Mississippi Maternal Mortality Review Committee

Building Capacity to Address Maternal Health Equity

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DIRECTOR/CHAIR MS MMRC, MS PERINATAL QUALITY COLLABORATIVE

MISSISSIPPI STATE DEPARTMENT OF HEALTH

OB/GYN- UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Mississippi Maternal Care & Outcomes Landscape

Total Population ~3million; 37k births per year

41 birthing facilities, 1 level IV NICU, 10 Level III

429 Ob/Gyns in 36 of 82 Counties

< 5% Births attended by Midwives, No Birth Centers

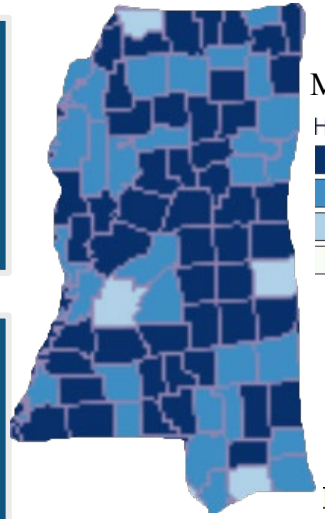
1 abortion provider in state, Jackson, MS

>65% Births Medicaid

- Changes to Medicaid controlled by state legislature

Highest Cesarean Section Rate 38.5%

Highest Preterm & Infant Mortality Rate

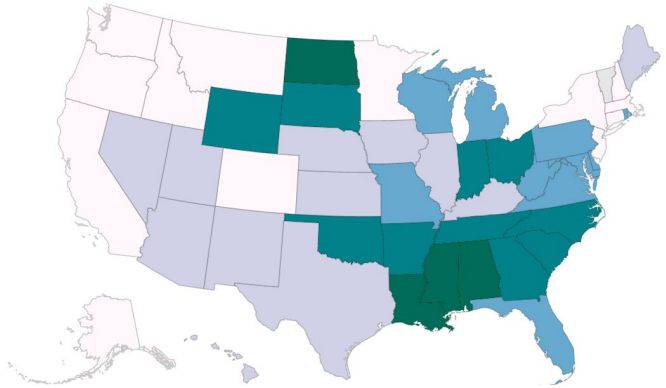


March of Dimes, Maternity Care Deserts Report, 2020

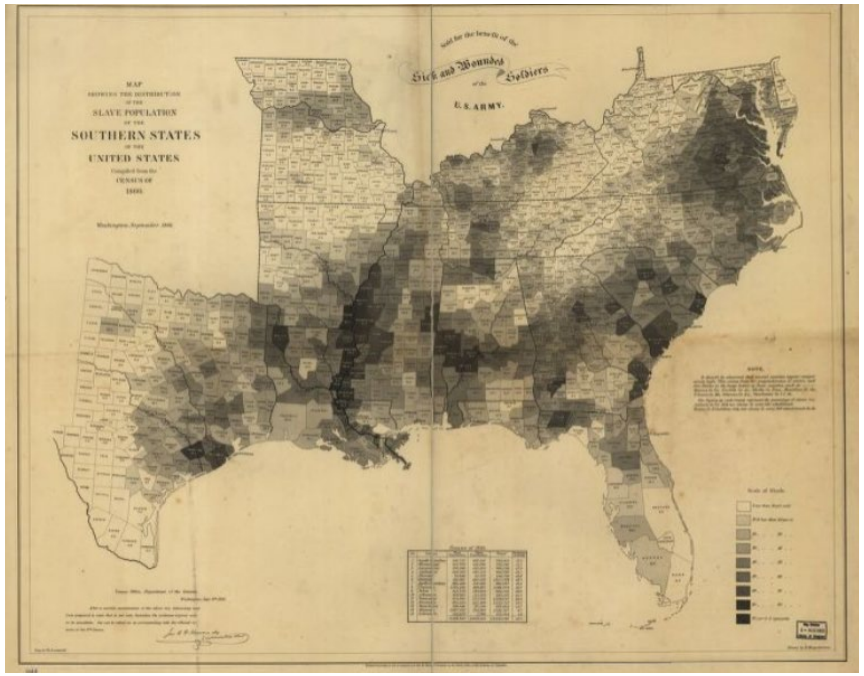
Hospitals offering offering obstetric care or freestanding birth centers

