

MATERNAL MORTALITY REVIEW COMMITTEES

*SHARING POWER WITH
COMMUNITIES*



NOVEMBER 2021

CONTRIBUTORS

Contributors to this report include: Angela Doyinsola Aina, Philicia Castillo-Sanders, Dr. Jamila Perritt, Marieh Scales, and Sang Hee Won. Special thanks to Drs. Monica R. McLemore and Linda S. Franck for their ongoing feedback and review throughout this project.

ACKNOWLEDGMENTS

The Black Mamas Matter Alliance would like to thank all the individuals who generously contributed their time, expertise, and experiences to this project. While we cannot specifically name everyone to maintain anonymity, we want to express our immense gratitude to each and every one of them as this project would not have been possible without their contributions. Lastly, we honor the lives and experiences of all the Black mamas who have needlessly died during pregnancy, childbirth, and the postpartum period and whose deaths could have been prevented.

This project was supported by the Centers for Disease Control and Prevention and the Association of Maternal and Child Health Programs.

SUGGESTED CITATION

Black Mamas Matter Alliance, Research and Evaluation Department. Maternal Mortality Review Committees: Sharing Power with Communities. Atlanta, GA. November 2021.

© Copyright Black Mamas Matter Alliance 2021

MATERNAL MORTALITY REVIEW COMMITTEES

*SHARING POWER WITH
COMMUNITIES*



OCTOBER 2021

A photograph of three business professionals in a modern office setting. A woman in the center, wearing a face mask and a blazer, is looking at a tablet. To her right, a man in a suit and face mask is also looking at a tablet. To her left, another woman is partially visible, also wearing a face mask. The background shows a large window with a grid pattern and some office furniture. The entire image has a purple tint.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	6
BACKGROUND	8
PROJECT OVERVIEW	10
PROJECT APPROACH	10
ENVIRONMENTAL SCAN PROCESS	11
A NOTE ON THIS PROJECT	12
KEY FINDINGS	13
Subordinate Inclusion Of Community Members	15
Lack Of Transparency, Inconsistent Data Provision, And Legislative Barriers As Inhibitors To Community Involvement	23
Participation In MMRCs Can Be Detrimental To Community Members	30
CONCLUSION	39
RECOMMENDATIONS	40
REFERENCES	43



EXECUTIVE SUMMARY

Maternal Mortality Review Committees (MMRCs) are intended to be multidisciplinary committees that conduct comprehensive reviews of pregnancy-related deaths to prevent future deaths. However, MMRCs have struggled to identify, engage, and meaningfully include diverse community members who can speak to the essential context, including the strengths and needs of the communities they represent.

This report summarizes the findings of an environmental scan that Black Mamas Matter Alliance conducted, in partnership with the Centers for Disease Control and Prevention and the Association of Maternal and Child Health Programs, to understand the challenges and opportunities for improvement that community members experienced while engaging, or attempting to engage, with MMRCs.

KEY FINDINGS

MMRCs may express a desire for including community voices and members but this inclusion was often subordinate. More often, MMRCs were perceived to:

- Distrust and devalue the expertise of community members
- Extract knowledge from communities
- Engage in tokenism and quota-filling from communities
- Exclude community members and organizations who challenge the status quo



Community members faced various barriers while attempting to join or meaningfully engage with MMRCs, including:

- Lack of knowledge, transparency, and diversity in the MMRC recruitment process
- Lack of timely and consistent access to data and communication of recommendations
- Legislative hurdles and lack of structural support, like compensation, impede community participation

Participation in MMRCs can be detrimental to community members whereby:

- The culture and environment of MMRCs can be unwelcoming and harmful
- MMRCs engage in harmful and disrespectful conversations about patients
- Community members carry the burden of teaching fellow MMRC members about the role of racism and discrimination
- Bias in medical records and the case abstraction process leads to a centering of the provider narrative, not the deceased birthing person

KEY RECOMMENDATIONS



Listen to and center the experiences of community members



Diversify membership and meaningfully engage communities



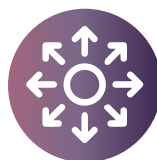
Provide training, guidance, and resources to strengthen the capacity of MMRCs



Provide additional funding to MMRCs



Increase transparency of MMRC processes and data



Strengthen the capacity of MMRCs to better examine and address racism and discrimination



BACKGROUND

The United States (U.S.) has the highest maternal mortality rate among high-income countries, and approximately 700 women die from complications related to pregnancy or childbirth each year.¹

In 2018, there were 17 maternal deaths per 100,000 live births in the U.S. compared to three deaths per 100,000 live births or fewer in the Netherlands, Norway, and New Zealand.² Significant racial and ethnic disparities exist in maternal mortality whereby Black women are two to three times more likely to die from pregnancy-related causes than white women.³ Sadly, research has shown that 60% of these deaths are preventable.¹ Although, there are no differences in preventability by race/ethnicity, comprehensive reviews of these disproportionate deaths among Black women have shown that these inequities are in large part due to persistent and systemic failures in our communities and health systems.^{4,5}

Systematically monitoring and assessing each maternal death is a vital step to inform prevention efforts and reduce inequities in maternal health. Two such data surveillance systems that collect and monitor data related to maternal mortality are the National Center for Health Statistics (NCHS)

Significant racial and ethnic disparities exist in maternal mortality whereby Black women are two to three times more likely to die from pregnancy-related causes than white women. Sadly, research has shown that 60% of these deaths are preventable.

and the Pregnancy Mortality Surveillance System (PMSS). The NCHS calculates maternal deaths as a death any time during pregnancy up to 42 days postpartum and utilizes death certificate information to assign ICD-10 codes as a source for maternal death classification.⁶ The PMSS defines maternal death as a death that occurs anytime during pregnancy up until one year postpartum and uses death certificates or linked birth records and fetal death records as a source for maternal death classification.⁶



While the use of vital statistics to measure maternal mortality are important, collecting and analyzing each maternal death to identify opportunities for prevention is critical. **Maternal Mortality Review Committees (MMRCs) have been offered as one way to address this need.** Like the PMSS, MMRCs identify cases of maternal death, but they have access to additional information, such as medical and social service records, that enables them to conduct a more comprehensive review, including an assessment of the impact of the social determinants of health.^{6,7} In-depth maternal mortality reviews are both a process “to comprehensively identify, review, and analyze deaths during pregnancy, childbirth, and the year postpartum; disseminate findings; and act on results” as well as a “group of experts and stakeholders in maternal health that convene regularly to review deaths and identify key learnings and opportunities to prevent future deaths.”⁸

One key to the success of MMRCs is the heterogeneity of its members who can provide a deeper contextual analysis of maternal deaths. Historically, MMRCs have been comprised mainly of physicians,⁹ but there has been a recent push to have this membership broadened to include,

Despite this broader desire toward interdisciplinary inclusivity, MMRCs have struggled to identify, engage, and meaningfully include diverse community members, especially those with lived experience who can speak to the strengths and needs of the communities they represent.

“expertise in public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental health, and behavioral health. Members might also include social workers, patient advocates, and other relevant, multidisciplinary stakeholders.”¹⁰ Despite this broader desire toward interdisciplinary inclusivity, MMRCs have struggled to identify, engage, and meaningfully include diverse community members, especially those with lived experience who can speak to the strengths and needs of the communities they represent.



