Maternal Child Health Equity Summit
January 12, 2021

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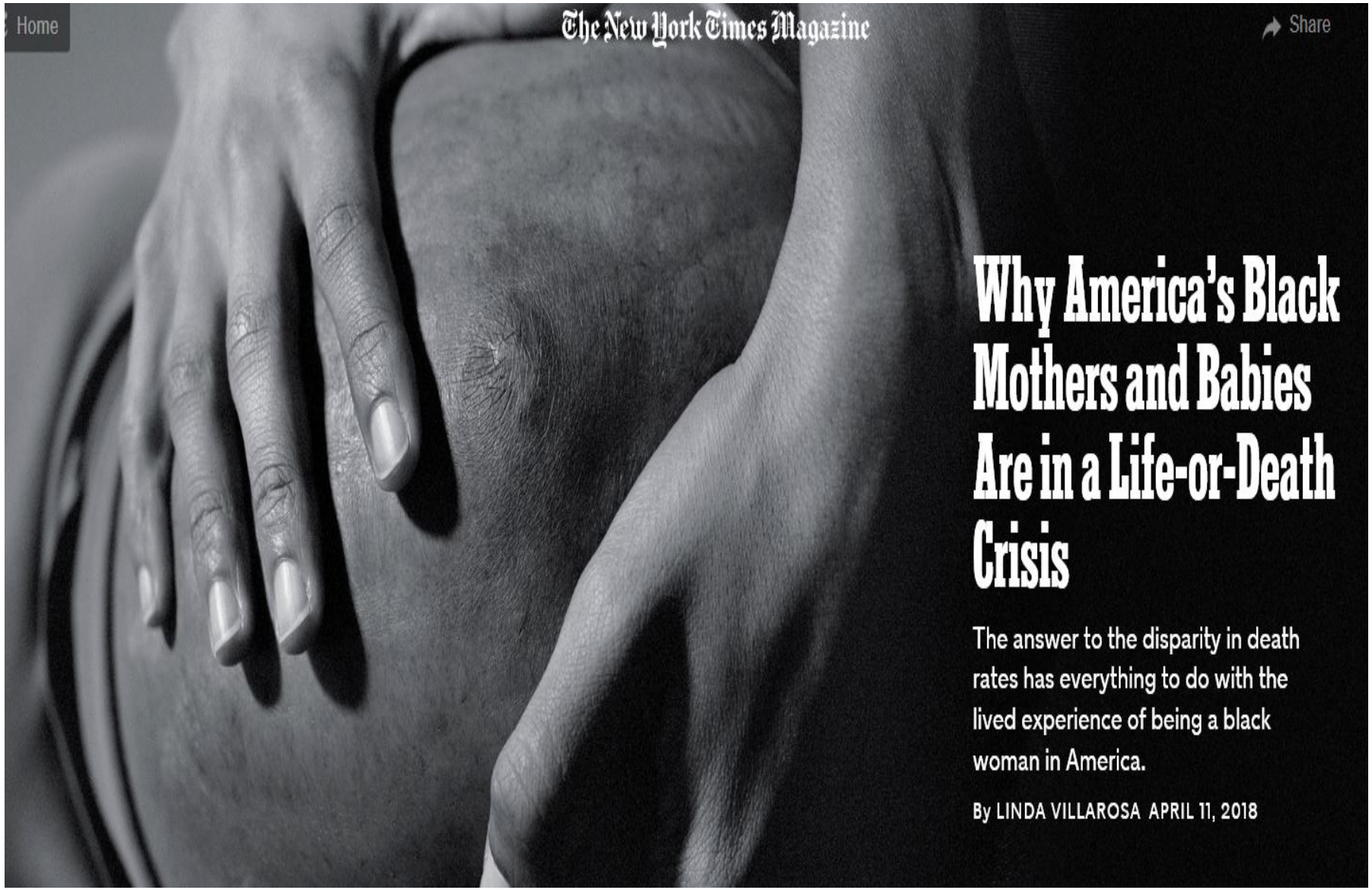
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The New York Times Magazine
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