growing recognition that discrimination contributes to adverse maternal health outcomes
• One quarter of women perceive discrimination during delivery hospitalization
• Associated with worse communication, lower patient ratings of care, less adherence to treatment recommendations, and poorer overall health

Impact of Discrimination on Perinatal Outcomes

- Women of color report more experiences of discrimination, food insecurity, and depression
- Women of color experience higher levels of chronic stress during pregnancy - results in compromised endocrine and immune function
- Burden remains higher across all income and education levels
- Results in greater rates of hypertensive disorder, preterm birth, low birth weight neonates and perinatal mortality among Black women

Impact of Structural Racism on Adverse Birth Outcomes

- Redlining, mortgage discrimination, and residential segregation contribute to health inequities in maternal care
- Results in diminished socioeconomic opportunities, differential risk exposure to social and environmental risks, and differential quality and access to care
- Inadequate housing, neighborhood poverty and violence, exposure to toxins and pollutions, and lack of social services cause increase in stress and maternal deprivation and isolation

MMRC members have reported that bias and discrimination play significant roles as contributing factors leading up to maternal death.

Yet no distinct category for bias or discrimination in MMRIA
Goals

• Design a consistent approach for documenting bias as a contributing factor to pregnancy-related deaths

• Provide recommendations specific to how to prevent bias as a contributing factor to pregnancy-related deaths

• Promote MMRC member understanding of opportunities to eliminate disparities

Ultimate goal:

• Eliminate disparities in pregnancy-related deaths & Achieve Health Equity
Language

- ‘Bias’ is a default term - loses culpability in conversation, while ‘discrimination’ is stronger and clearer
- Terminology needed to be inclusive, but balanced with legacy of racism
- Racism is rarely discussed in MMRCs; members may be unfamiliar with identifying racism or would be uncomfortable calling it out if given another option
- Need to show leadership in describing what is going on in maternal care in the U.S. for black women, while not assuming all discrimination in maternal care is racial (e.g. insurance-type, marital status, sexuality, disability, etc.)
### Contributing Factors

**Contributing Factor Key (Descriptions on Page 4)**

<table>
<thead>
<tr>
<th>Delay</th>
<th>Tobacco use</th>
<th>Continuity of care/care coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence</td>
<td>Chronic disease</td>
<td>Clinical skill/quality of care</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Childhood abuse/trauma</td>
<td>Outreach</td>
</tr>
<tr>
<td>Cultural/religious</td>
<td>Access/financial</td>
<td>Law Enforcement</td>
</tr>
<tr>
<td>Environmental</td>
<td>Unstable housing</td>
<td>Referral</td>
</tr>
<tr>
<td>Violence</td>
<td>Social support/isolation</td>
<td></td>
</tr>
<tr>
<td>Mental health conditions</td>
<td>Equipment/technology</td>
<td></td>
</tr>
<tr>
<td>Substance use disorder - alcohol, illicit/prescription drugs</td>
<td>Policies/procedures</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Added three new contributing factors**:  
- Structural Racism  
- Interpersonal Racism  
- Discrimination

- Will be on the version of MMRIA committee decisions form ([https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form](https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form)) set for release in May 2020.
**Structural Racism:** the systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.

Adapted from Bailey ZD. Lancet. 2017; 389(10077):1453-1463.

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**CONTRIBUTING FACTOR DESCRIPTIONS**