PROJECT OVERVIEW

In the spring of 2021, the Black Mamas Matter Alliance, supported by funding from the Centers for Disease Control and Prevention (CDC) and the Association of Maternal and Child Health Programs (AMCHP), conducted an environmental scan of nine state Maternal Mortality Review Committees (MMRCs) in the U.S. to gather information about the opportunities and challenges MMRCs face as they work to broaden committee membership and community engagement. The purpose of this scan was to capture the challenges and opportunities described by community members who have engaged with MMRCs in efforts to both help strengthen the capacity of public health leaders, including those administering and serving on MMRCs, and to better integrate strategies toward equitable practices across MMRC processes.



PROJECT APPROACH

The Black Mamas Matter Alliance (BMMA) collaborated with community-based organizations, partners, and representatives of MMRCs from nine target states to conduct this environmental scan. The nine target states were identified in partnership with the CDC and AMCHP and represent states from each region of the country; are current grantees of the CDC's Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program; and are states where BMMA's Kindred Partners and Collaborators are based. Kindred Partners are Black women-led organizations operating at the national, state, and local levels that center Black women and whose activities are guided by the birth justice, reproductive justice, and human rights frameworks. Collaborators are individuals who are also guided by the birth justice, reproductive justice, and human rights frameworks and who actively work on BMMA initiatives and activities. **For more information on Kindred Partners and Collaborators, please visit: blackmamasmatter.org/our-partners.**

ENVIRONMENTAL SCAN PROCESS

The following activities were conducted as part of this environmental scan:

- Orientation to the MMRC process with staff of the CDC's Maternal Mortality Prevention team
- Review of grey literature on MMRCs, such as state/city MMRC reports, CDC reports, guides, manuals, policies, and procedures
- Group discussions with BMMA's Kindred Partners and Collaborators who have directly or indirectly engaged with their state/city MMRCs (n=11)
- Group discussions with community representatives who are members of their state MMRCs (n=11) and
- Individual conversations with chairs, coordinators, and abstractors from three of the nine target states (n=8)

PARTICIPANTS OF ENVIRONMENTAL SCAN DISCUSSIONS AND CONVERSATIONS

BMMA KINDRED PARTNERS AND COLLABORATORS

Black women-led organizations and individuals who are guided by birth justice, reproductive justice, and human rights

COMMUNITY REPRESENTATIVES

Members of state MMRCs who represent local community constituents

OTHER MMRC MEMBERS

Chairs, coordinators, and abstractors of select state MMRCs

The interview guides for the group discussions and individual conversations were developed by BMMA project staff and sought to gather information on MMRCs' policies and procedures related to community engagement, membership recruitment and support, and the maternal mortality review process. The group discussions lasted approximately 90 minutes while individual conversations were between 60-90 minutes long. Participants provided verbal consent prior to the discussions; they were told that their participation was voluntary, identifying information would not be shared, and all responses would remain confidential. All participants were offered gift cards as remuneration for their time.

All the discussions and conversations were conducted virtually using Zoom, facilitated by

project staff, audio/video recorded, transcribed verbatim, and de-identified. We used NVivo (released in March 2020) to organize the data, code transcripts, and generate node reports. For group discussions, we developed a coding scheme based on the discussion guide topics and coded responses in NVivo using grounded theory methodology which allows for inductive emergence of themes from the data. Group discussion responses were then organized by theme. We further analyzed the data by summarizing emerging themes and concepts and exploring patterns for similarity and difference. Key findings that emerged were summarized through a narrative description and illustrative quotations. Interviews and quotes throughout this report have been edited minimally for clarity.



This environmental scan was exploratory and formative in nature. It was neither intended nor designed to be an exhaustive analysis of all the challenges and opportunities that exist for MMRCs. Moreover, this report is not a comprehensive guide for how MMRCs can integrate equity across its processes. Rather, this scan is a first step towards a process of discovery that all MMRCs should and need to take if they are to truly integrate equity across their review policies and procedures.

The recommendations presented in this report are derived from numerous conversations BMMA conducted with Kindred Partners and Collaborators and community representatives (“community members”) who have deep knowledge and expertise addressing maternal health issues in their communities. These community members helped identify gaps in how MMRCs operate and provided strategies for how MMRCs can improve their review processes. However, these recommendations are not meant to be blanket or universal solutions for all state and city MMRCs.

A blurred, purple-tinted photograph of a hospital hallway. In the foreground, a person is walking away from the camera. In the background, another person is walking towards the camera. The hallway is lined with doors and has recessed lighting in the ceiling. The overall atmosphere is clinical and busy.

KEY FINDINGS

Multiple stakeholders were engaged to provide a broad perspective and incorporate a variety of experiences. Kindred Partners and Collaborators (KP/Cs) and community representatives who currently serve on MMRCs shared their experiences engaging with MMRCs. MMRC chairs, abstractors, and coordinators discussed their experiences attempting to recruit and integrate community members on their MMRCs. There was significant overlap between what KP/Cs and community representatives said and experienced while engaging with MMRCs. There was less overlap between the experiences of these two groups and the chairs, abstractors, and coordinators who we spoke with. However, where there were similar themes, such overlaps are noted below.

In sharing their experiences, participants spoke at length about the challenges they faced. Those challenges are summarized below under **three major themes**:



Additionally, this section shares **potential opportunities for improvement** to address challenges discussed by KP/Cs and community representatives.

SUBORDINATE INCLUSION OF COMMUNITY MEMBERS

During the group discussions, KP/Cs and community representatives stated that while MMRCs may express a desire for including community voices and members, this inclusion was often subordinate. They described how MMRCs focused only on diversity without equity and engaged in tokenism to fulfill quotas on their committees. Community members who were active members of MMRCs did not feel their expertise or positionality was valued as

compared to other members of the committee. Respondents discussed that MMRCs appeared to distrust community members. They reported that MMRCs extracted community language and knowledge without true inclusion of communities. Finally, some KP/Cs discussed that some MMRCs deliberately excluded community members and organizations that challenged the status quo and/or worked to hold MMRCs accountable in maternal health equity discussions.

CHALLENGES

1

MMRCs distrust and devalue the expertise of community members

Community representatives experienced distrust from clinical members of MMRCs regarding their aptitude and ability to understand and follow committee rules. They felt that their expertise was not respected by fellow committee members and that only clinical members were thought to have the knowledge and ability to understand and adhere to MMRC rules.

“It really is insulting to community members. It’s almost like ‘well, everyone in this room has this magic letter behind their name that makes them super smart and super capable, but community members don’t have that. So, they are not capable.’ And it’s so insulting. Oftentimes, the community members are doing amazing work and understand this at a level that none of us at this table or on this call, unless we’ve had that experience, could ever understand it, and it’s so insulting to community.” — **COMMUNITY REPRESENTATIVE PARTICIPANT**

“Implicitly, I think there is still a positioning of where knowledge comes from, and sometimes in spaces like this, it’s like a token seat for ‘we have our community member,’ ‘everyone be polite,’ like ‘they are not as degreed and educated as the rest of us.’” — **COMMUNITY REPRESENTATIVE PARTICIPANT**



2

MMRCs extract knowledge from the community

KP/Cs and community representatives both discussed the challenge of MMRCs extracting knowledge from communities such as language, community strategies, and using community-based organizations' names to gain funding while failing to be accountable and integrate communities in equitable ways into maternal health work. For example, respondents described extraction through trainings without accountability for whether the language or strategies were being used to better engage communities. One KP/C Participant expressed that MMRCs have:

“Engagement of community that’s extractive. So again, extracting language, extracting community outreach strategies. Extracting knowledge through trainings, but then having no accountability of how that knowledge is being utilized or not.”