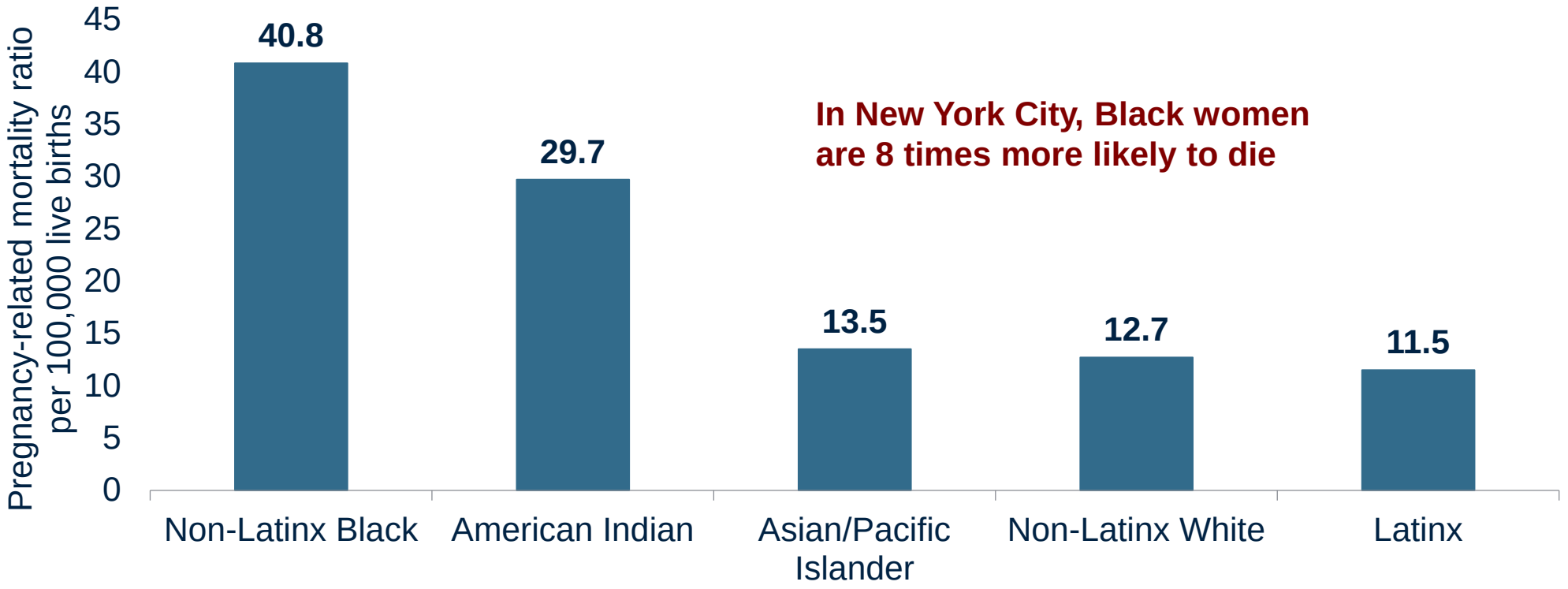
Why America's Black Mothers and Babies Are in a Life-or-Death Crisis
The answer to the disparity in death rates has everything to do with the lived experience of being a black woman in America.
By LINDA VILLAROSA APRIL 11, 2018