- No Hospitals or Birth Centers [1721]
- 1 Hospital or Birth Center [1034]
- 2-4 Hospitals or Birth Centers [318]
- 5 or more Hospitals or Birth Centers [66]

Infant Mortality Rates by State

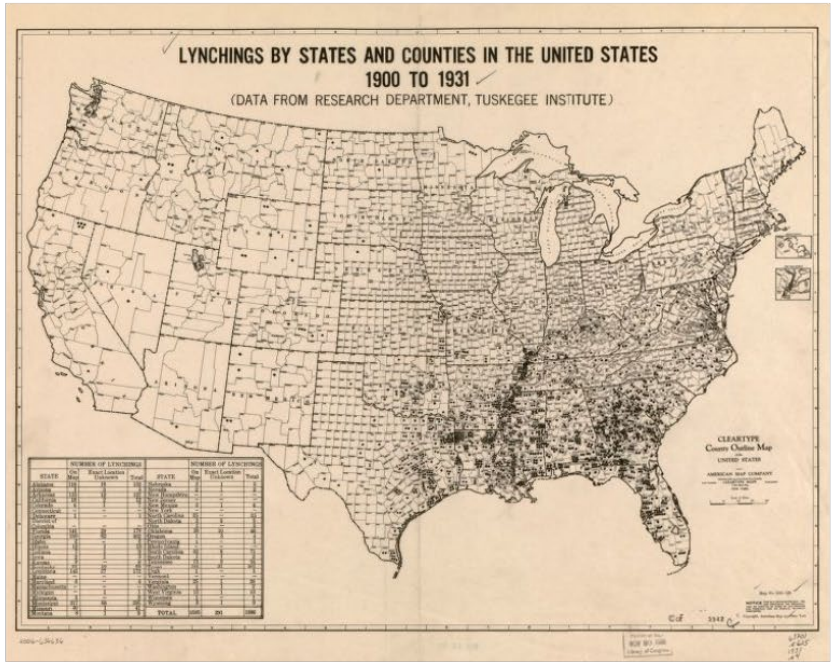


1860 Enslaved Population



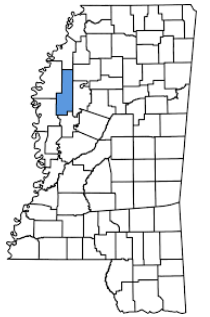
http://hdl.loc.gov/loc.gmd/g3861e.cw0013200

1900-1931 Lynchings



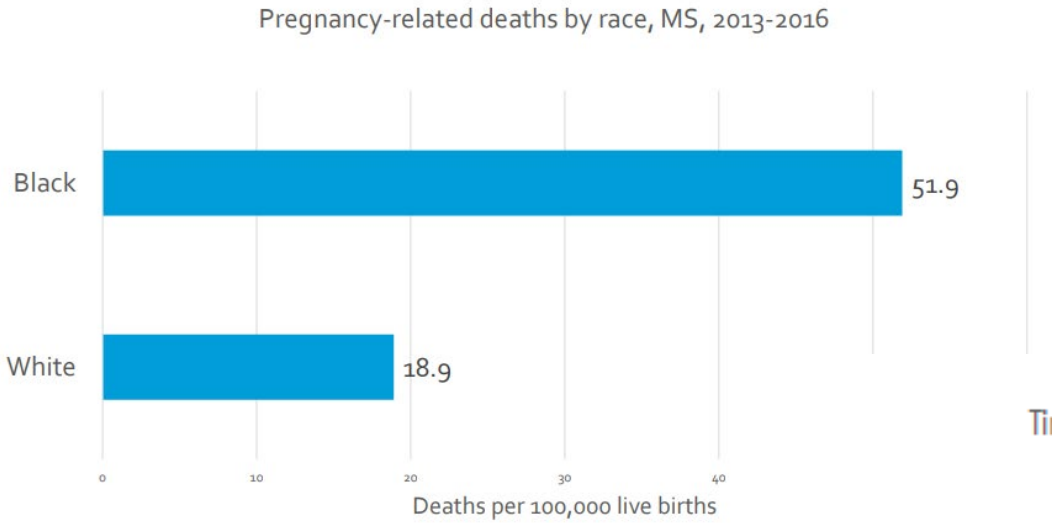
https://www.loc.gov/resource/g3701e.ct002012/