— **KINDRED PARTNER PARTICIPANT**

Another KP/C Participant stated:

“For example, we’re on the task force, but we’re not on the official team for the [state] Maternal Health Department. They will say, ‘oh, because [participant is] connected to the Black Mamas Matter Alliance,’ they’ll write in the grant that they’re connected to the Black Mamas Matter Alliance and get money. And we’re constantly seeing this over and over and over again. [...]. We do have to think about the ways and how people are having conversations with Black Mamas Matter Alliance and not really integrating us into the work in their process and then being extractive in being the ones to get the money.” — **KINDRED PARTNER PARTICIPANT**

3

MMRCs engage in tokenism and quota-filling from the community

KP/Cs and community representatives expressed that MMRCs bring Black, Indigenous, People of Color (BIPOC) individuals onto the committees as tokens and to fill quotas for community members, which did not lead to true representation or shifts in power. Instead, community members felt isolated, intimidated, and ostracized, especially when they were the only person in the room presenting a divergent point from the majority.

“I think this is the problem with organizations as a whole and with these committees when we say, [...] ‘make sure you’ve all got a Black person on there.’ So, that’s what happened when we tried to reach a quota or activate the whole tokenism of having a Black person on these organizations, because what happens is they walk in and they are one, maybe two in the room, and then when they do speak up, they do come from a place of passion, because they recognize that at any point in time, they could be attacked.” — **COMMUNITY REPRESENTATIVE PARTICIPANT**

In individual conversations, MMRC members described how their MMRC engaged in a diversity “checkbox” process to fill designated community member seats. This process led MMRCs to fill a single seat with individuals who represented a particular race, ethnicity, regional location, or job title on the committee. This resulted in an increase in diversity on the committee but did not achieve equity or inclusion of communities. However, when this issue was raised with MMRC members [who participated in individual conversations for this report], they did not view this checkbox process as a concerning practice, but instead a way to increase diversity, one seat at a time. Other MMRC members also expressed implementing a yearly survey to fulfill what they viewed as CDC’s diversity mandate. One MMRC member reported:

“For example, say a person from southeast [state] has been referred, and we don’t have anyone from southeast [state] or we have very few people from southeast [state]. And they’re a cardiologist and we only have one other cardiologist, and they’re female. And we have a male cardiologist and maybe they’re Black and the other one is white. And they have a large amount of experience and tenure and the other one maybe is just out of their fellowship. So, then we typically think, ‘okay, that’s a need that we have on our committee.’ If on the other hand, we have someone that comes to us, referred to us, and is from central [state] and is an OB, is right out of their fellowship, is white. Then we already have many from that, so we try to diversify our committee not only in expertise but race and ethnicity and years of tenure and geographic locations.” — **MMRC COORDINATOR**

4

MMRCs exclude community members and organizations who challenge the status quo

During the group discussion, KP/Cs frequently stated that MMRCs excluded people and organizations that made them uncomfortable, held them accountable, or challenged them around true equity discussions in maternal health.

“And then [MMRCs] also pick their darlings. They like the other Black- or folks of color-led organizations who are palatable to their liking, who aren’t going to challenge them. And so they like to stick with that.” —KP/C PARTICIPANT

CHALLENGES AND STRATEGIES ENGAGING WITH MMRCs AS IDENTIFIED BY COMMUNITY MEMBERS

CHALLENGES

STRATEGIES

Subordinate inclusion of community by MMRCs that:

- Distrust and devalue expertise of community members
- Extract knowledge
- Engage in tokenism and quota-filling
- Exclude those who challenge status quo

Barriers to engaging with MMRCs, including:

- Lack of knowledge, transparency, and diversity in recruitment process
- Lack of timely and consistent access to data and recommendations
- Legislative hurdles impede community participation

Participation in MMRCs can be detrimental to communities:

- Culture and environment are unwelcoming and harmful
- Harmful and disrespectful conversations about patients
- Communities carry burden of teaching about racism and discrimination
- Centering of provider narrative, not the deceased birthing person

- Make space for community to lead
- Support communities with resources and funding to implement solutions
- MMRCs should consist of BIPOC members who are rooted in community, provide holistic care, are most affected, and have lived experience

- Institute open calls for recruitment
- Compensate community members
- Increase accountability, frequency, and transparency of communications
- Ensure communities are intimately involved in creation of recommendations

- Ensure proportional representation and BIPOC leadership
- Eliminate burden of proof mentality for evaluating racism and discrimination
- Integrate family interviews
- Improve orientation of MMRCs
- Institute anti-racism trainings
- Provide training and guidance on trigger tools

OPPORTUNITIES FOR IMPROVEMENT



KP/Cs and community representatives expressed that MMRCs do not value the knowledge and expertise that community members possess to address maternal mortality. They described community members as an integral and necessary element of MMRCs who can provide unique contributions to improving outcomes and experiences of those most affected by inequities in maternal health.

“Community can bring the necessary public health, population health, and racial equity lens and perspective to the table to disrupt the medical model and approach traditionally taken. [Community has] expert knowledge of most impacted mothers, families, communities [and] contextual knowledge of root causes to better connect the dots on MMRCs on appropriate solutions and change.”

—KP/C PARTICIPANT



KP/Cs discussed the need for the CDC and state MMRCs to work to support impacted communities directly with resources and funding to implement their own solutions.

“The CDC should mandate [funding community orgs]. They should not be giving money to the states to get stuck in departments of health or wherever they are stuck, the funds, and not mandating that [a percentage] of funds be utilized to engage with the community’s most impacted through direct funding of community-based orgs.”—KP/C PARTICIPANT



In addition, respondents stated that MMRCs should have members who are rooted in the community and provide holistic care to birthing people, such as midwives and doulas.

Respondents stated that improvements in maternal mortality can only be achieved when MMRCs are less focused solely on clinical outcomes and more inclusive of holistic birthing approaches, which can then lead to more comprehensive solutions and recommendations that fit community needs.

“Having midwives [...] on the committee has been really valuable. [...] the midwife’s assessment is totally different than the OBs on the committee, and there’s only [one] midwife on the committee and she’s really having to fight hard as we know. Like you’re that one person in whatever it is to shift the perspective [and have] the opportunity to make change. And that’s such a big part of MMRCs, like, what was the opportunity for change? [...] you see that we’re missing a whole bed of information because we only have one person who would think outside of the box in the space in some ways, on a medical side.”

—KP/C PARTICIPANT



OPPORTUNITIES FOR IMPROVEMENT



Respondents also suggested that MMRCs should consist predominantly of the communities most affected by maternal mortality, which meant including BIPOC individuals and those with lived experience. KP/Cs and community representatives believed that MMRCs needed to be comprised of BIPOC or birthing persons with training in anti-racist praxis, holistic perspectives, the social determinants of health, and also those who have experienced a near-miss or had a family member or friend affected by maternal mortality. They also felt that these individuals should, at a minimum, be in positions of power on the MMRCs, such as chair or co-chair positions. Respondents expressed that having BIPOC leadership ensures that the issues of BIPOC birthing persons are centered and respectfully addressed on the committee.

“I would really make [the MMRCs] predominantly women of color. If you think about proportional representation, [...] which is more Black and Indigenous women, but just predominantly women of color [...] They should be 80% of the seats, because they are over 80% of the bodies impacted.”—KP/C PARTICIPANT

OPPORTUNITIES FOR IMPROVEMENT

“I think the chair has to be a Black woman or a birthing person. It changes the tone, whoever the chair [is] who people look to and also defer their sentiment. [...] the way that things are dismissed about social determinants and about racism and about a more holistic perspective, it’s easy to be dismissed when the person who sits at that level [says], ‘okay, let’s move on.’ If that person wants to move on every time we get to racism because they’re uncomfortable or it doesn’t reflect something that they think is true, it makes it very difficult. You’re always pushing against that. So to have someone on the chair with that level of consciousness, maybe it doesn’t have to be a Black birthing person, but ideally a birthing person or someone very intimately connected to the lived experience and not just sort of academic and medical.”—KP/C PARTICIPANT



In individual conversations, other MMRC members discussed the lack of diversity and BIPOC representation on their committees and the possible effect on the validity of their findings.