Acknowledgement

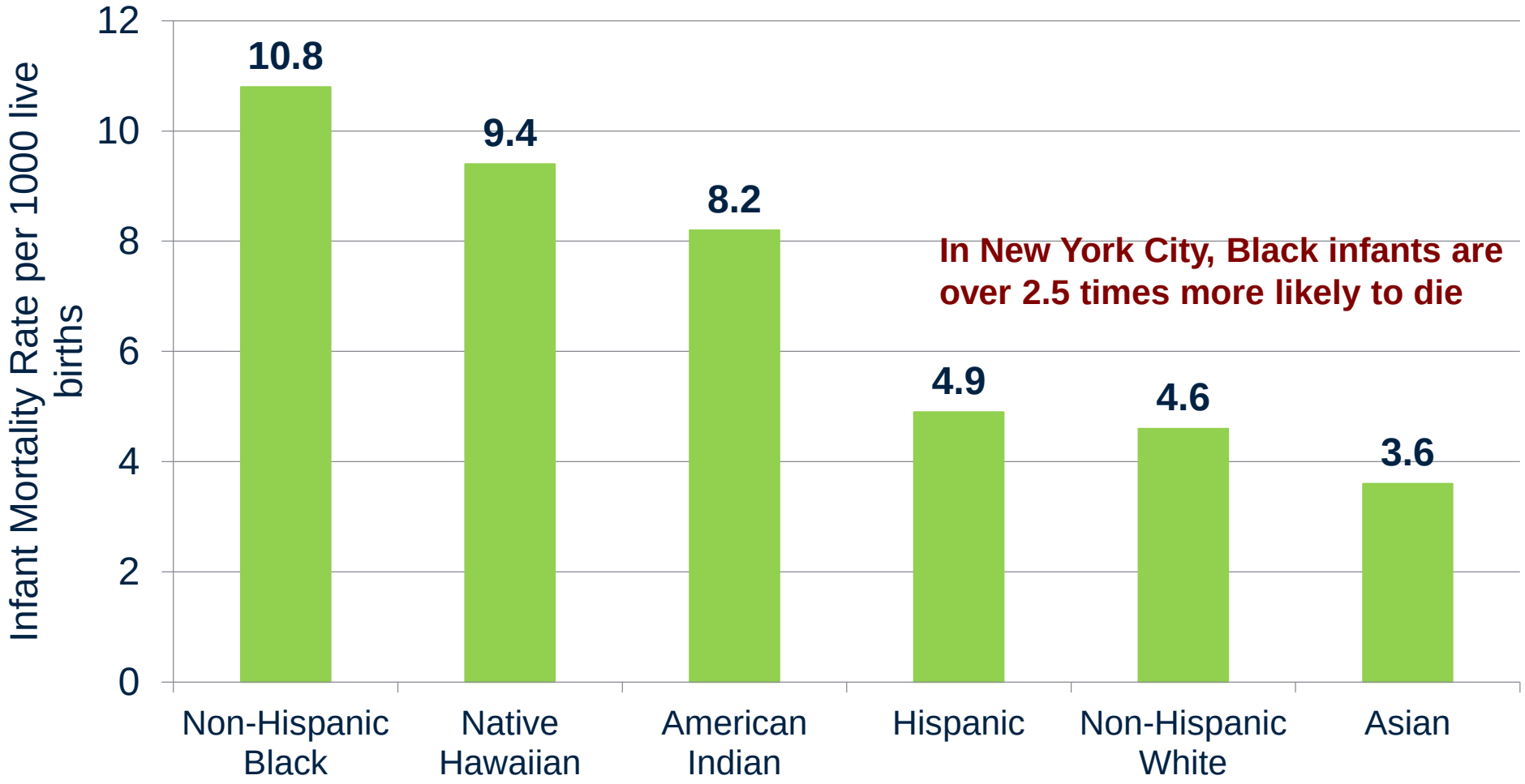
- Lessons learned from our discussions today have implications for Black, Brown, and Indigenous Birthing People
- We refer to “women” to describe pregnant individuals. However, we recognize that people of various gender identities, including transgender, nonbinary, and cisgender individuals, give birth and receive maternity care
- There is a long legacy of racism and discrimination that has been experienced by Black women and most of the research to date has been on cisgender women
- We have much work to do to expand our definitions and collect meaningful data on all birthing people

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



Petersen E et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016. MMWR. Sept. 6, 2019. vol 68. no 35; New York City DOHMH. Pregnancy-Associated Mortality in NYC, 2011-2015. Long Island City, New York. Feb. 2020. New York City Department of Health and Mental Hygiene (2020). Pregnancy Associated Mortality in New York City, 2011-2015.

Infant Mortality by Race-Ethnicity, 2018



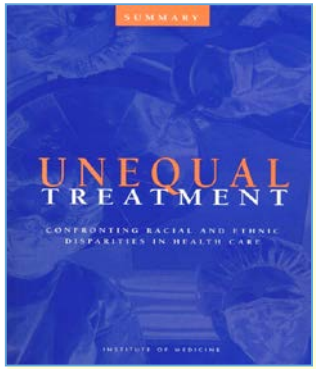
Ely DM, Driscoll AK. Infant mortality in the United States, 2018: Data from the period linked birth/infant death file. National Vital Statistics Reports, vol 69 no 7. Hyattsville, MD: National Center for Health Statistics. 2020. March of Dimes Peristat – NYC Data for 2015-2017

Impact of Institutional Racism on Maternal and Child Health

- Unequal access to resources
  - 1935 Social Security Act
- Housing discrimination - redlining
- Mistrust of the healthcare system
- Recent events

National Institute for Children's Health Quality. https://www.nichq.org/insight/impact-institutional-racism-maternal-and-child-health

Contribution of Quality of Care to Racial and Ethnic Disparities in Health and Healthcare



- Publication of Institute of Medicine's *Unequal Treatment*
  - Racial/ethnic disparities in care across a range of illnesses, services
  - *People of color receive lower quality care*
  - Provider stereotyping, and bias contribute to disparities
- Quality, Disparities, and Maternal and Infant Health
  - Racial/ethnic disparities in maternal and infant mortality and morbidity
  - Growing evidence that quality of care is an underlying cause
  - Quality of care varies across delivery hospitals and neonatal intensive care units
  - Site of care receiving increasing attention as mechanism for disparities in maternal and infant health

Institute of Medicine 2002; Horbar. JAMA Pediatr. 2017 Mar 6;171(3):e164396.Howell. Am J Obstet Gynecol. 2016 Jan;214(1):122.e1-e9. Creanga. Am J Obstet Gynecol. 2014 Dec;211(6):647.e1-16.