"Mississippi Appendectomy"



State Flag 1894-2020

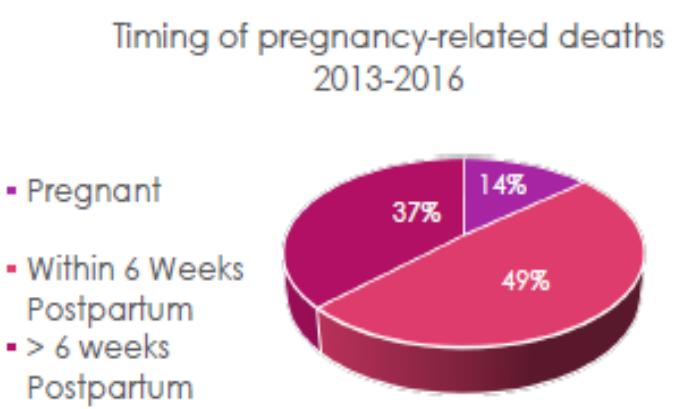
Maternal Mortality In Mississippi

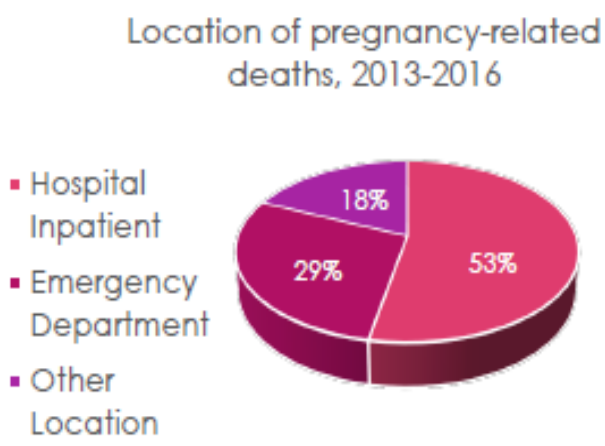


Leading Pregnancy Related Causes:

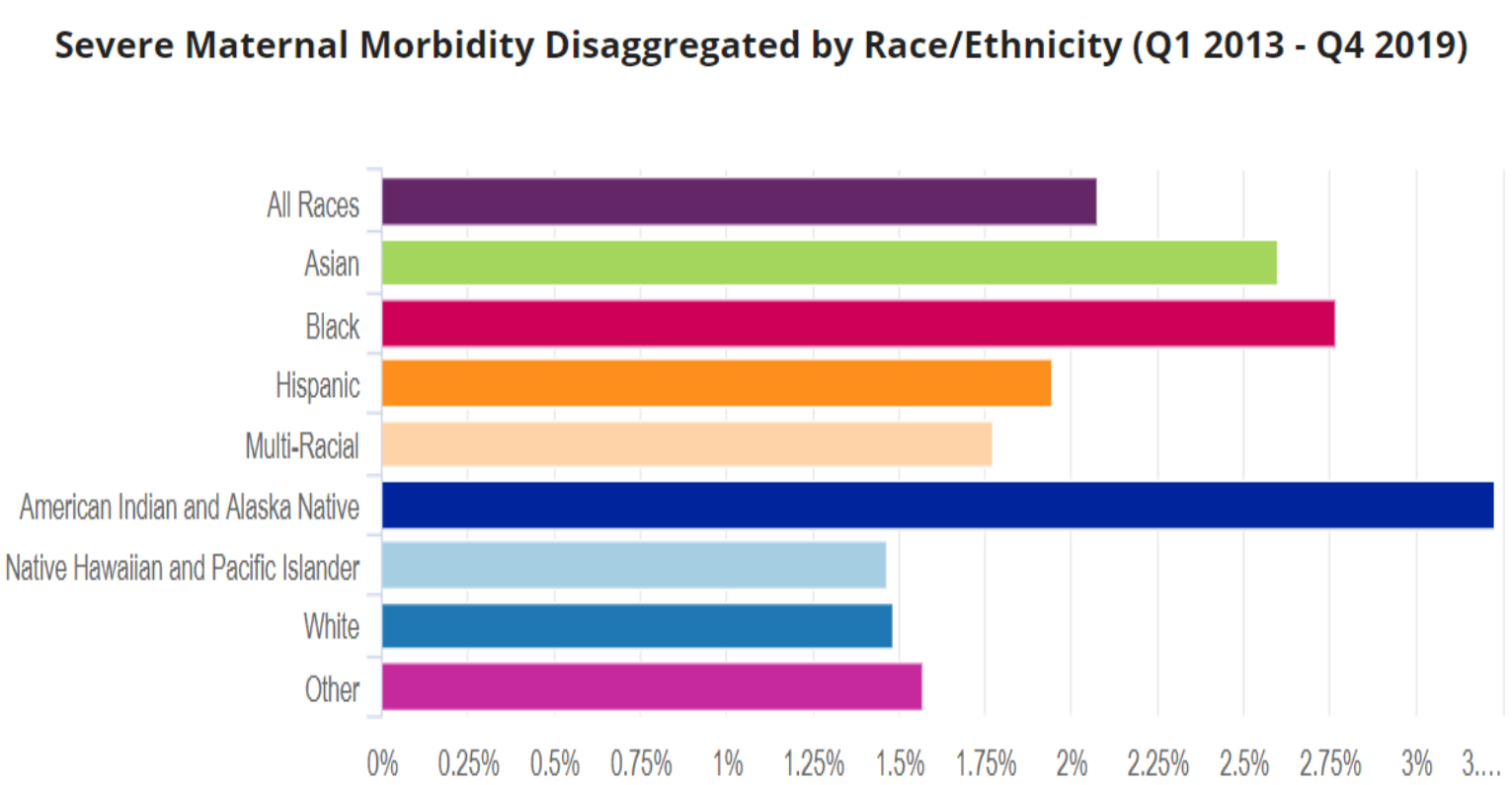
Cardiovascular Conditions
Severe Maternal Hypertension/Preeclampsia

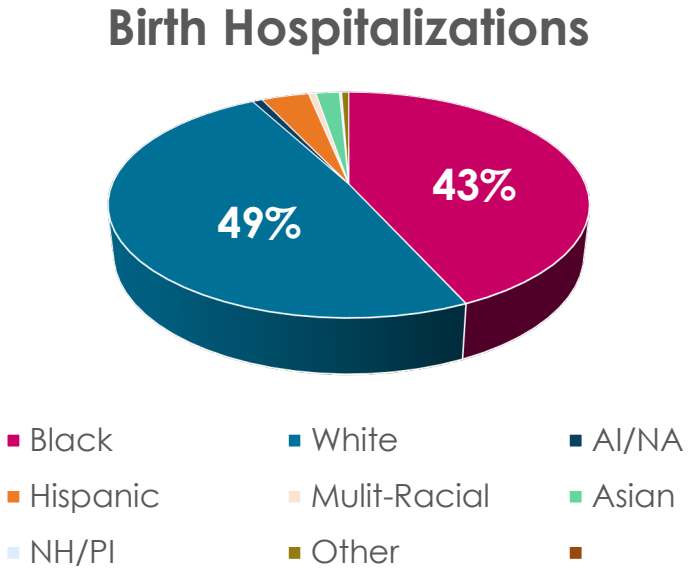
70-80% Black mothers





Severe Maternal Morbidity in Mississippi





AIM Data Center

Mississippi
Maternal Mortality Review Committee

- Maternal Mortality Review Committee Established in 2017
  - Passage of HB 494 creating committee and legal protections
  - CDC Funding 2018
  - All Pregnancy-Associated Deaths Identified within 1 year of end of pregnancy
  - In-Depth Committee Review of Pregnancy-related causes
  - Creation of recommendations for state to reduce maternal mortality
  - First report published 2019

