District of Columbia's Maternal Mortality Review Committee Annual Report 2021

DISTRICT OF COLUMBIA
MATERNAL MORTALITY REVIEW COMMITTEE
2021 ANNUAL REPORT

Presented To:

The Honorable Muriel Bowser, Mayor, District of Columbia

The Council of the District of Columbia

The Citizens of the District of Columbia

September 2023

MATERNAL MORTALITY REVIEW COMMITTEE
2021 ANNUAL REPORT

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DEDICATION

This Annual Report is dedicated to the memory of those whose lives were lost due to adverse events surrounding their pregnancy, birth, or during the postpartum period. As we learn, through this process, to support and advocate for women, trans, nonbinary, and gender expansive birthing people[1] involved with the maternal health system of care, our work will improve outcomes for all residents of the District of Columbia.

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[1] We intentionally use expansive language, including the term birthing people, in relation to gender identity in this document understanding that many people who experience pregnancy and pregnancy complications may not experience gender along the binary. Gender specific terms will be used in some places to be consistent with research or data reporting measures.

GREETINGS FROM THE CHIEF MEDICAL EXAMINER

During 2021, as the District of Columbia continued to recover from the aftermath of the COVID-19 pandemic, the members of the DC Maternal Mortality Review Committee (MMRC) remained steadfast in their advocacy for birthing persons and their families. This multidisciplinary group of maternal health professionals are truly the best of the best in the District of Columbia. The team continued to convene monthly and strategize to improve their review process, recommend changes to systems of care to the residents of the District of Columbia. Utilizing this unique opportunity to inform the public health community about inequities in health care that directly affects the lives of birthing persons is not an easy task. The DC MMRC is not afraid to ask the most difficult question – *"Could this death have been prevented?"* I am so appreciative of the work conducted by the DC Maternal Mortality Review Committee.

We present to you the 2021 DC Maternal Mortality Review Committee Annual Report. We hope that this report will help to inform our public health and medical communities, the District's public servants, and our residents.

Sincerely,

Francisco J. Diaz, MD FCAP FASCP
Chief Medical Examiner
Office of the Chief Medical Examiner
Washington, D.C.

GREETINGS FROM THE MMRC CO-CHAIRS

Aza Nedhari, CPM, LGPC
Executive Director, Mamatoto Village

Christina X. Marea, PhD, MA, MSN, CNM
Assistant Professor, School of Nursing, Georgetown University

In the fall of 2019, the members appointed to the DC Maternal Mortality Review Committee (MMRC) began to review cases of maternal mortality involving birthing persons who resided in the District of Columbia and died in 2018 during pregnancy or within a year of their pregnancy. We have observed how their community environments, access to healthcare, and engagement with social service or governmental agencies impacted their daily lives and their deaths. Every birthing person's life cycle was unique and complex – yet our case reviews reveal that many shared intersecting structural inequities that impacted access to quality health care and their abilities to achieve positive health outcomes. We understood that our call to action would not be easy. In our first annual report, we shared with the community how we were formed, the training we underwent, processes developed for case review, the impact of COVID on our operations, and the findings from the cases we reviewed.

We now present to you the 2021 DC Maternal Mortality Review Committee Annual Report, reflecting on our work from January 2021 through December 2021. We hope that our second report will help improve communication and advocacy among the District of Columbia's community of maternal health providers and advocates. By contextualizing the root cause of inequities in healthcare, we hope to improve the lives of birthing persons, their families, and their social environment. We appreciate the hard work, tenacity, and commitment of the DC MMRC members and the OCME Fatality Review Division to make D.C. an optimal place to be born and parent.

Committee Members and participants of the District of Columbia's Maternal Mortality Review Committee (MMRC) convene on the 4th Tuesday of each month. The following are the MMRC members, as appointed by the Honorable Mayor Muriel Bowser:

Donna Anthony, MPH
Hospital for Sick Children
Member from a Pediatric Hospital

Kristin Atkins, MD
Howard University Hospital
Member with experience in obstetrics & g ynecology from a District of Columbia Birthing Center

Roberta Bell, RN
March of Dimes
Obstetric Registered Nurse

Constance Bohon, MD
Capital Women's Care
American Congress of Obstetricians & Gynecologists Designee

Shermain Bowden, LICSW
Department of Behavioral Health
Department of Behavioral Health Designee

Rita Calabro, MD
Sibley Hospital
Member with experience in obstetrics & g ynecology from a District of Columbia Birthing Center

Christine Colie, MD
Medstar Georgetown University Hospital
Member with experience in obstetrics and gynecology from a District of Columbia Hospital or Birthing Center

Cherie Craft
Smart From the Start DC
Community Organization specializing in women's health, teen pregnancy, or public health designee

Janeen Cross, DSW
Howard University School of Social Work
Social Worker Specialized in Women's Health or Maternal Health

Monique Powell-Davis, MD
Mary's Center
Member with experience in Obstetrics & Gynecology from District of Columbia Hospital or Birthing Center

Theresa Early, M.Ed.
Department of Human Services
Department of Human Services Designee

Shakira Franklin
Certified Midwife

Melissa Fries, MD
MedStar Washington Hospital Center
Member with experience in obstetrics and gynecology from a District of Columbia Hospital or Birthing Center

Nancy Gaba, MD
MedStar George Washington University Faculty Associates
Member with experience in obstetrics and gynecology from a District of Columbia Hospital or Birthing Center

Kristinza Giese, MD
Office of the Chief Medical Examiner
Office of the Chief Medical Examiner Designee

Christina Marea, PhD, MA, MSN, CNM
Georgetown University School of Nursing
Community of Hope
Member with experience in obstetrics and gynecology from a District of Columbia Hospital or Birthing Center

Ebony Marcelle, CNM, MS, FACNM
Community of Hope
Member with experience in obstetrics and gynecology from a District of Columbia Hospital or Birthing Center

Aza Nedhari, CPM, LGPC
Mamatoto Village
Community Organization specializing in women's health, teen pregnancy, or public health designee

Iman Newsome
Doula Member

Jamila Perritt, MD MPH
Physicians for Reproductive Health
Community Organization specializing in women's health, teen pregnancy, or public health designee

Pamela Riley, MD
Department of Health Care Finance
Department of Health Care Finance designee