<table>
<thead>
<tr>
<th>DELAY OR FAILURE TO SEEK CARE</th>
<th>Poor communication/lack of case coordination or management/ lack of continuity of care (system perspective)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The woman was delayed in seeking or did not access care, treatment, or follow-up care/actions (e.g. missed appointment and did not reschedule).</td>
<td>The patient was not rescheduled or followed up due to lack of communication or coordination.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADHERENCE TO MEDICAL RECOMMENDATIONS</th>
<th>Adherence to Medical Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>The woman did not accept medical advice (e.g. refused treatment for religious or other reasons or left the hospital against medical advice).</td>
<td>The patient did not follow the recommended treatment plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KNOWLEDGE - LACK OF KNOWLEDGE REGARDING IMPORTANCE OF EVENT OR OF TREATMENT OR FOLLOW-UP</th>
<th>Knowledge and Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>The woman did not receive adequate education or lacked knowledge or understanding regarding the significance of a health event (e.g. shortness of breath as a trigger to seek immediate care) or lacked understanding about the need for treatment/follow-up and evaluation for a health event (e.g. needed to keep appointment for psychiatric referral after an ED visit for exacerbation of depression).</td>
<td>The patient did not understand the importance of the health event or the need for treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CULTURAL/RELIGIOUS, OR LANGUAGE FACTORS</th>
<th>Cultural and Language Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstration that any of these factors was either a barrier to care due to lack of understanding or led to refusal of therapy due to beliefs (or belief systems).</td>
<td>The cultural or religious beliefs were barriers to care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENVIRONMENTAL FACTORS</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors related to weather or terrain (e.g. the advent of a sudden storm leads to a motor vehicle accident).</td>
<td>The environmental conditions influenced the patient's health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)</th>
<th>Violence and Intimate Partner Violence (IPV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical or emotional abuse other than that perpetrated by intimate partner (e.g. family member or stranger); IPV. Physical or emotional abuse perpetrated by the woman's current or former intimate partner.</td>
<td>The patient experienced physical or emotional abuse.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MENTAL HEALTH CONDITIONS</th>
<th>Mental Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The woman carried a diagnosis of a psychiatric disorder. This includes postpartum depression.</td>
<td>The patient suffered from a psychiatric disorder.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUBSTANCE USE DISORDER - ALCOHOL, ILLICIT/ PRESCRIPTION DRUGS</th>
<th>Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use disorder is characterized by recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems or disability. The committee may determine that substance use disorder contributed to the death when the disorder directly compromised a woman's health status (e.g. acute methamphetamine intoxication exacerbated pregnancy-induced hypertension, or woman was more vulnerable to infections or medical conditions).</td>
<td>The patient had a substance use disorder.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL SUPPORT/ISOLATION - LACK OF FAMILY/ FRIEND SUPPORT SYSTEM</th>
<th>Social Support and Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social support from family, partner, or friends was lacking, inadequate, and/or dysfunctional (e.g., domestic violence, no one to rely on to ensure appointments were kept).</td>
<td>The patient lacked social support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INADEQUATE OR UNAVAILABLE EQUIPMENT/ TECHNOLOGY</th>
<th>Inadequate or Unavailable Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment was missing, unavailable, or not functional, (e.g. absence of blood tubing connector).</td>
<td>The patient lacked necessary equipment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LACK OF STANDARIZED POLICIES/PROCEDURES</th>
<th>Lack of Standardized Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility lacked basic policies or infrastructure germane to the woman's needs (e.g. response to high blood pressure or a lack of or outdated policy or protocol).</td>
<td>The facility lacked standardized policies.</td>
</tr>
</tbody>
</table>

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*Will be on the version of MMRIA committee decisions form ([https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form](https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form)) set for release in May 2020.*
Interpersonal Racism: discriminatory interactions between individuals resulting in differential assumptions about the abilities, motives, and intentions of others and differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization.

Adapted from Jones CP. Am J Public Health. 2000; 90(8): 1212–1215.
Discrimination: treating someone more or less favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making.

Adapted from Smedley BD. National Academies Press (US); 2003.

Will be on the version of MMRIA committee decisions form (https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form) set for release in May 2020.
Challenges:

• Difficult to identify racism from a medical record
• Lack of context for the abstractor
• Incomplete medical and non-medical/social records
• Lack of understanding and acceptance that racism is present in medical care among MMRC members
Example of one MMRC’s approach to identifying racism as a contributing factor in pregnancy-related deaths

Developed by Texas Maternal Mortality Review Committee to help identify racism as a contributing factor from the social worker’s notes and the medical record

Texas is currently piloting the tool and will be training abstractors and committee members to identify racism

Does not prove racism, but increases awareness to the possibility that racism and discrimination were contributing factors to a maternal mortality

*In development by the Texas Maternal Mortality Review Committee
Negative patient/provider/facility interaction
(stigmatizing language, dismissing concerns, case notes suggest provider/facility conflict)

Excessive gatekeeping
(inability to reach provider, leaving messages, etc.)