“...we don’t have enough voices from communities of color on our committee. As a result, maybe our results aren’t valid, it almost seems like we would need to go back and look at these questions, or certain cases, in particular, to help better understand the process and to better refine the decisions and the recommendations that we’re coming up with.”—MMRC CHAIR



All respondent groups mentioned that MMRCs should ensure that those with lived experience who have been impacted by maternal mortality are represented on the committee. This includes those who experienced a near miss, or someone who nearly died during pregnancy or childbirth, or are the family members and friends of birthing people who have been affected by maternal mortality. However, KP/Cs and community representatives expressed that inclusion of those with lived experience requires trauma-informed training and mental wellness support as those with lived experience can be retraumatized while reviewing maternal death cases. One KP/C participant argued that MMRCs should be:

“leaving room for at least two spots on the committee for purely ‘lived-experience’ community members who don’t work in any of the systems (not professionals in the field, simply patients, clients) and can help make recommendations about how the system could reach them. [For example] those with near-misses.”

OPPORTUNITIES FOR IMPROVEMENT



When discussing a harmful and traumatic experience that occurred on an MMRC, one KP/C participant recommended having mental wellness support for committee members by stating:

“This is intense. And, how do we do this? How have you been sitting in these things for all these years, listening to these stories? And so having someone that has experience with MMRCs or at least experience listening to trauma on a regular basis and then helping them with tools to conceptualize and reframe how important it is, what we’re doing. And every time it feels painful that this woman’s life is in front of our eyes, that we also can make it so that it doesn’t happen to someone else.[...] So I think maybe adding somebody to the committee for the well-being of people, especially [someone] who this is their lived experience or family lived experience. So not just the chief psychiatrist at the hospital who’s involved. [...] somebody who’s really from the community that can support those people because they seem to be the only ones that not only, but often, feel the most affected.”—KP/C PARTICIPANT



In individual conversations, MMRC members stated that their MMRCs see value in including those with lived experience on the committee.

“I think we need to engage patient and survivor voices as much as possible, whether that’s like us, maybe through expansion of our statute to include a survivor of severe maternal morbidity, which actually was a recommendation in our report in December, or if you’re not able to do it through your statute, engaging with organizations with lived experience or in the community for example, [a local birthing person’s voice program]. If you’re not able to maybe have that membership on your committee, at least having those groups come and present or talk to committees when possible.”—MMRC COORDINATOR

THEME 2

LACK OF TRANSPARENCY, INCONSISTENT DATA PROVISION, AND LEGISLATIVE BARRIERS AS INHIBITORS TO COMMUNITY INVOLVEMENT

KP/Cs and community representatives discussed various barriers they faced in attempting to join MMRCs, while other MMRC members described challenges to recruiting community members onto MMRCs. KP/Cs and community representatives both discussed a lack of transparency in the recruitment process. They reported a lack of knowledge regarding the process of joining the MMRC or how decisions were made around who was invited or permitted to join. They described inconsistent reporting of MMRC findings, which

resulted in significant delays and deprived their communities of timely access to data. KP/Cs, community representatives, and other MMRC members discussed legislative barriers that limited the ability of MMRCs to provide compensation to those who needed financial support to participate, required background checks, and limited the number of community members. Respondents noted that these practices have limited the ability of community members to join and meaningfully participate in MMRCs.

CHALLENGES

1

Lack of knowledge, transparency, and diversity in the MMRC recruitment process

KP/Cs and community representatives noted the lack of transparency around MMRCs as well as the recruitment process. One participant felt that MMRCs were “so secretive that it’s prohibitive,” which inhibited new membership and diversity on the committee. Knowledge about MMRCs was thought to only be shared with a select few, which were usually colleagues of clinical members on the committee. In addition, respondents asserted that public knowledge around the application and selection processes were not readily available, accessible, or openly communicated.

“I’ll just add to that that prior to the 2019 CDC review, our understanding [was] that it wasn’t clear how to become a member of this committee. And the person that we know who sits on that committee now because of her background, her work, she contacted the review committee and asked to join and to be a part.”

And there was a process, but it was[n't] very publicly transparent how that would be done. And it does appear that most folks who are on it are recruited from within, you know, [...] the general audience of folks who have typically been engaged. So, the opportunity to really move beyond the typical audience of folks who are engaged has been limited until that CDC review that demanded more community representation and more diversity. And that seems to be opening the way..." — KP/C PARTICIPANT

In individual conversations, other MMRC members recognized that previous committee nominations have lacked transparency and discussed the desire to have a more transparent process moving forward.

"I will say we've had a lot of scrutiny with how we have put members on the committee in general and how we have nominated people that I think will need to sort of be more transparent about moving forward and more open in terms of having a clear process to be sure that it's [done in] a more transparent and equitable way." — MMRC CHAIR

"Well, in the past, when we have reached out to some potential members, they're aware that the initial composition of the committee was white and clinical, and, you know, academic heavy and there wasn't a lot of comfort in joining that kind of committee. And until it was really more diverse and had clear mechanisms for bringing more people of color to the table and especially this community-led and person of color-led organizations, there was certainly some reluctance at the time when we invited them, being that they already knew that they were going to be joining a committee that was in place, that was not representative." — MMRC CHAIR

2

Lack of timely and consistent access to data and communication of recommendations

KP/Cs and community representatives expressed that communities needed awareness of and access to MMRC data for their own advocacy and organizing efforts. They stated that having significant data, reporting, and publication delays, hindered community members from optimally serving their communities. Moreover, the lack of community representation on MMRCs also prohibited the development and inclusion of recommendations for prevention that were responsive to the needs of the community.

"But there is zero transparency in my state about anything. The last report that's up here is from 2008, [...] 2008 is the most recent report. There's a trends report that ends in 2013, but that's the most current information we have. And our state has built this huge platform on how terrible our rates are and what we

need to do, but we don't have any information on even what's happening. So very disappointing to go back to this and look at it and see it identically the same way it was when I left it.”—KP/C PARTICIPANT

3

Legislative hurdles and lack of structural support like compensation, impede community participation

KP/Cs, community representatives, and other MMRC members discussed state legislative statutes that prevented or limited MMRCs from adding community members to the committee. Seats were often reserved for individuals with specific positions in the local public health department such as medical directors and epidemiologists or those with specialty licenses in obstetrics and gynecology, maternal fetal medicine, or cardiology. In addition, legislation further limited the number of seats for community members, which did not provide true representation of community voices on the committee. Some respondents also discussed the challenges of MMRCs imposing lengthy background checks for applicants, which further prohibited community inclusion. Lastly, KP/Cs and community representatives discussed the burden of not being able to receive compensation, especially if they were volunteering their time.

“The state opted to make the process of participation be that on the same level as if you were a state appointed position. Meaning you had to go through a vetting process. And that vetting process includes [a] criminal background check, your credit report, and your work history. So a lot of committee members don't want to go through that. That was one of the reasons why I said if I'm not getting paid, why do you need to know so much information about my background? I have nothing to hide, but just the fact that you want all this information just for me to attend two meetings. So those are the challenges that we have, just getting people past that hurdle to be included.”—KP/C PARTICIPANT

“If you are working for a big system, you're getting paid to be there. We are not. I personally am not. I'm working for myself in my own non-profit. To take four hours out of my day is a lot. It is a lot, and then the monies that go to these MMRCs, everyone else is being paid to be there. So then, to require these community organizations that are already getting the short end of the stick on funding as it is, which is a whole [other] conversation about racism and philanthropy that I could really go off about, but to already ask us to take four hours out of our day to speak up and to be there, and to be a voice and a presence.”