Rebecca Winter
DC Health
DC Health designee

Introduction

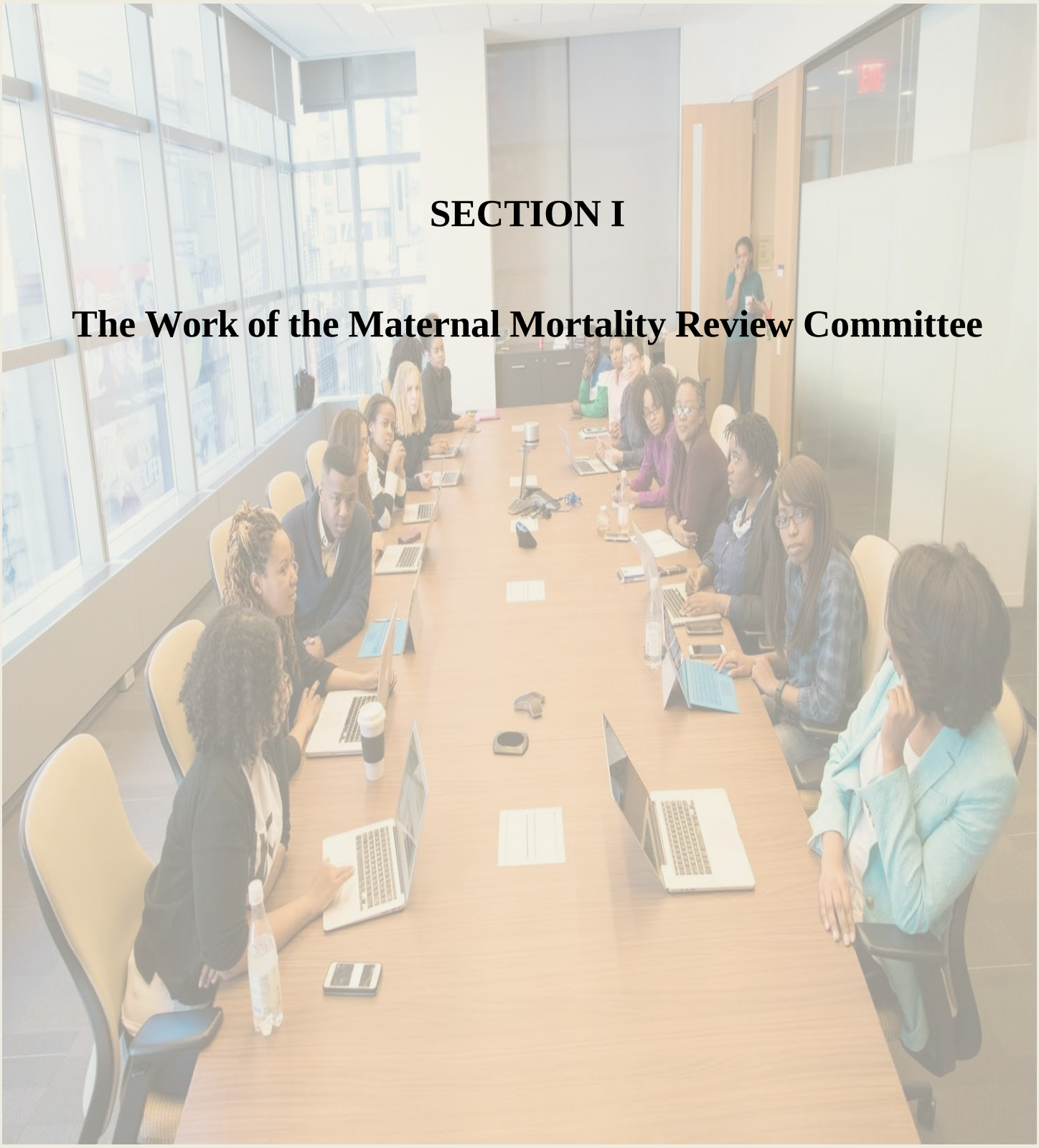
Maternal death affects the lives and well-being of everyone connected to the birthing person, including their children, partners, friends, family, and community. The impact of maternal deaths has profound implications for our public health, education, social, and public safety systems. The Maternal Mortality Review Committee (MMRC) evaluates the response of these systems through their retrospective review of the circumstances surrounding maternal deaths.

In 2018, DC Law 22-111 established the District of Columbia's MMRC. With administrative support from the Office of the Chief Medical Examiner, the MMRC reviews fatalities of DC residents during pregnancy or within one year of the end of a pregnancy. Through the identification of causes associated with maternal mortalities, and utilization of data collected from government agencies and community-based organizations, the MMRC constructs systems-based recommendations to reduce maternal mortalities. Our aim is to develop systems within our city that aim to prevent maternal mortality through improved health care services, social services, and community building.

The MMRC is proud to present its second Annual Report. This report presents our findings regarding the factors that contributed to these deaths and recommendations the MMRC developed in 2021 from our review of maternal deaths that occurred in 2018.

Section 1: "The Work of the MMRC" highlights the discussions of the MMRC during the case review process, and how we identified factors contributing to maternal death.

Section 2: "Recommendations and Beyond" provides a detailed list of the recommendations submitted by the MMRC to District Government agencies and their partners.



SECTION I

The Work of the Maternal Mortality Review Committee

In 2021, the MMRC convened in both open and closed sessions. During "open meeting" sessions, which are available for the public to attend, members discussed the purpose of the MMRC and answered questions from District residents, college students, local clergy, and reporters regarding the review process, committee composition and objectives of the committee. During the "closed sessions," attended by committee members and invited guests, the discussion focused on the circumstances surrounding 2018 deaths of four birthing persons, all of whom were residents of the District of Columbia.

To facilitate the 2021 maternal mortality review process, the OCME Fatality Review Division (FRD) reviewed records from the following District Government agencies and community-based organizations:

Table 1: FRD Records of Review

Agency or Community-Based Organization	Types of Records
Office of the Chief Medical Examiner	Autopsy and Investigative Reports
Metropolitan Police Department	Investigative Records
DC Health	Vital Records
Department of Human Services	Economic Security and Family Services Administration Records
Community of Hope Mary's Center	Social Service and Medical Records
MedStar Washington Hospital Center George Washington University Hospital Howard University Hospital Unity Health Care DC Behavioral Health Sibley Memorial Hospital	Medical Records
DC Fire and Emergency Medical Services	Emergency Medical Services Records
Child and Family Services Agency	Child Welfare Records

The cases reviewed included pregnancy-related deaths and one that occurred as the result of intimate partner violence during pregnancy. Deaths reviewed occurred both during pregnancy and the postpartum period. Two deaths occurred in the decedent's private homes, one death occurred in a healthcare facility, and one death occurred in a public space.

Pregnancy Relatedness

During the MMRC case review meetings, members utilize the MMRIA form, a CDC data system available to MMRCs, to provide support in determining if and how the death was pregnancy related.

The MMRIA Form identifies four (4) categories of pregnancy relatedness:

- ***Pregnancy Related:*** The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

- ***Pregnancy Associated, But Not Related***: The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy.

- ***Pregnancy Associated but Unable to Determine Pregnancy Relatedness***: The death of a woman while pregnant or within one year of pregnancy, due to a cause that could not be determined to be pregnancy-related or not pregnancy-related.

- ***Not Pregnancy Related or Associated***: Care identification error - decedent was not pregnant or within one year of the end of a pregnancy at the time of death.