Indicated labs not ordered / delayed labs ordered

Leaving against medical advice

Repeated ED visits in short time frame (for urgent care)

Cultural incompetence
(lack of translator, awareness of other culture)

Lack of access to health care before, during, and after pregnancy
(structural bias)

Treatment decisions and recommendations inconsistent with best practices

8a. Over-treatment
8b. Under-treatment
8c. Delay in treatment
8d. Inadequate pain management
8e. Assumptions about patient’s adherence to treatment
8f. Other, please specify

From the record review, do you perceive that any of these factors might have impacted this woman’s course? **Select all that apply**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNK</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNK</th>
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</table>

*In development by the Texas Maternal Mortality Review Committee*
Recommendations

- Developed collaboratively with your whole committee
- Align with identified issues and contributing factors
## Standardized Committee Decisions Form (Page 2)

### Committee Determination of Preventability
A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

<table>
<thead>
<tr>
<th>WAS THIS DEATH PREVENTABLE?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANCE TO ALTER OUTCOME?</td>
<td>GOOD CHANCE</td>
<td>SOME CHANCE</td>
</tr>
</tbody>
</table>

### Contributing Factors and Recommendations for Action
(Entries may continue to grid on page 5.)

#### Contributing Factors Worksheet
What were the factors that contributed to this death? Multiple contributing factors may be present at each level.

<table>
<thead>
<tr>
<th>CONTRIBUTING FACTOR LEVEL</th>
<th>CONTRIBUTING FACTORS (choose as many as needed below)</th>
<th>DESCRIPTION OF ISSUE (enter a description for each contributing factor listed)</th>
<th>COMMITTEE RECOMMENDATIONS (WHO?) should (DO WHAT?) (WHEN?) Map recommendations to contributing factors.</th>
<th>PREVENTION LEVEL (choose below)</th>
<th>EXPECTED IMPACT LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT/FAMILY</td>
<td></td>
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<tr>
<td>PROVIDER</td>
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<tr>
<td>FACILITY</td>
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</tr>
<tr>
<td>SYSTEM</td>
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<tr>
<td>COMMUNITY</td>
<td></td>
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</tr>
</tbody>
</table>

### Contributing Factor Key (Descriptions on Page 4)
- Delay
- Adherence
- Knowledge
- Cultural/religious
- Environmental
- Violence
- Mental health conditions
- Substance use disorder - alcohol, illicit/prescription drugs
- Tobacco use
- Chronic disease
- Childhood abuse/trauma
- Access/financial
- Unstable housing
- Social support/isolation
- Equipment/technology
- Policies/procedures
- Communication
- Continuity of care/care coordination
- Clinical skill/quality of care
- Outreach
- Law Enforcement
- Referral
- Assessment
- Legal
- Other

### Prevention Level
- PRIMARY: Prevents the contributing factor before it even occurs
- SECONDARY: Reduces the impact of the contributing factor once it has occurred (i.e., treatment)
- TERTIARY: Reduces the impact or progression of what has become an ongoing contributing factor (i.e., management of complications)

### Expected Impact Level
- SMALL: Education/counseling (community- and/or provider-based health promotion and education activities)
- MEDIUM: Clinical intervention and coordination of care across continuum of well-woman visits (protocols, prescriptions)
- LARGE: Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies/LARC)
- EXTRA LARGE: Change in context (promote environments that support healthy living/ensure available and accessible services)
- GIANT: Address social determinants of health (poverty, inequality, etc.)

MMRIA committee decisions form (https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form)
Standardized Committee Decisions Form (Page 2)

## Contributing Factors and Recommendations for Action

### Contributing Factors Worksheet
What were the factors that contributed to this death? Multiple contributing factors may be present at each level.

<table>
<thead>
<tr>
<th>Contributing Factor Level</th>
<th>Contributing Factors (choose as many as needed below)</th>
<th>Description of Issue (enter a description for each contributing factor listed)</th>
<th>Committee Recommendations [Who?] should [do what?] [when?] Map recommendations to contributing factors.</th>
<th>Prevention Level (choose below)</th>
<th>Impact Level (choose below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Family</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Provider</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Facility</td>
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<tr>
<td>System</td>
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<tr>
<td>Community</td>
<td></td>
<td></td>
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</tbody>
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- Outreach
- Law Enforcement
- Referral
- Assessment
- Legal

- Structural Racism
- Interpersonal Racism
- Discrimination

MMRIA committee decisions form (https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form)
## Standardized Committee Decisions Form (Page 2)

**Committee Determination of Preventability**

A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

**WAS THIS DEATH PREVENTABLE?**
- [ ] Yes
- [ ] No

**CHANCE TO ALTER OUTCOME?**
- [ ] Good chance
- [ ] Some chance
- [ ] No chance
- [ ] Unable to determine

### Contributing Factors and Recommendations for Action

#### Contributing Factors Worksheet

What were the factors that contributed to this death? Multiple contributing factors may be present at each level.