—COMMUNITY MEMBER PARTICIPANT

In individual conversations, MMRC members also discussed the limitations their state legislative statutes imposed on their ability to add community members to their MMRC.

“I think we’re limited because our statute includes/describes what our membership composition should be. And so we don’t have a lot of flexibility in changing that unless there was statutory change by the legislature. So I think [...] sometimes [the] statute can be restrictive in our ability to do that.”

— MMRC ABTRACTOR

During individual conversations, one member discussed how such legislation presented a bureaucratic barrier for recruitment of community members.

“Yeah, so our recruitment in the past, I think, was overwrought and created a lot of bureaucratic barriers. It was a full vetting process through the office of our governor. And at one point before I was in this role, that was interacting a lot with the planning around the committee [and] asked why we were doing it that way. Because usually that happens with a medical review board or something that requires a lot of background, you know, checking, licensure, and vetting.”

— MMMRC COORDINATOR

OPPORTUNITIES FOR IMPROVEMENT



KP/Cs and community representatives recommended that all MMRCs implement open calls for applications to provide equal access to membership and increase transparency of the recruitment process.

“There needs to be open calls for participation. Community orgs should be funded to help with that community outreach for those open calls and for those community meetings.”—KP/C PARTICIPANT



Some respondents stated that their MMRCs had already instituted open calls for applications. One MMRC member discussed their MMRC’s efforts to implement an open call for applications and collaborate with community members on the application process.

“And we’re in the process of putting together an open call. Borrow[ing] a little bit from actually what we had seen the Georgia MMRC [do], we’re trying to make the application less clinically relevant where, we used to ask for a CV, so we’re not asking for a CV, or credentials, per se, we’re just sort of trying to say, what is your experience and why do you want to be on the committee? And what voices do you represent? We wanted to put it out this month but we were trying to get some more input now from other community groups on the actual application process.”

—MMRC CHAIR

OPPORTUNITIES FOR IMPROVEMENT



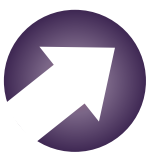
KP/Cs and community representatives advocated for MMRCs to work with their local legislative bodies to secure compensation for community members. This was particularly essential for community members who often were not compensated by their day jobs for serving on the committee like some of their clinical counterparts.

“If we’re getting all this funding for the state to have an MMRC, then people that aren’t associated with these large organizations that are required to already be there need to be compensated for their time.”—COMMUNITY REPRESENTATIVE PARTICIPANT



While compensation was an important strategy to increase equity, respondents reported that it was but one strategy that would increase community engagement. In individual conversations, one MMRC member discussed the lessons they learned about how just adding language about compensation into their legislation wasn’t enough for their community members.

“[...] we wanted to revise the legislation to expand the numbers of members of people on the committee and specifically to also sort of ensure that there was language stating that the committee should represent the diversity with the State and should it, if we had community members or members of the committee that maybe would face financial hardship from participating in the committee, that we would be able to sort of remunerate them for wages lost by participating on these committees. So we put forth this legislation, and we got a lot of actual criticism from the community saying that this was not enough. And they wanted it to be more inclusive and that we needed to have specific information about what the clinical co-chair was, as well, and what that role was going to serve.” —MMRC CHAIR




KP/Cs and community representatives suggested that MMRCs should prioritize the provision of timely and consistent access to data. They suggested that this could be done through a communications plan developed with anti-racism experts that included press releases, public campaigns, and direct conversations with the community about findings and recommendations. In addition, KP/Cs and community representatives discussed the need for oversight and accountability around data releases. One suggestion was to provide additional funding for MMRCs to have increased capacity to review cases and dedicated anti-racist experts who help MMRCs disseminate information in a timely manner.

“It would be nice to have regular briefings after every MMRC meeting that are open to the public where even if they can’t release the exact numbers and data, they at least release those recommendations in a timely manner. [...] And the second thing is there should be people who are experts and do anti-racism work or social justice work, partnering with the state health departments or the


OPPORTUNITIES FOR IMPROVEMENT

MMRC department communications team where they do a joint press release or community conversation about it.”—KP/C PARTICIPANT

“Another recommendation is to increase funding for the MMR teams to have the capacity to rapidly review the cases so the data is not four or five years lagging. This must be a priority.”—KP/C PARTICIPANT

 One MMRC member discussed their MMRC’s attempt to diversify the dissemination strategy and communications plan of their biennial report to make the report more accessible to a wider audience. They also discussed how their legislation determines how often they produce a report.

“Right now, our statute requires us to publish a biennial report, every two years. The audience for that report is the general public and our legislators. However, if we’re going to engage different audiences, I think part of the work will be developing a communication campaign and to better disseminate findings to all different types of audiences and not just a report posted on a web page that we distribute through our stakeholder networks. So thinking through ways that we can do infographics, or I don’t know, like all the different ways that we can disseminate our message and make it more concise and digestible for different groups.”—MMRC COORDINATOR

 KP/Cs and community representatives expressed that the community needs to be intimately involved in the creation of recommendations. While MMRCs were charged with issuing recommendations to prevent maternal mortality, community members expressed confusion and concern around the fact that MMRCs lack involvement or accountability towards ensuring proper implementation of the recommendations. This was often delegated to community members and organizations who were not included in the discussion and formulations of those recommendations.

“And then I found that when community members’ voices weren’t truly heard, the recommendations still tended to come back to the status quo.”—KP/C PARTICIPANT

“Nobody on the MMRC or the Department of Health would even join the effort to advocate for [extending Medicaid postpartum], even though it came from their recommendations. So, it’s just frustrating that all this work is happening. A report goes out and then nobody talks about it, and then we just keep moving on and keep reviewing deaths. So, it’s a little frustrating.”

—COMMUNITY REPRESENTATIVE PARTICIPANT



OPPORTUNITIES FOR IMPROVEMENT



Other MMRC members purported that the role of the MMRC was only to issue, not implement, the recommendations, which was a responsibility that they thought fell onto community-based organizations. Thus, respondents identified the need for a collaborative discussion between communities and MMRCs about their respective roles in developing, implementing, and being held responsible for implementation of those recommendations.

“I think there’s been some misunderstandings about the role of the MMRC too. [...] we’re not actually an implementing agency[...] we want the other actors in the state to take the recommendations and make changes. And I think helping others understand how we get cases, how we review cases, and what kind of recommendations we come up with, and then what we want to be done with those recommendations will also help, I think. And I think there’s been a little bit of misunderstanding about what the MMRC is in the state as well. So I think we’re hoping that through the community meetings, we’ll be able to sort of explain what the MMRC is, how we’ve been working, and also get input and build more collaborations and understanding.”—MMRC CHAIR

PARTICIPATION IN MMRCs CAN BE DETRIMENTAL TO COMMUNITY MEMBERS

KP/Cs and community representatives discussed the harm they undergo from participating in MMRC meetings and serving on committees.

Respondents reported that they were frequently challenged on their viewpoints, described other members as antagonistic toward them, relayed that other members spoke about patients in harmful ways, and reported that they often carried

the burden of teaching other MMRC members about the role of racism and discrimination in maternal mortality. Respondents discussed the challenges of identifying bias in medical records with fellow committee members and ensuring that the deceased birthing person, not the provider, is centered in conversations. In maternal health equity discussions.