NIH-Funded Research: Mixed Methods Studies to Investigate the Contribution of Hospital Quality to Disparities in Maternal and Infant Health

- Maternal: quantitative and qualitative study to investigate contribution of hospital quality to disparities in severe maternal morbidity in New York City hospitals
- Infant: quantitative and qualitative study to investigate contribution of hospital quality to disparities in very preterm birth (<32 weeks) morbidity-mortality
- TODAY – Dissemination of findings to national audience

Funded by NICHD # R01HD078565 and NIMHD # R01MD007651

Objectives for MCH Equity Summit

- Disseminate research findings on quality of care and disparities to a national audience
- Engage stakeholders, researchers, community organizations in interpreting these findings
- Share best practices of high performing hospitals
- Develop priority actionable items to improve MCH Equity

MCH Equity Summit Planning Committee

Elizabeth Howell, MD, MPP

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Christa Christakis, MPP

Executive Director, ACOG District II

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Chair of OB/Gyn, Columbia University

Wendy Wilcox, MD, MBA, MPH, FACOG

Chair of OB/Gyn and Reproductive Science, NYC H+H/Kings County

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Acknowledgements

- Eunice Kennedy Shriver National Institute of Child Health and Human Development (R01HD078565)
- National Institute on Minority Health and Health Disparities (R01MD007651)

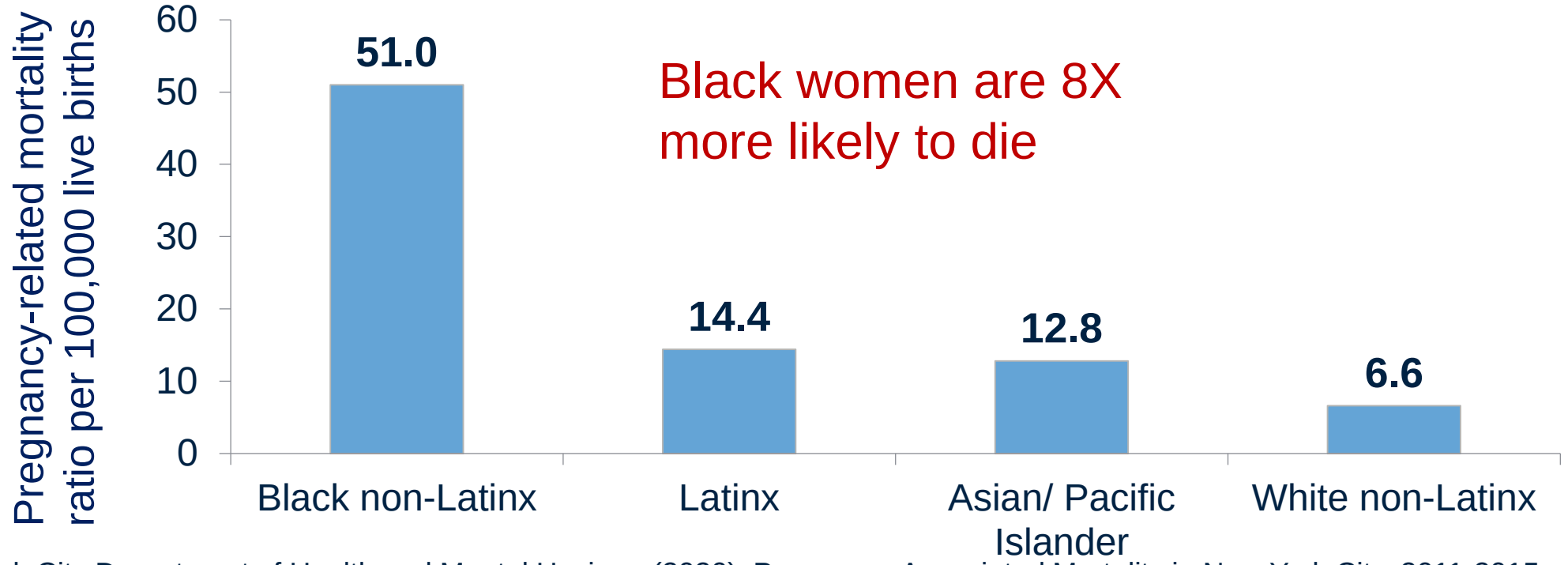
Quality, Disparities, and the Current Maternal Health Care Crisis