CAUSES OF DEATH, PREVENTABLE EVENTS AND CASE DISCUSSIONS OF THE MMRC

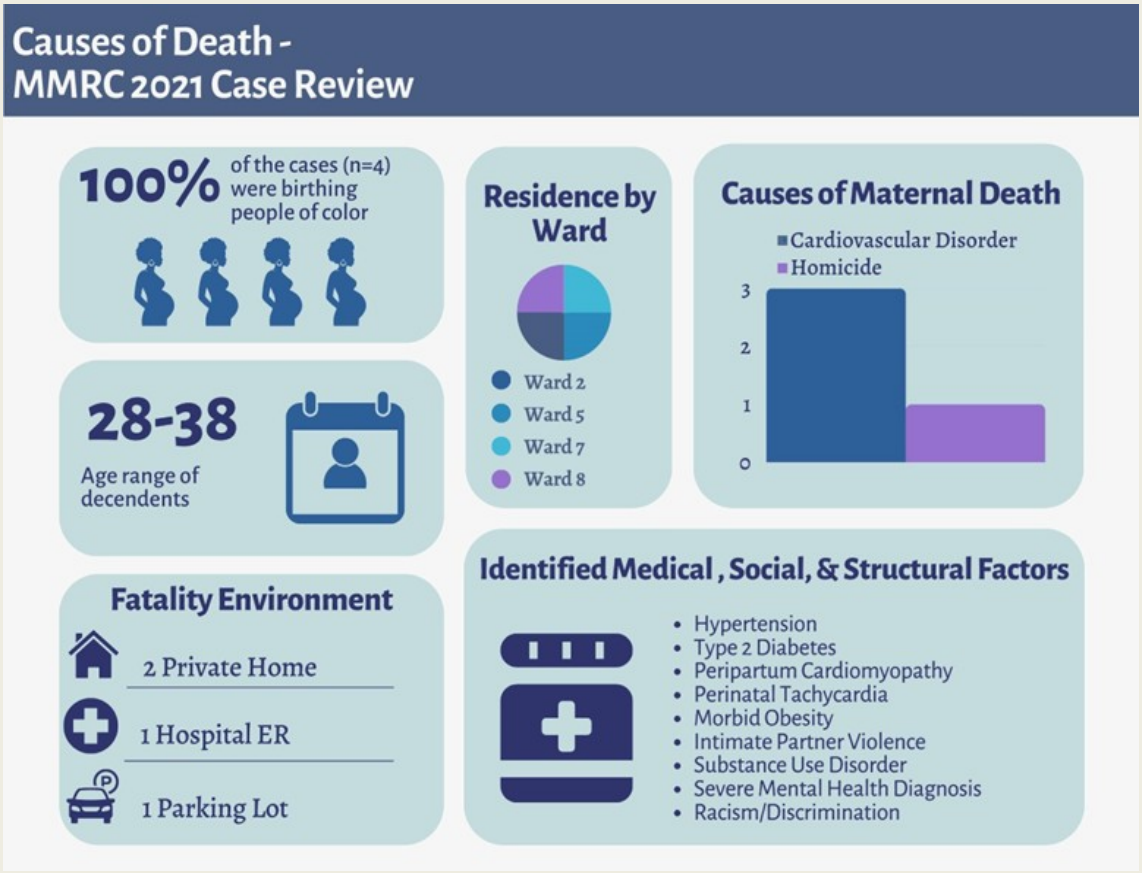


FIGURE 1: MMRC 2021 CASE REVIEW FINDINGS

Case Findings - An Overview of Committee Discussions

In the reviewed cases, the causes of death often mirrored their history of medical, environmental, economic barriers and social risks. As observed by the MMRC, there is an opportunity for provider and social services engagement, intervention, and preventive actions such as educational counseling during prenatal and postpartum care appointments.

The MMRC identified contributing factors related to structural racism, discrimination, difficulty accessing care, and lack of material resources - often due to structural marginalization including, but not limited to, lack of adequate transportation, employment, childcare and/or care coordination. Barriers to care cab disrupt the birthing person's care coordination. The MMRC observed that decedents had difficulty in executing a plan of care, particularly in the face of structural barriers combined with complex medical needs. This is sometimes documented in a medical chart as noncompliance;" however, committee members discussed how this language can obscure financial constraints, limited access to medication, lack of understanding or information about the treatment, fear of side effects, cultural beliefs, or personal preferences.

The MMRC discussed how discrimination presented in medical and social services documents can convey both subtle and explicit bias. This may impact the birthing person's experiences of care and trust of the health care system. The MMRC discussed the importance of healthcare providers avoiding "compliance" language and focusing on shared decision-making. It is important to note that behaviors not in alignment with provider recommendations can stem from several reasons, including financial constraints, limited access to medication, lack of understanding or information about the treatment, fear of side effects, cultural beliefs, or personal preferences. Healthcare providers play a crucial role in addressing these barriers, educating, and supporting adherence to treatment plans in partnership with birthing people.

The MMRC also discussed the importance of providers identifying and addressing chronic diseases that may compromise the wellbeing of birthing persons. As indicated in the review of national trends, cardiovascular and metabolic disorders contributed to some of the maternal deaths reviewed. The cardiovascular and metabolic conditions affecting pregnancy were cardiomyopathy, hypertension, hemorrhage, anemia, diabetes, and tachycardia. The members discussed the importance of providers identifying and addressing chronic diseases that may compromise the pregnancy, also taking into consideration the social, environmental, and economic barriers that may impede access to care.

The MMRC observed opportunities for providers and social service engagement, intervention, and preventive actions including educational counseling during prenatal and postpartum care appointments. Birthing persons with complex health and social needs may require assistance with the management of their postpartum medical care, particularly considering the demands of infant care, fatigue, and physical limitations during the postpartum period.

The MMRC noted the manifestation of structural racism through the case review process. Decedents experienced unemployment challenges economic insecurity, unstable housing, and concerns for safe public transportation. Care coordination and discharge planning should include the discussion of these challenges to benefit the overall health outcomes of birthing people.

The MMRC noted some decedents had risk factors that were presented over their life course, sometimes beginning from an early age. These exposures often overlapped and intersected with forms of structural marginalization. This was observed in the case of a decedent intermittently involved with child welfare services as a child and then again as a parent. Another life course risk exposure was intimate partner violence. The MMRC noted how the experience of intimate partner violence (IPV) contributed to mental health issues, leading to self-medication and substance abuse, and unstable housing. The MMRC agreed - people experiencing IPV deserve support to address both the relationship issues, and other areas of their life for improved stability and autonomy. The District of Columbia has resources available for those experiencing IPV through multiple District Government agencies. As observed by the MMRC, the lethality of IPV should be addressed as a public health issue. The MMRCs agreed all domestic violence homicides are preventable. An IPV death can be pregnancy associated, as the pregnancy and postpartum period can trigger increased violence leading to death.

The MMRC noted how failures of communication between the health care team and birthing persons was a contributing factor with opportunities for improvement. Key informant interviews would better assist committee members in understanding the experiences of birthing people. Better communication and documentation can support care and care coordination. Members agreed obstetric units should have a protocol for documenting patient phone calls. Committee members discussed this as an opportunity for a "Key Informant Interview Program" which involves having a trained interviewer conduct interviews with

individuals connected to the birthing person who died.

MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM

The maternal mortality review process includes a discussion of the decedent's lifespan, as their social and environmental history is provided through the review of medical and government records. Through its collaboration with the CDC, the MMRC utilizes the MMRIA Decisions Form during its review of cases to discuss and document these contributing factors. The MMRC process is designed to not place blame, but instead to evaluate and make recommendations for systemic changes that can impact outcomes. Recognizing contributing factors during the assessment phase of prenatal care or discharge planning as potential facilitators or barriers to medical treatment and healthcare services can help to improve our healthcare system's response and prevention of maternal mortality. Twenty (20) of the twenty-eight (28) contributing factors listed on the MMRIA Decisions Form were selected by the members during their review of cases in 2021.

The MMRC found structural racism, poor communication, and lack of access/financial resources as leading contributing factors prevalent in the maternal mortality cases reviewed. Poor discharge planning or failure to make timely, comprehensive, or appropriate assessments and biased language in healthcare records are characteristics of structural racism. These contributing factors of maternal mortality foster poor communication as birthing people navigate the healthcare system while dealing with multiple social problems, and/or chronic diseases.

Contributing Factors Observed in the 2021 MMRC Case Reviews

The MMRC identified these contributing factors during the case review meetings through the MMRC's utilization of the CDC's MMRIA© form at least once:

- Violence: Defined as physical or emotional abuse perpetrated by a current or former intimate partner, family member, friend, acquaintance, or stranger.
- Unstable Housing: Defined as an individual who has "lived on the street," in homeless shelter, or in a transitional or temporary circumstance with family or friends.
- Social Support/Isolation: Defined as an individual whose social support from family, partner, or friends was lacking, inadequate or dysfunctional.
- Structural Racism: Defined as 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, healthcare, criminal justice, etc. – (Adapted from Bailey ZD. Lancet. 2017 and Dr. Carla Ortique)
- Lack of Standardized Policy/Procedures: Defined as a facility lacking basic policies and infrastructure germane to the individual's needs.
- Legal: Defined as legal considerations that impact outcomes.
- Lack of Knowledge: Defined as the provider, or their patient does 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 or the need for treatment/follow-up after an evaluation for a health event.

- Delay: Defined as the provider or patient delay in referring or accessing care, treatment, or follow-up care/actions.

- Lack of Continuity of Care/Poor Communication: Defined as fragmented care (uncoordinated or comprehensive) among healthcare facilities or units. This can include records not being available between inpatient and outpatient units within the hospital, such as the emergency department, and labor and delivery.

- Clinical Skill/Quality of Care: Defined as personnel who were not appropriately skilled for the situation or did not exercise clinical judgment consistent with standards of care.

- Chronic Disease: Defined as the occurrence of one or more significant pre-existing medical conditions.

- Provider Assessment: The provider assessment includes actions placing the individual at risk for poor clinical outcomes. For example – A provider transfers or transports a patient to a provider who is unable to address the patient's medical needs.

- Patient or Provider Adherence: Defined as a provider or patient who did not follow protocol or failed to comply with standard procedures.

The MMRC identified the following contributing factors more than twice during the case review process:

- Lack of Access/Financial Resources: Defined as systemic barriers, e.g., lack or loss of healthcare insurance or other financial duress, as opposed to adherence to medical recommendations, impacting their ability to care for themself. Other barriers to accessing care: insurance non-eligibility, provider shortage in their geographical area, and lack of public transportation. Cases reviewed demonstrated the impact of the lack of finances how pregnant people and their providers by the lack of finances and resources. This could include a pregnant person who did not seek services because they were unable to miss work, find childcare or afford postpartum visits after insurance expired.

- Mental Health Conditions: Defined as a documented diagnosis of a psychiatric disorder. This includes postpartum depression. If a formal diagnosis is not available, a committee of subject matter experts (e.g., psychiatrist, psychologist, licensed counselor) can determine the criteria for a mental health condition based on available information.

- Discrimination: Defined as 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.

- Obesity: Defined as an adult who has a BMI of 30 or higher. Examples of obesity associated complications of pregnancy include increased relative risk of gestational diabetes, cardiovascular

complications of pregnancy, and cesarean birth.

The homicide case review identified violence, and lack of social support and isolation, mental health conditions, poor communication, and structural racism as issues - problems observed in domestic violence cases. One natural death case identified lack of policies, delay in medical treatment, lack of continuity of care, and lack of knowledge as provider related contributing factors. Legal issues, and obesity were contributing factors for one natural death reviewed by the MMRC.

MMRC members endorsed DC Law-23-132. The legislation expands Medicaid for postpartum medical treatment and health care services throughout the year after the delivery. This will ideally provide an opportunity to address medical issues that may occur because of pregnancy, or chronic disease exacerbated due to the pregnancy. If desired, birthing persons can utilize Medicaid to prepare for any future pregnancies.

SECTION II

RECOMMENDATIONS AND BEYOND

Maternal Mortality Review Committee Recommendations

During the 2021 operational year, the MMRC developed recommendations for District Government agencies and community-based partners that address the need for improvements in systems and/or programs that will initiate positive health outcomes for birthing persons and their families. These recommendations were initially formulated by members at the closure of the case review, and formally adopted by the MMRC Recommendations Subcommittee and approved by a vote of the full MMRC committee. The MMRC Recommendations Subcommittee addresses each aspect of the recommendation, which includes the following: (1) the statement of need, (2) the beneficiary population and (3) how the implementation of the recommendation may impact the overall policies, practice, legal and budget aspects of the receiving District Government Agency or community partner.

These recommendations address the need for improvements in (1) maternal community healthcare, (2) training and communication, (3) access for birthing persons to high-risk providers in all healthcare settings and (4) funding for programs that address the needs of birthing people.

Recommendation #1
The DC Department of Health should develop a multi-tiered community informed strategy to provide grants to maternal health institutions to increase meaningful access to the number of high-risk perinatal specialists available at the point of care.

DC Health agreed with this recommendation.

Response:
State and regional authorities should work together with the multiple institutions within a region, and with the input from their obstetric care providers, to determine the appropriate coordinated system of care and to implement policies that promote and support a regionalized system of care. These relationships enhance the ability of women to give birth safely in their communities while providing support for circumstances when higher-level resources are needed.

On July 1, 2022, the DC Department of Health's (DC Health) Community Health Administration released a Request for Applications for the Preterm Birth Reduction Initiative. $1.7 million in local funds would be granted to maternal health institutions to support the implementation of evidence-based strategies to reduce maternal risk factors and the occurrence of preterm births among high-risk District residents. In late December 2022, four grantees- Community of Hope, Unity Health Care, Howard University Hospital, and MedStar Washington Hospital Center were awarded funding to identify women at risk for preterm birth through enhanced screening, use of assessment tools, and protocols for linkages to specialized care and comprehensive services. These grant-funded projects are in alignment with best practices that emphasize a tiered, connected system, or a network of providers, where women seen by regular prenatal care providers can easily access or be transferred to specialized providers if they are at considerable risk.