CHALLENGES

1

The culture and environment of MMRCs can be unwelcoming and harmful to community members

KP/Cs and community representatives indicated that the culture and dynamics of MMRCs supported a hierarchical divide between clinical and non-clinical members whereby the perspectives of clinical providers were always prioritized. Respondents described the culture of MMRCs as unwelcoming. They also reported experiencing or witnessing antagonistic behavior by other MMRC members when community members stated disparate viewpoints. In addition, KP/Cs and community representatives indicated they received no support from MMRC leadership when they have raised concerns regarding these issues.

“...in the experience of an MMRC, it is generally not, at least in my experience, a welcoming environment that’s set up for success. A power structure, very much, between us [and] them, and I’m not an us.” — COMMUNITY MEMBER PARTICIPANT

“Recently, when we all [community members] did speak up and be a voice and a presence, the next meeting came and [the other MMRC members] were like, ‘There was so much tension in our last meeting.’ It wasn’t tension, we just simply stated how we felt. So that was one of those microaggressions that we felt as Black women that had spoken up. So, I think first of all, to give up my time while you’re trying to gather funding already to survive and to make sure that the people

that I serve are benefited, and then to then turn around and when I do speak up, to be told that I'm causing tension in the room and it's just too much."

— **COMMUNITY MEMBER PARTICIPANT**

2

MMRC members engage in harmful and disrespectful conversations about patients

Community representatives indicated that the environment of MMRCs can be harmful and trauma-inducing. They reported that maternal death cases are often discussed with dark humor and a lack of respect for the deceased birthing persons who were frequently blamed for their own deaths.

"...why would anybody want to come sit in that room? Why would they like to listen to people being blamed for their substance use addictions, why [when] they are blamed for the color of their skin, they are blamed for their economics. I've brought up many times the parts of what the abstractor wrote that I think is just offensive and inappropriate."—**COMMUNITY REPRESENTATIVE PARTICIPANT**

"I think in one of the quick conversations I've had, we've talked about the death of someone that was more of a unicorn case, hard to diagnose, but it was someone that had an HIV-positive status, and by the end of it, someone was laughing. And when we asked the question, 'could this death have been preventable?' They laughed and said, 'Yeah, use a condom.' The kind of things that I've heard in that committee make me feel like we should be reporting these providers for the way they talk about patients."—**COMMUNITY REPRESENTATIVE PARTICIPANT**

2

MMRC members engage in harmful and disrespectful conversations about patients

Community representatives and KP/Cs who currently serve on MMRCs expressed that the role of racism and discrimination in maternal mortality was not well understood among MMRC members. This resulted in KP/Cs and community representatives carrying the burden of teaching fellow MMRC members about the impact racism has on maternal deaths. Respondents described frustration that their MMRCs were unable to move past a singular focus on interpersonal racism to one that focuses on systemic and institutional racism or an exploration of the root causes of health inequities and maternal mortality.

"These anti-racist equity lenses are usually brought in when the community that is most impacted, are represented, are brought in. So we know—I know that here in [state] with the addition of Black women—who we know who are sitting on the



committee—that the burden is on them really right now to bring that lens. But it’s not driven by the institution or the infrastructure of our systems. And that’s where the shift needs to happen. The question is, how do we embed and acknowledge and name racism as a root cause to these drivers so that institutionally we’re automatically examining maternal mortality data through that lens and then effectively coming up with solutions....”—KP/C PARTICIPANT

“I think a lot of people are still stuck on blatant racism. A lot of, unfortunately, white people don’t think racism exists unless it’s blatant, and they don’t understand micro-aggressions, and they don’t understand the different time period of racism that we’re in. So, I think the conversation that we had in our last one was, ‘Of course, it’s going to be always difficult to say that it was just point blank, period,’ [...] because it wasn’t blatant, because somebody did not walk in the room and called the patient the N-word, or because no one hung a noose from the ceiling, that they didn’t consider it racism. So, there needs to be a conversation about the difference between macro-aggression and micro-aggression, and there needs to be some kind of conversation that exists that we’re in a timeframe where blatant racism might not exist. It might not just come out that way.”

—COMMUNITY REPRESENTATIVE PARTICIPANT

4

There is bias in medical records and the case abstraction process leading to a centering of the provider narrative

KP/Cs and community representatives expressed that there was bias in medical records and that these records prioritized the viewpoint of the provider, not the deceased birthing person. Respondents discussed clinical staff who failed to document instances of discrimination in the patient record or used discriminatory, stigmatizing, or coded language. In addition, respondents discussed the challenges of reviewing the case narrative when abstractors imposed their own implicit bias onto the abstraction process.

“I have to wonder about the extraction process, sometimes. Where are the biases? Are there biases? How are those being reviewed? Where are we pulling from? Because [that] is going to be inherent in what’s reported. We’ve all looked at what’s reported in these medical records. At least for me, I automatically know that I’m getting the perspective from the provider, period. So, [that] is not the right kind of information but it’s symbolic of the problem, of how we center the provider versus the patient.” — **COMMUNITY REPRESENTATIVE PARTICIPANT**

“I think first and foremost, any conversation I have, I am a Black woman but secondly, I am a clinician. I’m a certified nurse/midwife. So, when we get these reports and when we get our medical records to review and report on, a medical record is going to give you the bare minimum. A medical record is not going to say, ‘The patient complained of her pain eight times, and I denied her pain medicine eight times. Finally, on the ninth one, gave her oxycontin.’ It’s going to be very self-benefiting for clinicians. So, this is another reason why I think you need to have doulas present in the room because of those experiences, and they don’t work for the system, and we need to have people outside of these large systems, because how do I challenge the system that I’m working for?”
— **COMMUNITY REPRESENTATIVE PARTICIPANT**

In individual conversations, other MMRC members affirmed their belief that bias can be present in medical records.

“So there is a lot of bias and medical documentation based on a nurse’s perspective. And do I think that that could be racially and ethnically skewed? Yeah, I do.” — **MMRC ABTRACTOR**

OPPORTUNITIES FOR IMPROVEMENT



KP/Cs and community representatives purported that many of the challenges they faced could be mitigated by ensuring that MMRCs have proportional representation and are led by BIPOC individuals. Respondents indicated that shifting power towards BIPOC members and chairs who are trained in anti-racist praxis could create more equitable, welcoming, and respectful spaces for communities to engage in identifying solutions to address maternal mortality. This shift was also seen as a way to ensure that the experiences of the deceased birthing person are centered in the case narrative and subsequent MMRC recommendations.

“There’s only so much implicit bias training that we can do for white people. [...] I’m sick of implicit bias training and health equity trainings and modules and then the same stuff keeps happening. We need to strategically get the people who are most impacted in positions of power.”—KP/C PARTICIPANT



KP/Cs expressed that MMRCs need to move away from a medical model that requires burden of proof when evaluating the role of racism and discrimination in maternal deaths. They purported that using this model leads to an undercounting of the role of racism and discrimination in maternal deaths.