Missing the Mark on Equity

- Despite identifying major gaps in evidence-based obstetric care and creating needed recommendations.
  - Overly focused on medical record as data source
  - Over representation of clinicians committee
  - Recommendations highly clinical
  - Lack of patient/family voice & input
  - Avoidance of discussing racism, politics as sources of disparities

Is The Mississippi MMRC Equipped To Address Inequities & Black Maternal Mortality?

- Does our MMRC Have:
  - Representation and inclusivity of committee members?
  - A process to recognize and eliminate personal bias and racism in review process?
  - Data sources that are wholistic, capture perspective of pregnant & birthing people & families and evaluated for racism & bias?
  - Knowledge about health equity, social determinants of health, racism as underlying causes of Black maternal health inequities?
  - Awareness of Black community strengths, solutions and scholarship?
  - Has influence and authority to create policy and systems level change?

Equity Mission Statement for MMRC

As a committee we are committed to addressing health equity in our approach to understanding maternal deaths and creating recommendations. We seek to eliminate preventable maternal mortality and close racial and socioeconomic disparities in maternal health outcomes.

Committee Representation

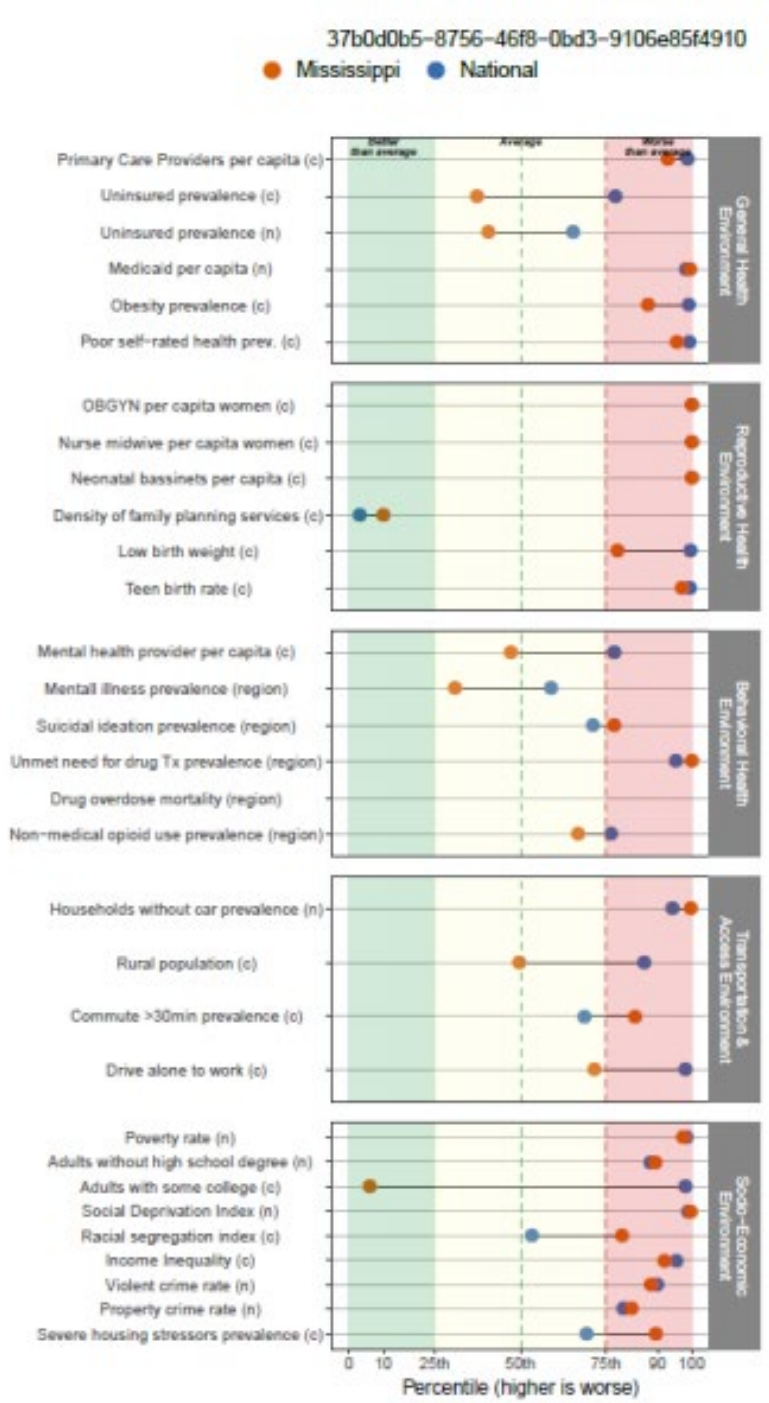
- Legislation and guidelines *not* prescriptive of committee membership