<table>
<thead>
<tr>
<th>Contributing Factor Level</th>
<th>Contributing Factors (choose as many as needed below)</th>
<th>Description of Issue (Enter a description for each contributing factor listed)</th>
<th>Committee Recommendations [Who?] should [Do what?] [When?]</th>
<th>Map recommendations to contributing factors.</th>
<th>Prevention Level (Choose below)</th>
<th>Expected Impact Level (Choose below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Family</td>
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<td>Provider</td>
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### Recommendations of the Committee

If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events?

**Prevention Level**
- PRIMARY: Prevents the contributing factor before it ever occurs
- SECONDARY: Reduces the impact of the contributing factor once it has occurred (i.e., management of complications)

**Expected Impact Level**
- SMALL: Education/counseling (community- and/or provider-based health promotion and education activities)
- MEDIUM: Clinical intervention and coordination of care across continuum of well-woman visits (protocols, prescriptions)
- LARGE: Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies/LARC)
- EXTRA LARGE: Change in context (promote environments that support healthy living/ensure available and accessible services)
- GIANT: Address social determinants of health (poverty, inequality, etc.)

[MMRIA committee decisions form](https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form)
Specific and Actionable Recommendations from State MMRCs

_____ should ________  ________.  
(who?)  (do what?)  (when?)

**WHO** is the entity/agency who would have been/be responsible for the intervention?*

**WHAT** is the intervention and **WHERE** is the intervention point?*
- Patient/Family
- Provider
- Facility
- System
- Community

**WHEN** is the proposed intervention point?
- Among women of reproductive age ("preconception")
- In pregnancy and in the postpartum period
  - Labor & Delivery (L&D)
  - Prior to L&D hospitalization discharge
  - First 6 weeks postpartum
  - 42-365 days postpartum
Achieving Health Equity Requires:

- Valuing all individuals and populations equally
- Recognizing and rectifying historical injustices
- Providing resources according to need
Specific and Actionable Recommendations

Example 1:

- Hospitals should mandate comprehensive communication training addressing implicit bias, explicit bias, racism, and shared-decision making for all healthcare professionals on a continuous basis.

Valuing all individuals and populations equally
Specific and Actionable Recommendations

Example 1:

- **Hospitals** should mandate comprehensive communication training addressing implicit bias, explicit bias, racism, and shared-decision making for all healthcare professionals on a continuous basis.
Specific and Actionable Recommendations

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Specific and Actionable Recommendations

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- Hospitals should mandate comprehensive communication training addressing implicit bias, explicit bias, racism, and shared-decision making for all healthcare professionals on a continuous basis.

when?
Specific and Actionable Recommendations

Example 2:

- Facilities should assess patient education materials, photography and artwork in public spaces, furniture, and signage to ensure a positive reflection of diversity, immediately.

Recognizing and rectifying historical injustices  Health Equity
Specific and Actionable Recommendations

Example 2:

- **Facilities** should assess patient education materials, photography and artwork in public spaces, furniture, and signage to ensure a positive reflection of diversity, immediately.
Specific and Actionable Recommendations

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Specific and Actionable Recommendations

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Specific and Actionable Recommendations

Example 3:

• OB clinicians should screen patients for social determinants of health (SDOH) at prenatal and L&D visits, including late entry into healthcare system, and work with social workers to address specific needs and care coordination relevant to the SDOH.
Specific and Actionable Recommendations

Example 3:

• **OB clinicians** should screen patients for social determinants of health (SDOH) at prenatal and L&D visits, including late entry into healthcare system, and work with social workers to address specific needs and care coordination relevant to the SDOH.
Specific and Actionable Recommendations

Example 3:

- OB clinicians should **screen patients for social determinants of health (SDOH)** at prenatal and L&D visits, including late entry into healthcare system, and work with social workers to address specific needs and care coordination relevant to the SDOH.
Specific and Actionable Recommendations

Example 3:

• OB clinicians should screen patients for social determinants of health (SDOH) at prenatal and L&D visits, including late entry into healthcare system, and work with social workers to address specific needs and care coordination relevant to the SDOH.
Achieving Health Equity Requires:

- Valuing all individuals and populations equally
- Recognizing and rectifying historical injustices
- Providing resources according to need
## CONTRIBUTING FACTORS AND RECOMMENDATIONS FOR ACTION

### CONTRIBUTING FACTORS WORKSHEET
What were the factors that contributed to this death? Multiple contributing factors may be present at each level.