Expected Outcomes: Among the maternal and child health outcome objectives in the DC Health Framework for Improving Community Health is a reduction in severe maternal morbidity from 259/10,000 to 233/10,000 deliveries for the overall population and 323/10,000 to 290/10,000 for Black or African Americans.

This is expected to be achieved between January 2023 – January 2027.

Recommendation #2
DC Department of Health should require health care providers to demonstrate completion of training that address cultural sensitivity, anti-racism, stigmatizing language in medical documentation and adverse childhood experiences (ACES). Medical providers should prove completion of training for initial licensure and each licensing cycle.

DC Health agreed with this recommendation.

Response:
Primary care settings offer an opportunity to identify and address adverse childhood experiences (ACES). A study has shown positive association of screening such as "less maternal psychological aggression, fewer minor maternal physical assaults, and improvements among providers in addressing depression, substance misuse, intimate partner violence, and serious parental stress."[1] The American Medical Association, one of the nation's largest professional association of physicians, has adopted a plan that includes understanding and operationalizing anti-racism equity strategies through training and tool development. This includes a long-term goal of embedding anti-racism, diversity, belonging, and multicultural organizational principals to create systems that are equitable and create opportunities to achieve optimal health. [2]

DC Health will continue existing efforts to provide racial equity, respectful care, and implicit bias training for District health care providers. DC Health's Director of the Office of Health Professional Licensing Board will consider potentially incorporating the completion of cultural sensitivity, anti-racism, stigmatizing language in medical documentation and adverse childhood experiences (ACES) training into the "public health priorities" continuing education that is required for all medical providers during the license renewal process.

DC Health oversees the work of the DC Perinatal Quality Collaborative (DC PQC), DC's network of clinical teams, public health experts, and other community stakeholders that participate in data-driven, clinical quality improvement initiatives to improve maternal and infant health outcomes, which has implemented racial equity and implicit bias trainings for clinical teams composed of staff and providers at 100% of the birthing hospitals (Howard University Hospital, Medstar Washington Hospital Center, Sibley Memorial Hospital, Georgetown University Hospital and GW University Hospital) in the District taking part in the Alliance for Innovation on Maternal Health, Severe Hypertension in Pregnancy patient safety bundle. The DC PQC also coordinated training through the Preeclampsia foundation on patient education for providers and staff at these birthing hospitals.

Expected Outcomes: Maternal clinical teams are trained in racial equity and implicit bias.

Recommendation #3
The District of Columbia should increase the awareness of vital community health programs and services potentially through a maternal health focal point within DC Health that would interface with the Perinatal Quality Collaborative.

DC Health agreed with this recommendation.

Response:
The American College of Obstetricians and Gynecologists (ACOG) recommends all individuals be screened by obstetrician–gynecologists and other obstetric care providers for mental health conditions at least once during the perinatal period for depression, anxiety, and other behavioral disorders, and again postpartum. During the postpartum period, it is recommended that a full assessment of physical, social, and psychological well-being occur no later than 12 weeks after birth.

DC Health plans to embark on a prenatal care campaign to enhance awareness of the importance of prenatal and postpartum care to maternal and infant health outcomes. Entry and participation in prenatal care provides the opportunity for screening for depression. A guidance document for clinicians on substance use screening, including tobacco, alcohol, marijuana, and opioid use is in progress; it will include screening and education prompts and increase awareness of resources for clinicians, providers, and patients.

DC Health partners with the DC Hospital Association on implementation of the Perinatal Quality Collaborative. The Family Health Bureau within DC Health's Community Health Administration serves as the focal point for coordination and oversight of the work of the PQC, as well as the focal referral point for linkages to community resources and services through the Help Me Grow program.

Through implementation of the Preterm Birth Reduction Initiative, DC Health has provided additional funding to improve perinatal connectivity through digital platforms, including increased support technology enhancements allowing for improved awareness of and tracking of referrals to community services.

In accordance with D.C. Official Code § 73-1234, a Perinatal Mental Health Taskforce has been established by the Department of Health Care Finance. The taskforce, which includes DC Health representatives, will study and provide comprehensive policy recommendations for improving mental health in the District.

Expected Outcomes:
Improved Social Determinants of Health screening and increased referral and connectivity to services; Increased capacity to educate, screen, diagnose, prevent and treat perinatal and postpartum depression and other related behavioral disorders; Increased organizational/workforce capacity to screen and support individuals at-risk for perinatal depression and other related behavioral disorders through education and training; Improve mental health and well-being of pregnant and postpartum individuals through increased access to appropriate treatment and recovery services.

The expected outcome will be achieved by the fiscal year 2024.

Recommendation #4
DC Health should ensure health care providers are trained in the use of health literacy practices that promote assessment and communication to support patients across the spectrum of health literacy levels. Further, DC Health should require health care providers to offer access to language/ interpreters to individuals who prefer to communicate in a language other than English.

DC Health agreed with the recommendation.

Response:
The National Action Plan to Improve Health Literacy contains seven (7) goals that will improve health literacy and strategies for achieving them:

1. Develop and disseminate health and safety information that is accurate, accessible, and actionable.
2. Promote changes in the health care system that improve health information, communication, informed decision-making, and access to health services.
3. Incorporate accurate, standards-based, and developmentally appropriate health and science information and curricula in childcare and education through the university level.
4. Support and expand local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health information services in the community.
5. Build partnerships, develop guidance, and change policies.
6. Increase basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy.
7. Increase the dissemination and use of evidence-based health literacy practices and interventions.

The Language Access Act of 2004 mandates that District of Columbia Government agencies provide linguistically relevant access to all available programs and services to individuals with limited or no English language proficiency (LEP & NEP). This policy establishes procedures and responsibilities in the furtherance of implementing this mandate. As a primary recipient of federal funding through grants and cooperative agreements, the District of Columbia Department of Health (DC Health) must comply with terms of agreement and have controls in place to ensure that sub recipients of funding take reasonable steps to make their programs, services, and activities accessible by eligible persons with limited and non-English proficiency. Although there is no Federal Office of Management and Budget language that specifically addresses language access, they require DC Health as a recipient of funds to comply with the Civil Rights Act of 1964 as amended. DC Health certifies that the agency will enforce that statute and use it as a compliance measure with our grantees and contractors. DC Health has set up internal controls that ensure this as well as monitoring implementation of what is “deemed” reasonable for grantees. The District of Columbia Language Access Act of 2004 clearly defines what is reasonable in detail.