“One of the shortcomings that I am starting to realize is that there is not a lot of guidance for the clinicians themselves, [...] to understand these structural issues in a way that it actually informs how they are determining what the reason is for the outcome, for the death. So, whenever I raise my hand and I say that probably had some impact with systemic racism, there is always a huge debate around this. The debate is always centered around, ‘How do you know? How do you know it was with this particular person that had suffered from that? We know that there is systemic racism but how do you know that this particular person suffered from it?’ I say you’re missing the boat there, because if you’re saying that you understand systemic racism, then you have to understand that this person doesn’t live in a vacuum, or didn’t live in a vacuum, and that she’s going to have this impact.[...] I’m really wondering how that is going to be addressed, because I feel like the people on this particular committee that I’m on are struggling to understand these issues.”—COMMUNITY REPRESENTATIVE PARTICIPANT

“When some of us have started to say, ‘Yes, yes. Was there discrimination? Yes.’ We’ve been told by the chair that the CDC won’t allow us to mark that down unless we can point out to how systemic discrimination or racism showed up in their case. To [the other MMRC members’] point, this is not always documented in their medical charts. [...] So, we keep saying, are we going to send notes to the CDC or whoever, ‘We have got to measure and count these deaths as discrimination and in [State], overwhelmingly, people die with substance use and overdose.’ We always



OPPORTUNITIES FOR IMPROVEMENT

have questions, ‘Was this accidental or intentional?’ We basically never know, and we’re not counting these deaths in the way that we should because our people are saying that the CDC won’t let us name discrimination unless we can prove it.”

—COMMUNITY REPRESENTATIVE PARTICIPANT



KP/Cs and community representatives also recommended that family member interviews, conducted by trained community health workers, should be integrated into the review process to provide a more comprehensive perspective than can be achieved from medical records alone. However, adequate trauma support services to family members who participate in the interviews was suggested since recalling the death of a loved one could be a traumatic experience.

“I think incorporating the voice of the family members and... that would add so much to actually focusing on these people as if they are real people and I feel like that’s what lasts when we do our reviews.”—COMMUNITY REPRESENTATIVE PARTICIPANT

“I wouldn’t recommend any family interviews that didn’t address the trauma of just talking about it again and didn’t also offer up wraparound support for those family members, because after that interview is over, the family needs to know who to follow when this has created an issue for them. So, I think that has to be thoughtfully and respectfully done.”—COMMUNITY REPRESENTATIVE PARTICIPANT

OPPORTUNITIES FOR IMPROVEMENT



In individual conversations, other MMRC members agreed with the need to implement family/key informant interviews to gain additional perspectives on the birthing person's social context and environment. They also recognized that staff with appropriate trauma training should conduct the interviews.

“Staffing-wise we also want to make sure we have the right type of person in that role. And following the informant guide, it sounds like a social worker or someone who has expertise and grief counseling as well. I think it’s also a question, and this is something we’re also looking into whether our statute would even permit the ability to do informant interviews and what our current protections are around that.”—MMRC ABTRACTOR



KP/Cs and community representatives expressed that MMRCs need to improve their orientation for community members by apprising them of the full responsibilities and expectations of being an MMRC member before joining. They felt that community members should be informed about the potential of secondary trauma and that support should be provided for their wellbeing if they chose to join. Assent should be obtained from the member confirming that they were ready to hear these cases, especially if they had a near miss or lost a family member or friend to maternal mortality. Respondents stated that members deserved clarity around what is expected as a community member, the technical nature of the committee, and the demands of the position.

“If they are truly engaging true community members, especially community members who’ve had near-misses or maybe had a little bit of experience, maybe have lost a family member or a friend, or a loved one, that they are ready to be in this type of situation, where they are going to be hearing cases like this, because they may not be ready. So, just a bit of assurance that they are ready to be put in this type of situation.”—COMMUNITY MEMBER PARTICIPANT

“[...]it’s still not super clear what the terms are. The person that’s serving isn’t clear on how long the terms are, [...] when it ends or what the formal process to inviting others is. So there needs to be clarity around that.”—KP/C PARTICIPANT



KP/Cs and community representatives also expressed the need for greater inclusion of members who have experience applying an anti-racist lens as well as the need for anti-racist trainings focused on addressing systemic racism. They noted that MMRCs would benefit from shifting their focus from only addressing interpersonal racism to addressing systemic racism and exploring the root causes of health inequities in maternal mortality. One participant suggested that MMRCs should:



OPPORTUNITIES FOR IMPROVEMENT

“...not rely on implicit bias training and to have deeper, more anti-racism training that really is part of an orientation for all members[...] But I would say it’s the traditional members who need the most training because so many of them lack any cultural sensitivity...”—KP/C PARTICIPANT

“[...] we need to emphasize that these bodies, which are made up, as we said, of physicians, surgeons, surgeon general for the state or medical examiner, often are missing community representation, whether it’s personal, community, or organization[al] or whatever it is that they must be responsible for understanding the social structural drivers of what they’re interpreting; what they’re being asked to interpret and analyze. Because they’re not capable or competent as we’ve seen in making recommendations that are really turning the tide because they don’t come with that understanding. They don’t come with the sensitivity to what communities are experiencing on the ground; they do not identify with it. They’re interpreting women’s deaths based on their own prejudices and biases. If we’re absent from those rooms and those spaces, what we get is the same recycled nothingness as we’ve shown in our state as far as effective solutions.”

—KP/C PARTICIPANT

OPPORTUNITIES FOR IMPROVEMENT



In individual interviews, one MMRC member agreed with the need for their committee to have training that goes beyond implicit bias and delves into structural racism. Other MMRC members did not mention the need for more extensive training and reported that they have begun implementing implicit bias training.

“...we’ve talked to the committee about different training opportunities, but I think implicit bias training is really important, but I also think having training on the historical systems that perpetuate structural racism is really important if you’re going to identify that as a factor.”—MMRC COORDINATOR



Another MMRC member described specific trigger tools, or tools that systematically help identify and document racism and bias in medical records, as helpful with checking their own implicit biases while abstracting cases. They also discussed the need to provide funding to the MMRC to work with equity consultants to better operationalize the trigger tools to identify racism and discrimination in medical records. In response to a question on how abstractors identify bias in medical records, one MMRC member stated:

“Well, it’s a challenge, right? [...] I think we try and identify it in our trigger tool, if we feel like something is not named or stated, like maybe they didn’t explicitly say, ‘Oh, this stupid drug user,’ whatever, like they didn’t write that in the medical chart. But somehow you get the sense of the way it was charted. Like some of it’s just intuitive. We all sort of look at our own bias. When you’re using intuition or whatever else to say, ‘This is what I think was going on, but I’m not really sure.’ So I think it’s a constant challenge. [...] we’re going to start working with a consultant. [...] I’ve been calling it like our equity consultant. But it’s someone we’ve hired specifically to look at some of our forms and work with myself and like the abstraction team towards better identifying racism and discrimination and how to better use our trigger tool and or adapt it and or change it or anything else. So we actually have some funding that we set aside from the [Erase MM] grant to actually hire someone.”—MMRC ABTRACTOR



CONCLUSION

KP/Cs, community members, and other MMRC members shared their experiences engaging, or attempting to engage, with MMRCs. They presented a variety of challenges and potential opportunities for MMRCs to integrate equitable practices throughout their processes. This included listening to and centering community voices, especially those most impacted by maternal mortality. KP/Cs and community members maintained that all conversations regarding maternal deaths, policy solutions, and improvements needed to the systems contributing to maternal mortality should start and end with communities. They stated that community members have the expertise and ability to bring new solutions to MMRCs. **However, this requires incorporating BIPOC leadership and proportional representation onto MMRCs to shift power to community members, and to move beyond token efforts to diversify membership.**

Integrating equity into MMRCs requires real systemic change and that can only be achieved when the communities who are most impacted

KP/Cs and community members maintained that all conversations regarding maternal deaths, policy solutions, and improvements needed to the systems contributing to maternal mortality should start and end with communities.