- Expanded States usual process of requesting nominations from professional organizations (ACOG, AWHONN, ACNM)
- Multiple members within roles to ensure equity and racial/geographic concordance across positions.
- Recognizing and correcting gaps as regular objective for committee.
- Addition of Patient advocates, Black Community Mental Health , Domestic Violence specialists

Equity Subcommittee

- Objectives:
  - Develop and apply a health equity framework to all aspects of MMRC
  - Provide space and time to acknowledge, discuss and develop solutions to structural and interpersonal racism, discrimination and social determinants of health particularly affecting Black mothers/people.
  - Develop enhanced skills in interpreting and applying social determinants of health data
  - Participated in Equity Pilot with CDC, M. Kramer PhD, using social-special dashboard of metrics capturing key community factors

Kramer MR , Strahan AE , Preslar J et al. Changing the conversation: applying a health equity framework to maternal mortality reviews. Am J Obstet Gynecol 2019;221:609–e1.



Community Vital Signs Dashboard

Kramer,M, 2019

Committee Education

- All expected to complete and engage in ongoing education on health equity, anti-racism and bias.

- June Launched Birth Equity Foundations training by National Birth Equity Collaborative for MMRC members.
  - 2 hour introductory workshop
  - 1 hour interactive lecture
  - Follow up workshops

Racial equity trainings focus on the structural and social dynamics working within health care institutions and communities that prevent optimal births for every woman, particularly women of color. With trainings on racial equity, social determinants of health inequities, collective impact and advocacy, participants will begin to realize their role within the transformation of systems.

NBEC NATIONAL BIRTH EQUITY COLLABORATIVE

Review Process

- Name given to every mother/person rather than case number or anonymized.
- Race, ethnicity, SES, employment, marital status, insurance, education -> listed after event details
- CDC Maternal Mortality Review Information Application (MMRIA) Committee Decision Form updated in 2020 to include evaluation of discrimination, racism , E. Howell et. al


DID **DISCRIMINATION**** CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

**Encompasses Discrimination, Interpersonal Racism, and Structural Racism as described on page 1.

Excerpts from- CDC, MMRIA, Committee Decision Form, v21

COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH

DID **DISCRIMINATION**** CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

**Encompasses Discrimination, Interpersonal Racism, and Structural Racism as described on page 1.

CONTRIBUTING FACTOR KEY
(DESCRIPTIONS ON PAGE 4)

- Access/financial
- Adherence
- Assessment
- Chronic disease
- Clinical skill/ quality of care
- Communication
- Continuity of care/ care coordination
- Cultural/religious
- Delay
- Discrimination
- Environmental
- Equipment/ technology
- Interpersonal racism
- Knowledge
- Law Enforcement
- Legal
- Mental health conditions
- Outreach
- Policies/procedures
- Referral
- Social support/ isolation
- Structural racism
- Substance use disorder - alcohol, illicit/prescription drugs
- Tobacco use
- Trauma
- Unstable housing
- Violence
- Other

DISCRIMINATION
Treating someone less or more 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. (Smedley et al, 2003 and Dr. Rachel Hardeman).