The District’s Health Literacy plan leverages grant dollars received from the Centers for Disease Control and Prevention (CDC) and the Office of Minority Health (OMH) to DC Health’s health literacy plan to address health disparities and health literacy in relation to COVID-19. This plan has focused on learning what works in terms of health literacy and building the requisite infrastructure essential to support sustainability of these efforts within the context of the updated national definition of Health Literacy. This new definition recognizes the important role of organizations in supporting improving individual and community health literacy capacity. The overarching goal is to make health literacy a priority across all sectors in the District, including establishment of shared health literacy goals as part of development of the new Healthy People DC 2030 the 10-year community health plan for the District, through 2030. Launched over the last 18 months, DC Health’s Advancing Health Literacy Project supports an equity-focused, multi-stakeholder collaborative informing the development of a people-centered health-literacy model that will promote the transformation of individual, organizational, and professional health literacy practice in the District.

To date, steady progress has been made on the following four (4) major components:

- Establish Strategic Health Literacy Goals
- Launch a Health Literacy Learning Collaborative
- Collaborate with Community Based Organizations
- Building a Health Literacy Learning Support Portal

1. Establish Strategic Health Literacy Goals: Development and selection of validated personal health literacy measures occurred and will be included in 2023 DC Behavioral Risk Factor Surveillance System (BRFSS). Health literacy indicators have been developed for inclusion in the 2023 Community Health Needs Assessment data collection activities informing Healthy People DC 2030.

2. Launch a Health Literacy Learning Collaborative: Eight Community-based Organizations (CBOs), and an academic evaluation partner, have joined the Advancing Health Literacy Learning Collaborative (a component of the Advancing Health Literacy to Reduce Health Disparities Related to COVID-19 and Preventable Disease Program, which is aimed at closing health literacy gaps to advance health equity and improve outcomes in COVID19 and other preventable diseases). The Learning Collaborative aims to facilitate engagement between community-based organizations to share best practices around building continuous organizational capacity to advance health literacy and address health disparities.

3. Collaborate with Community Based Organizations: The DC Health team holds individual monthly meetings with each CBO partner to review individual CBO needs, technical assistance, work plans, project timeline, and necessary support for setting up health or community trainings. Building a Health Literacy Learning Support Portal: Content for a Practice Change and Learning Support Portal, which will provide health information content and resources intended to meet three key audiences: residents, organizations (non-health) and practitioners/clinicians, has been refined, user tested, and went live as a soft launch with a focus on individual health literacy, and ultimately, will contain content supporting the different engagement and learning needs of individuals, organizations, and providers.

At DC Health, Language Access is part of the portfolio of the Office of Communications and Community Relations (OCCR) within the Office of the Director. The Language Access Coordinator (LAC) is responsible for working with the DC Health Office of Grants Management (OGM) staff to plan and to implement procedures to ensure that entities funded through sub grants comply with the requirements of the Language Access Act of 2004 as well as federal law, regulations, and grant terms of agreement. When engaging with a Limited English Proficient (LEP)/Non-English Proficient (NEP) customer, DC Health employees and grantees are responsible for promptly utilizing the Language Line Services mechanism or any other method provided by the LAC to facilitate meaningful access to DC Health services directly provided by the Department or by any of its agents. Certified bilingual employees are only to be used as interpreters if the Language Access Line is unavailable, or if, after being attempted, the Language Access Line is situationally inadequate to provide linguistically relevant access. In addition, the LAC is responsible for providing guidance upon request to any employee requiring assistance providing linguistically relevant access to a DC Health stakeholder.
Both within DC Health and the grantees that provide direct services, LEP/NEP customers may insist on using a family member or friend as their interpreter or may otherwise refuse the agency's language access services. In such cases, the agency must obtain written consent that waives the customer's rights to translation and interpretation services. To do so, agency members must provide customers with a waiver form in their primary language, which the DC Office of Human Rights (DCOHR) supplies. If a written translation is not available in the customer's primary language or if the customer is unable to read, the agency may use sight translation to convey the contents of the waiver form to the customer.

The Language Access Coordinator (LAC) is responsible for working with the DC Health Office of Grants Management (OGM) staff to plan and to implement procedures to ensure that entities funded through subgrants comply with the requirements of the Language Access Act of 2004 as well as federal law, regulations, and grant terms of agreement by doing the following:

- Include language access compliance requirements for funded entities in all Notices of Funding Availability (NOFA), Request for Applications (RFAs) and Requests for Proposal (RFP) issued by the agency.

- Require that all DC Health-funded entities and contractors certify in writing that they will meet language access compliance requirements in contracts, memorandums of understanding, or work agreements signed between funded entity/contractor and DC Health.

- Ensure that funded entities and contractors obtain language access compliance training through the DC Office of Human Rights (DCOHR) or using training material approved by DCOHR.

- Provide guidance on language access compliance to funded entities and contractors by referring them to translation and interpretation vendors, and by providing them with a clear process for collecting data and for reporting all encounters with LEP/NEP customers to the agency.

- Grantees will provide DC Health grants monitors with data on the number of clients requesting and receiving LEP/NEP support through interpretation and translation services.

- All newly hired employees must attend language access training within 60 days of hire to ensure they are informed of the most updated language access and cultural competence resources.

Expected Outcomes:

1. Inclusion of Health Literacy as a Healthy People DC 2030 strategic goal for the District.
2. Implementation of a Sustainable Health Literacy Learning Collaborative.
3. Development of a Health Literacy Practice Change and Learning Support Portal for residents, organizations, and providers in the District.

This is expected to be achieved by June 2024.

Recommendation #5

DC Health (State Health Planning and Development Agency-SHPDA) should ensure there is embedded high risk obstetric and medical care available East of the River. This will ensure that distance and time are not barriers to care. This will encourage long term relationships between providers and their clients, community members, and community-based support services.

DC Health agreed with this recommendation with modification. The following is the modified recommendation:

The DC Health and the State Health Planning and Development Agency (SHPDA) should examine the need for high-risk obstetric services and other specialty health care services in the District of Columbia, particularly in Medically Underserved Area and Medically Underserved Population designations, during the health systems planning process. The evaluation of need should include metrics such as the distance and time patients are required to travel for care.

In accordance with D.C. Official Code § 44-404, the State Health Planning and Development Agency (SHPDA) is responsible for the development of a proposed Health Systems Plan (HSP) to guide health policy in the

District of Columbia and to address the health status and health systems goals of the Department of Health. The HSP is supposed to present data collected pursuant to § 44-405 to:

1. Articulate issues with respect to maintaining and improving the health of District of Columbia residents.
2. Demonstrate health care trends over multi-year periods.
3. Identify health needs of District of Columbia residents.
4. Identify needs of the health care delivery system; and
5. Prioritize health care issues.

The HSP is scheduled to be developed during the calendar year 2023 and published by June 2024.

Expected outcomes:
Identify the need for high-risk obstetric services and other specialty health care services in the District of Columbia, particularly in Medically Underserved Area and Medically Underserved Population designations.

Recommendation #6
DC Health should compile a list of DC providers who are available and able to provide care for birthing persons with complex medical needs. This resource list should be easily accessible and regularly updated for public access.

DC Health agreed with this recommendation.