are meaningfully engaged throughout the data collection, review, recommendation, and implementation phases. State and local MMRCs need funding, training, and support to accomplish this, and the CDC has the opportunity to provide these tangible supports to MMRCs in their pursuit to create a more equitable review process. **Following are recommendations that participants identified as useful starting points for both the CDC and MMRCs to consider.**

RECOMMENDATIONS

FOR CDC



Listen to and center the experiences of community members

- Actively listen to and collaborate with community members who have the expertise and solutions to address maternal mortality
- Encourage states to engage with their local communities to jointly assess which of these recommendations are best to implement for their state



Diversify membership and meaningfully engage communities

- Mandate that MMRCs must have proportional BIPOC membership, especially in leadership positions levels
- Reduce the number of designated seats for similar clinician specialties as a way to diversify expertise on the committee
- Mandate that MMRCs prioritize inclusion of members who practice holistic pregnancy care versus a traditional medical model



Provide training, guidance, and resources to strengthen the capacity of MMRCs

- Provide guidance and funds for MMRCs to hire trained community health workers to conduct family interviews
- Support the provision and training of tools like the Texas trigger tool¹¹ to help MMRCs better assess racism and discrimination in cases
- Provide guidance that encourages less emphasis on “proving racism” in the same way other contributing factors are deliberated and proven
- Mandate that MMRCs provide trauma support services to all members



Provide additional funding to MMRCs

- Provide funds for states to hire health equity experts to train and provide guidance to MMRCs
- Increase funding to MMRCs to enhance their capacity to more rapidly review cases in a timely manner



Listen to and center the experiences of community members

- Listen to community members who have the expertise and solutions to address maternal mortality
- Collaborate with local community members to ensure that MMRC recommendations are appropriate and responsive to the needs of communities
- Engage with local communities to jointly assess and collaborate on which of these recommendations are best to implement for your state



Diversify membership and meaningfully engage communities

- Implement proportional BIPOC representation on committees, especially in leadership positions
- Prioritize members who practice holistic pregnancy care versus a traditional medical model
- Reduce the number of designated seats for similar clinician specialties as a way to diversify expertise on the committee



Provide training, guidance, and resources to strengthen the capacity of MMRCs

- Improve the orientation, training, and support for community members who are joining and serving on MMRCs
- Provide trauma-informed training and mental wellness support for members
- Provide trauma support services to friends and family members who participate in the key informant interviews
- Partner with health equity experts to train and recruit community members onto MMRCs who understand systemic racism and have foundations in anti-racist praxis
- Provide trainings to increase awareness of bias in medical records amongst members



Increase transparency of MMRC processes and data

- Implement open calls for MMRC membership
- Increase the transparency of the selection process for MMRC membership
- Partner with community groups to advocate for changes to restrictive legislative statutes that hinder community engagement, including restricting the number of and compensation for community members
- Disseminate communication materials to the public that increases transparency about the role of MMRCs
- Implement greater provision of data frequency and transparency to the public in a timely manner
- Involve communities in the creation of recommendations and discuss with communities which actors in the state are responsible for recommendation implementation



Strengthen capacity of MMRCs to better examine and address racism and discrimination

- Utilize tools like the Texas trigger tool for MMRCs to assess racism and discrimination in cases
- Implement family/key informant interviews into the MMRC process to provide additional perspective on the maternal mortality case
- Center the deceased birthing person--not the provider--in MMRC case deliberations
- Partner with anti-racist communications specialists to disseminate MMRC recommendations

REFERENCES

1. Petersen EE, Davis N, Goodman D, Cox S, Mayes N, Johnston E, Syverson C, Seed K, Shapiro-Mendoza C, Callaghan W, Barfield W. Vital signs: pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017 [Internet]. MMWR Morb Mortal Wkly Rep. 2019 May [cited 2021 Aug 28]. 6 p. Available from: <https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm>
2. Tikkanen R, Gunja MZ, FitzGerald M, Zephyrin L. Maternal mortality and maternity care in the United States compared to 10 other developed countries. The Commonwealth Fund. 2020 Nov [cited 2021 Sept 3]. Available from: <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>
3. Hoyert D, Miniño A. Maternal mortality in the United States: Changes in coding, publication, and data release [Internet]. Hyattsville (MD): U.S. Department of Health and Human Services; 2020 Jan. 18 p. Report No.: 2. Available from: <https://pubmed.ncbi.nlm.nih.gov/32510319/>
4. Petersen EE, Davis, N, Goodman D, Cox S, Mayes N, Johnston E, Syverson C, Seed K, Shapiro-Mendoza C, Callaghan W, Barfield W. Racial/ethnic disparities in pregnancy-related deaths — United States, 2007–2016 [Internet]. MMWR Morb Mortal Wkly Rep 2019 [cited 2021 Sept 20]. 6 p. Available from: <https://doi.org/10.15585/mmwr.mm6835a3>
5. Mehta PK, Kieltyka L, Bachhuber MA, Smiles D, Wallace M, Zapata A, et al. Racial inequities in preventable pregnancy-related deaths in Louisiana, 2011–2016. In: Obstetric Gynecology [Internet]. 2020 Feb [cited 2021 Aug 13]. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7299502/pdf/nihms-1594777.pdf> doi:10.1097/AOG.0000000000003591.
6. St. Pierre A, Zaharatos J, Goodman D, Callaghan WM. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. In: Obstetrics & Gynecology [Internet]. Wolters Kluwer Health, Inc. 2018 [cited 2021 Sept 13]. Available from: [10.1097/AOG.0000000000002417](https://doi.org/10.1097/AOG.0000000000002417)
7. Report from Maternal Mortality Review Committees: A view into their critical role [Internet]. Building US capacity to review and prevent maternal deaths. c2017 [cited 2021 Sept 13]. 50p. Available from: <https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIReport.pdf>
8. 7 things to know | review to action. Review to action: Working together to prevent maternal mortality n.d. <https://www.reviewtoaction.org/learn/7-things-to-know> [cited 2021 Sept]. Available from: <https://www.reviewtoaction.org/learn/7-things-to-know>.
9. Foretia B. Maternal Mortality Review Committees: a decade of challenge and growth [Internet]. Washington, DC: Association of Maternal and Child Health Programs; 2020 Feb [cited 2021 Sept 10]. Available from: <http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Pages/Maternal-Mortality-Review-Committees-A-Decade-of-Challenge-and-Growth.aspx>
10. Report from nine Maternal Mortality Review Committees [Internet]. Review to Action; 2018 [cited 2021 Sept 15] 76 p. Available from: <https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf>
11. Howell, E. Identifying racism & discrimination as contributing factors in pregnancy-related deaths n.d. [PowerPoint Presentation]. Review to Action; [cited 2021 Sept 21]. Available from: <https://portal.ct.gov/-/media/DPH/Maternal-Mortality/Identifying-Racism--Discrimination-as-Contributing-Factors-in-Pregnancy-Related-Death.pdf>



THE BLACK MAMAS MATTER ALLIANCE (BMMA) is a national network of Black women-led organizations and multi-disciplinary professionals who work to ensure that all Black Mamas have the rights, respect, and resources to thrive before, during, and after pregnancy. BMMA honors the work and historical contributions of Black women's leadership within their communities and values the need to amplify this work on a national scale. For this reason, BMMA does not have chapters. The alliance is composed of existing organizations and individuals whose work is deeply rooted in reproductive justice, birth justice, and the human rights framework.

© Copyright Black Mamas Matter Alliance 2021

BLACKMAMASMATTER.ORG



@BLKMAMASMATTER



@BLACKMAMASMATTER