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 and Dr. Carla Ortique).

INTERPERSONAL RACISM
Discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in 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. (Jones, CP, 2000 and Dr. Cornelia Graves).

Excerpts from- CDC, MMRIA, Committee Decision Form, v21

Broadening Scope

Characteristics of pregnancy-associated deaths from suicide, drug overdose and homicide

	Suicide N=7	Drug Overdose N= 9	Homicide N= 10
Average Timing* (Average, Range)	**6 months** (41- 329 days)	**5 months** (4-265 days)	**5 months** (pregnant- 213 days)
Average Age (Average, Range)	**23 years** (20-28 years)	**29 years** (23-41 years)	**26 years** (19-32 years)
Percent Race (Highest percent)	**71% White**	**66% White**	**60% Black**

*during pregnancy or days postpartum

Informant Interviews

- 2020 initiated informant interviews with commitment to include for all reviewed events.
- Licensed clinical social worker with training in trauma, bereavement counseling
- Provision of resources, connection to services
- **Uncover details omitted from records, out of hospital events, perceptions of care quality, experience of disrespect, discrimination, holistic view of life, ongoing challenges/generational harm**

Pre – Interview Stage
Preparation
+ Planning

Interview Stage
Outreach
+ Contact

Post Interview Stage
Completion

MMRC Impact on Statewide Change

- 1st recommendation of MMRC was extension of Medicaid to 12 months postpartum
- MS Lawmakers *removed* this provision in 2021 session citing cost
- Engaging lawmakers now for 2022
- Promotion of policy changes to support Doula payment and Midwifery care

MMRC Impact on Statewide Change

- Funding towards Mississippi based Black woman led organizations addressing gaps
  - Maternal Mental Health- MomMe
  - Community Grants for Doula services, Townhalls, BP Cuffs

six dimensions

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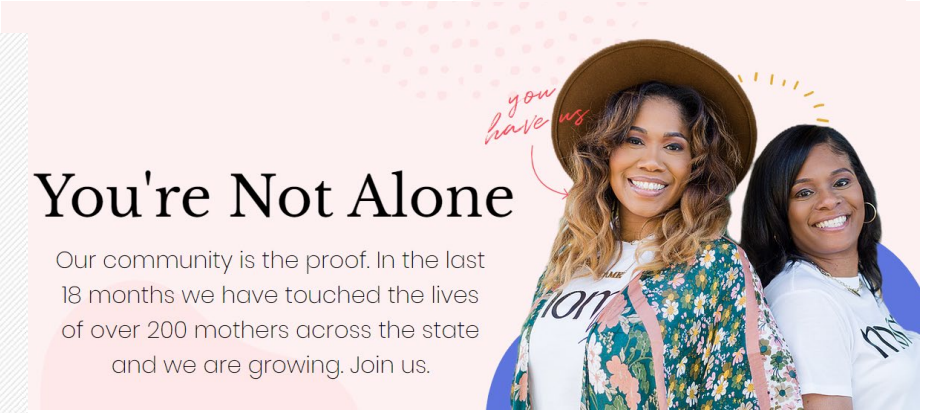

www.Momme.rocks

Acknowledgements- MMRC/MSPQC Staff

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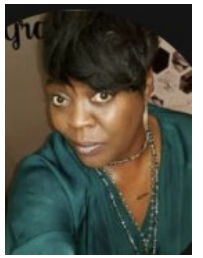

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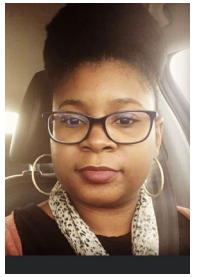

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Thank You

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AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

MISSISSIPPI STATE DEPARTMENT OF HEALTH

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

BlueCross BlueShield of Mississippi
It's good to be Blue.