Response:
Different hospitals and other facilities have various capacities to provide different levels of risk-appropriate obstetric care. For example, perinatal regionalization provides individuals the ability to know that there are hospitals within the geographic location that can address routine and risk-appropriate care. The list will provide the list of specialists that will support the care coordination that is involved amongst hospitals and facilities for the various levels of care.

DC Health's Community Health Administration and Health Regulations and Licensing Administration will aim to produce a list of specialists for high-risk obstetric care and leverage the partnership with LinkU to ensure the information is easily accessible. DC Health will also collaborate with the District Perinatal Quality Collaborative (DC PQC), DC's network of clinical teams, public health experts, and other community stakeholders that participate in data-driven, clinical quality improvement initiatives to improve maternal and infant health outcomes, and other key stakeholders, including DC Positive Accountable Community Transformation (a collective impact coalition) and Department of Health Care Finance, to develop a comprehensive guide including social service resources and support for health care providers, patients, and community–based organizations. In addition, the agency will collaborate across programs to assess and review existing resource guides which can be updated or adapted for providers and patients in the District.

The District of Columbia's Perinatal Quality Collaborative (DCPQC) has launched a website which is updated frequently and provides key resources on perinatal health for providers, patients, and families. The DCPQC has gathered input on development of a guide from key stakeholders through a sub-committee of the DC PQC, the Mapping Taskforce, as well as focus groups with patient family representatives. DC Health is currently engaged in revamping its website to improve accessibility. DC Health has partnered with an external evaluator on a Perinatal Health Needs Assessment to gather additional insights into the experiences

and overall needs of District residents, providers, and caregivers. The assessment resulted in accompanying briefs that outline key policy recommendations. DC Health's Preterm Birth Reduction Initiative aims to support the implementation of evidence-based strategies to reduce maternal risk factors and the occurrence of preterm births among high-risk District residents. In late December 2022, four grantees- Community of Hope, Unity Health Care, Howard University Hospital, and MedStar Washington Hospital Center were awarded funding to identify women at risk for preterm birth through enhanced screening, use of assessment tools, and protocols for linkages to specialized care and comprehensive services. These grant-funded projects emphasize a tiered, connected system, or a network of providers, where women seen by regular prenatal care providers can easily access or be transferred to specialized providers, if they are at high risk.

Expected Outcomes:
Improved accessibility to District-wide services and connectivity by fiscal year 2024.

Recommendation #7
DC Health should mandate the standardization of comprehensive postpartum instructions and discharge information, utilizing existing resources such as the Perinatal Quality Collaborative.

DC Health agreed with this recommendation.

Response:
The postpartum care plan should be reviewed and updated after the woman gives birth. It is suggested that the care plan include contact information and written instructions regarding the timing of follow-up postpartum care.

In accordance with the Better Access for Babies to Integrated Equitable Services Act of 2018 (BABIES Bill), DC Health is drafting Hospital and Birthing Facility Discharge Regulations. The discharge regulations aim to standardize comprehensive postpartum instructions and education as well as pertinent evidence-based discharge information and instructions.

DC Health has sought out key stakeholder feedback including from members of the District of Columbia Hospital Association/Perinatal Quality Collaborative as an antecedent step to submission for public comment on the draft hospital discharge regulations.

Expected Outcomes:
Hospitals, birthing facilities, and nurse-midwives (where applicable) will implement standards for postpartum patient services and education indicated in the regulations in accordance with the BABIES Bill.

The aim for the proposal rulemaking is to be published before the end of fiscal year 2023.

Recommendation #8
DC Health, in collaboration with the DC Hospital Association should require that all providers who care for pregnant people provide information (created by DC Health) that enumerates the rights of pregnant workers including contact information for resources if they believe their rights have been violated. The information should include an outline of what pregnancy discrimination may look like in various job settings.

DC Health and the DC Hospital Association agreed and collaborated as requested.

Response:
The Protecting Pregnant Workers Fairness Act 2014 (PPWFA) requires District of Columbia employers to provide reasonable workplace accommodations for employees whose ability to perform job duties is limited because of pregnancy, childbirth, breastfeeding, or a related medical condition. The act requires employers to provide reasonable accommodations for pregnancy, childbirth, and related conditions such as lactation, miscarriage, stillbirth, abortion, infertility, and menstruation. Employers must provide requested accommodations that promote pregnancy health and that allow pregnant patients to work comfortably and safely. Currently all District employers must post and maintain a PPWFA workplace poster in a conspicuous place and provide an employee with notice of the law within 10 days of an employee notifying them of their pregnancy or other conditions addressed in the Act.

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on Employment Considerations (#733) recommends that obstetric care providers aid patients to obtain accommodations by writing appropriate work accommodation notes that allow patients to work safely during pregnancy. Obstetrician-gynecologists and obstetric care providers can play a vital role in ensuring that patients are able to continue work. Such accommodations are important to ensure patients are guaranteed pay, benefits, and job protection.

DC Health, District of Columbia Hospital Association (DCHA) and the members of the DC Perinatal Quality Collaborative (DCPQC), will leverage existing partners and stakeholders including the DC Office of Human Rights (OHR), DC Department of Employee Services (DOES), DC Primary Care Association (DCPCA), the Medical Society of the District of Columbia (MSDC), Federally Qualified Health Centers (FQHCs), providers, community-based organizations, and patient and family representatives to bring awareness to patient rights during the prenatal and postpartum periods. DC Health and DCHA will work to provide education and training on guidelines for healthcare providers for how to write effective notes to employers that maximize the likelihood patients will receive accommodations as needed.

In accordance with the Better Access for Integrated Equitable Services Act of 2018 (BABIES bill), DC Health is drafting Hospital and Birthing Facility Discharge regulations. The guidance aims to standardize comprehensive postpartum instructions and education as well as pertinent evidence-based discharge information and instructions. DC Health has developed the guidance in collaboration with DCHA and the members of the DCPQC regarding standard education and information to be disseminated to patients at the point of hospital discharge. Information regarding the PPFWA, Paid Family Leave, and additional resources to support patients and families will be included. In addition, this information will also be disseminated to patients by providers during the prenatal period. Hospitals, birthing facilities, and nurse midwives (where applicable) will implement standards for prenatal and postpartum patient services and education indicated in the regulations in accordance with the BABIES bill.

DC Health will include language in subgrant requirements and grant agreements with DC Health funded entities.

The DC Office of Human Rights (OHR) has developed workplace posters and fact sheets which are readily available (in English and Spanish) to employers and employees in the District. Through the Office of Paid Family Leave and Department of Employee Services (DOES), 12 weeks of paid family leave, medical, or parental leave benefits, including 2 weeks prenatal leave, are available to employees in the District. The benefit is provided separate from any existing company benefits provided by an employer. DC Health, in collaboration with DCHA and the members of the DCPQC will facilitate discussions to identify the best

method of dissemination to provide accessibility, including seeking provider and patient and family representatives' feedback. In addition, DC Health and DCHA will distribute guidelines to providers on how to effectively communicate existing policies and regulations, and how best to provide support to patients to ensure continued employment.