### RECOMMENDATIONS OF THE COMMITTEE
If there was at least some chance that the death could have been averted and feasible actions that, if implemented or altered, might have changed the outcome.

<table>
<thead>
<tr>
<th>CONTRIBUTING FACTOR LEVEL</th>
<th>CONTRIBUTING FACTORS (choose as many as needed below)</th>
<th>DESCRIPTION OF ISSUE (enter a description for EACH contributing factor listed)</th>
<th>COMMITTEE RECOMMENDATIONS [Who?] should [do what?] [when?]</th>
<th>Map recommendations to contributing factors.</th>
<th>How it helps to achieve health equity</th>
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<tr>
<td><strong>PATIENT/FAMILY</strong></td>
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<td><strong>PROVIDER</strong></td>
<td>Interpersonal Racism; Discrimination</td>
<td>Communication failures, stereotyping by providers, concerns not addressed, ignored and improperly treated symptoms, lack of appropriate referral or consultation</td>
<td>OB clinicians should screen patients for social determinants of health (SDOH) at prenatal and L&amp;D visits, including late entry into healthcare system, and work with social workers to address specific needs and care coordination relevant to the SDOH.</td>
<td>Providing resources according to need</td>
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<tr>
<td><strong>FACILITY</strong></td>
<td>Structural Racism; Discrimination</td>
<td>Stereotyping by providers, racist policies and practices, failure to mandate anti-racism training, lack of quality care for racial minorities</td>
<td>Hospitals should mandate comprehensive communication training addressing implicit bias, explicit bias, racism, and shared-decision making training for all healthcare professionals on a continuous basis.</td>
<td>Valuing all individuals and populations equally</td>
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<tr>
<td><strong>SYSTEM</strong></td>
<td>Structural Racism; Discrimination</td>
<td>Lack of resources, inadequate staffing in hospitals serving minority communities, lack of providers accepting patients insured by Medicaid</td>
<td>State governments should expand access to Medicaid to include coverage for specialists for high-risk patients during prenatal, delivery, and postpartum care.</td>
<td>Providing resources according to need</td>
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<tr>
<td><strong>COMMUNITY</strong></td>
<td>Structural Racism</td>
<td>Disconnect between community and hospital leaders and clinicians, lack of patient and community engagement</td>
<td>State MMRCs should include community members to ensure the patient perspective and lived experience is incorporated into the entire process.</td>
<td>Valuing all individuals and populations equally</td>
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</table>
Members of the CDC-MMRIA Discrimination Working Group
• Elizabeth Howell, MD, MPP
• Breannon Babbel, PhD, MPH – Senior Public Health Program manager, National Indian Health Board
• Allison Bryant Mantha, MD, MPH – Vice Chair of Quality, Equity and Safety at Massachusetts General Hospital
• Andria Cornell, MPH – Associate Director of Women’s & Infant Health at AMCHP
• Joia Crear Perry, MD, FACOG – President of the National Birth Equity Collaborative
• Rachel Hardeman, PhD, MPH – Assistant Professor of Health Policy & Management, Univ of Minn.
• Cornelia Graves, MD – Medical Director at Tennessee Maternal Fetal Medicine
• William Grobman, MD, MBA – Professor of OB/GYN, Northwestern (Maternal Fetal Medicine)
• Sascha James-Conterelli, DNP, CNM, FACNM – President of the NYS Association of Licensed Midwives
• Camara Jones, MD, MPH, PhD – Assoc. Professor of Community Health & Preventive Medicine, Morehouse
• Breana Lipscomb, MPH – US Maternal Health Campaign Manager, Center for Reproductive Rights
• Carla Ortique, MD – Chair of the Committee on Maternal & Perinatal Health, Texas Medical Association
• Alison Stuebe, MD, MSc – Associate Professor of Maternal and Child Health and OB/GYN, UNC
• Kaprice Welsh, CNM, MSN, MPH – Chair of the Georgia Perinatal Quality Collaborative Health Equity Committee
Questions and Comments
THANK YOU

For questions contact Anna Kheyfets at Anna.Kheyfets@mountsinai.org

Follow us on Twitter: @LizHowellMD @MountSinaiWHRI