Complaints can be filed with OHR through completion of the PPWFA questionnaire, which can be completed online or submitted via email or mail. OHR is responsible for reviewing all claims and performs initial mediation and investigations. If it is determined that probable cause exists, the Commission on Human Rights administrative judges will make a final determination.

Expected Outcomes:
Increased awareness among providers, employers of various sectors, patients and employees of available benefits and rights during prenatal and postpartum, and breastfeeding periods.

The expected outcome will be achieved by the fiscal year 2024.

Recommendation #9
The MMRC recommends that CFSA expand training to health care providers, including community-based organizations and home care organizations, to connect families with Family Success Centers and other supports.

The Child and Family Services Agency responded "no" and provided the following explanation:

Response
CFSA offers mandated reporter training to include health care providers, personnel, and contractors, among others; it is available online 24 hours/day, 7 days/week. If requested, CFSA is open to providing more targeted training to mandated reporters who need additional clarification. Additionally, CFSA will be establishing a Warm-line to provide District residents with access and linkages to community-based supports in FY24.

What's Next…

Key Informant Interviews

In 2020, the CDC published the Informant Interview Guide for Maternal Mortality Review Committees as a resource to assist MMRCs across the country with their development of a Key Informant program. Key Informants are critical to this process, as they interview front-line observers of adverse events that lead to maternal mortality. Fatality Review Division staff at the DC OCME review records from multiple medical providers, community-based providers and government agencies involved with the maternal health of birthing people. A narrative report is composed and provided for the fatality review. Information on these interactions from the perspective of birthing persons is often not captured in agency documentation, leaving unanswered questions. MMRC member Dr. Constance Bohon, brought this program to the MMRC's attention. Now advocated by the full MMRC, it is the hope to include the narrative of a key informant interviewer to understand the perceptions of birthing people and develop recommendations that would have a greater impact within the maternal health community. The MMRC agreed to continue to advocate for funding and implementation of the Key Informant program through its recommendation process, and in discussion with local leaders, Congress, and the Council of the District of Columbia.

Evaluation of the District's Drug Testing Policies

MMRC member Dr. Melissa Fries in collaboration with the District of Columbia's Child Fatality Review Committee's Infant Mortality Review Team (IMRT) conducted an evaluation of the benefits and harms of universal drug testing of birthing persons at the time of delivery. Through Dr. Fries' presentation before the MMRC, the committee noted the disparate policies regarding drug testing and screening in the District of Columbia across hospital and health systems. These policies are often determined by institutional practice and provider discretion which have shown to be influenced by implicit and explicit bias. The District of Columbia is one of only twenty-three jurisdictions that involve child welfare authorities in cases where infants test positive for drugs that are deemed illicit at birth (Fries, 2021). There is a disparity in this reporting, as only one hospital in the District of Columbia tests all birthing persons at delivery. Concomitantly, that same hospital serves the largest proportion of Black and Brown birthing persons and those living on low incomes.

At other hospitals, birthing persons may opt-out of testing. Some hospitals rely on "risk-based screening," or profiling birthing persons based upon their appearance (observed as being "high") or having a history of drug use. A family's involvement with child welfare, a social determinant of health, can be a stressful situation for birthing people that may lead to court involvement and the dismantling of the family. Drug screening during pregnancy raises important concerns, particularly regarding its disproportionate impact on Black and Indigenous families. While the rates of drug use during pregnancy are similar between Black and White women, Black women are more frequently subjected to reporting, investigations, and child removals[2]. This disparity highlights a systemic bias within the reporting process. While healthcare providers may aim to connect individuals with necessary services, research does not support this approach as an effective mechanism. Instead, it can have punitive consequences, discouraging individuals from seeking the care they need. Recognizing these issues is crucial in addressing the negative experiences of birthing persons during drug screenings. For these reasons, the MMRC agreed to continue this discussion as the IMRT engages with leaders from other states and conduct a wide survey of participants throughout the maternal health community.

[2] Winchester ML, Shahiri P, Boevers-Solverson E, Hartmann A, Ross M, Fitzgerald S, Parrish M. Racial and Ethnic Differences in Urine Drug Screening on Labor and Delivery. Matern Child Health J. 2022 Jan;26(1):124-130. doi: 10.1007/s10995-021-03258-5. Epub 2022 Jan 6. PMID: 34988865.

APPENDIX A

Glossary

- **Discrimination**: treating someone 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.
- **Hemorrhage:** [Postpartum] hemorrhage is defined as excessive bleeding after birth and can lead to shock (dangerously low blood pressure) and death.
- **Homicide**: the death results from an injury or poisoning or from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but not a requirement for classification as a homicide.
- **Hypertensive Cardiovascular Disease**: Hypertensive disorders of pregnancy place the birthing person at risk of preeclampsia/eclampsia, and the fetus at risk of preterm birth, placental abruption (the placenta separates from the wall of the uterus before birth), and cesarean birth.
- **Key Informant**: Someone who conducts interviews with others to gain insight into factors that the participant believes contributed to the death and the context around those factors in the decedent's life.
- **Maternal Mortality Review Information Application (MMRIA or "Maria")**: A data system developed by the CDC available to all Maternal Mortality Review Committees to support review functions. The form consists of a collection of clinical and non-clinical information surrounding the birthing person's life and death. This form assists MMRCs in determining if the death was related to pregnancy, preventable, and the factors contributing to the death. This form allows committees to determine recommendations to prevent future deaths.
- **Natural Death**: According to the CDC, natural death is defined as deaths due solely or totally to disease and/or the aging process.
- **Obesity**: According to the CDC, obesity is defined as an adult who has a BMI of 30 or higher. Obesity can pose significant health risks during pregnancy, potentially affecting both the birthing person and the developing baby.
- **Pre-eclampsia**: Pregnancy disorder characterized by high blood pressure, sometimes with fluid retention and protein in the urine.
- **Eclampsia**: Eclampsia is the new onset of seizures or coma in a pregnant woman with preeclampsia. These seizures are not related to an existing brain condition.
- **Pregnancy induced Cardiomyopathy**: Cardiomyopathy is a disease of the heart muscle that may be hereditary or acquired. Cardiomyopathy makes the delivery of blood to the body difficult and can lead to heart failure. Symptoms of cardiomyopathy include shortness of breath, swollen feet, and legs and bloating.

- **Structural Racism**: Defined as 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, healthcare, criminal justice, etc. – (Adapted from Bailey ZD. Lancet. 2017 and Dr. Carla Ortique)

Acknowledgement

On behalf of birthing persons throughout the District of Columbia, the Office of the Chief Medical Examiner expresses its appreciation for the work of the Maternal Mortality Review Committee. This cooperative group of concerned experts in the field of maternal health leave their positions to volunteer their time and mental energy to discuss the details of the circumstances surrounding maternal deaths. As the goal is to improve the experiences of all birthing persons, we hope the discussions within this annual report will help support those most at risk of maternal mortality. We thank you for your service.

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