Maternal Child Health Equity Summit

January 12, 2021

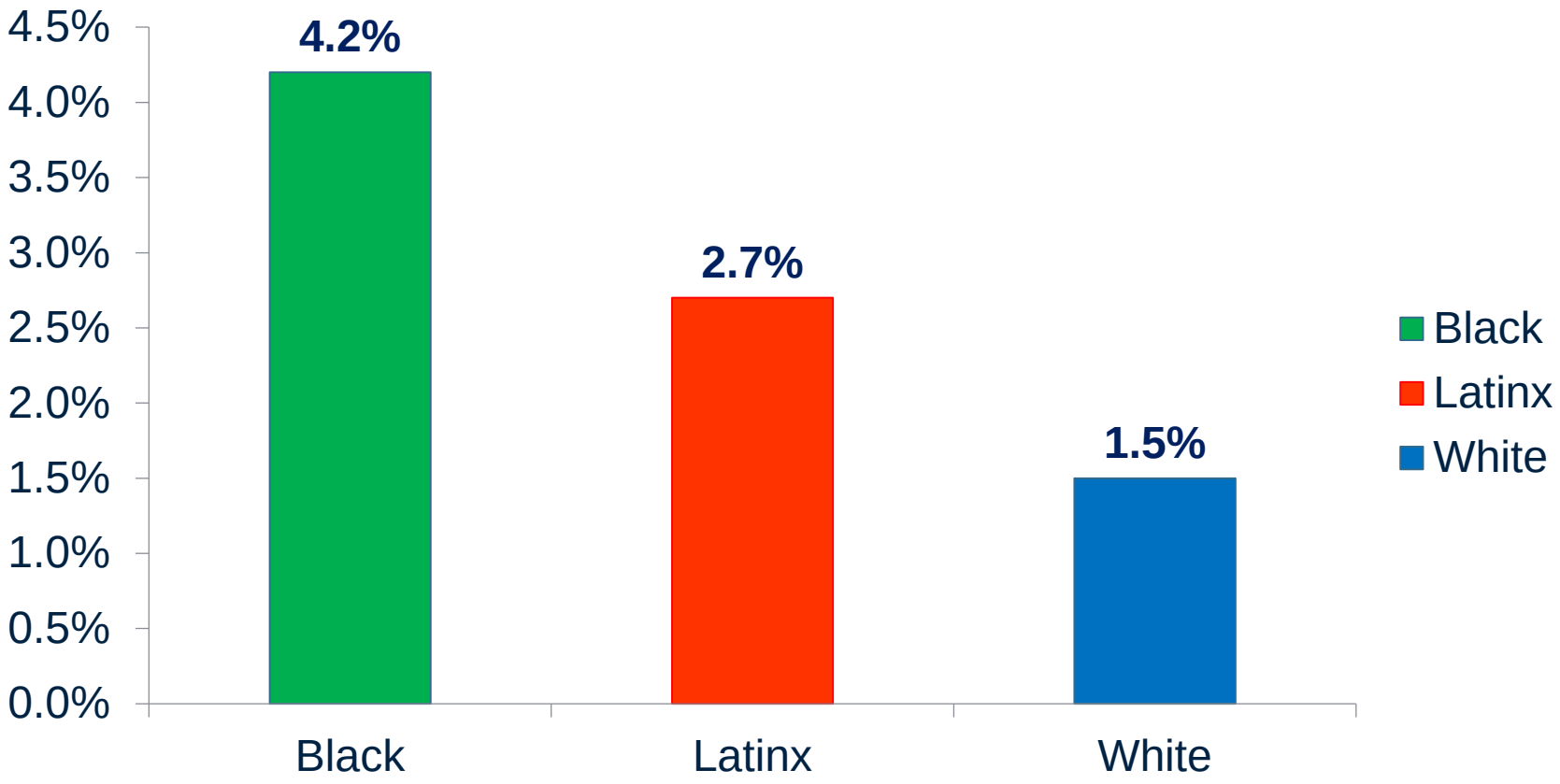
National Institute on Minority Health and Health Disparities (R01MD007651)

Pregnancy-Related Mortality Ratios in New York City



New York City Department of Health and Mental Hygiene (2020). Pregnancy Associated Mortality in New York City, 2011-2015.

Severe Maternal Morbidity Rates in New York City



Howell Am J Obstet Gynecol. 2016 Aug;215(2):143-52; Howell. Obstet Gynecol. 2017 Feb;129(2):285-294.

Racism & Discrimination

Patient Factors
- Socio-demographics: age, education, poverty, insurance, marital status, employment, language, literacy, disability
- Knowledge, beliefs, health behaviors
- Psychosocial: stress, weathering, social support

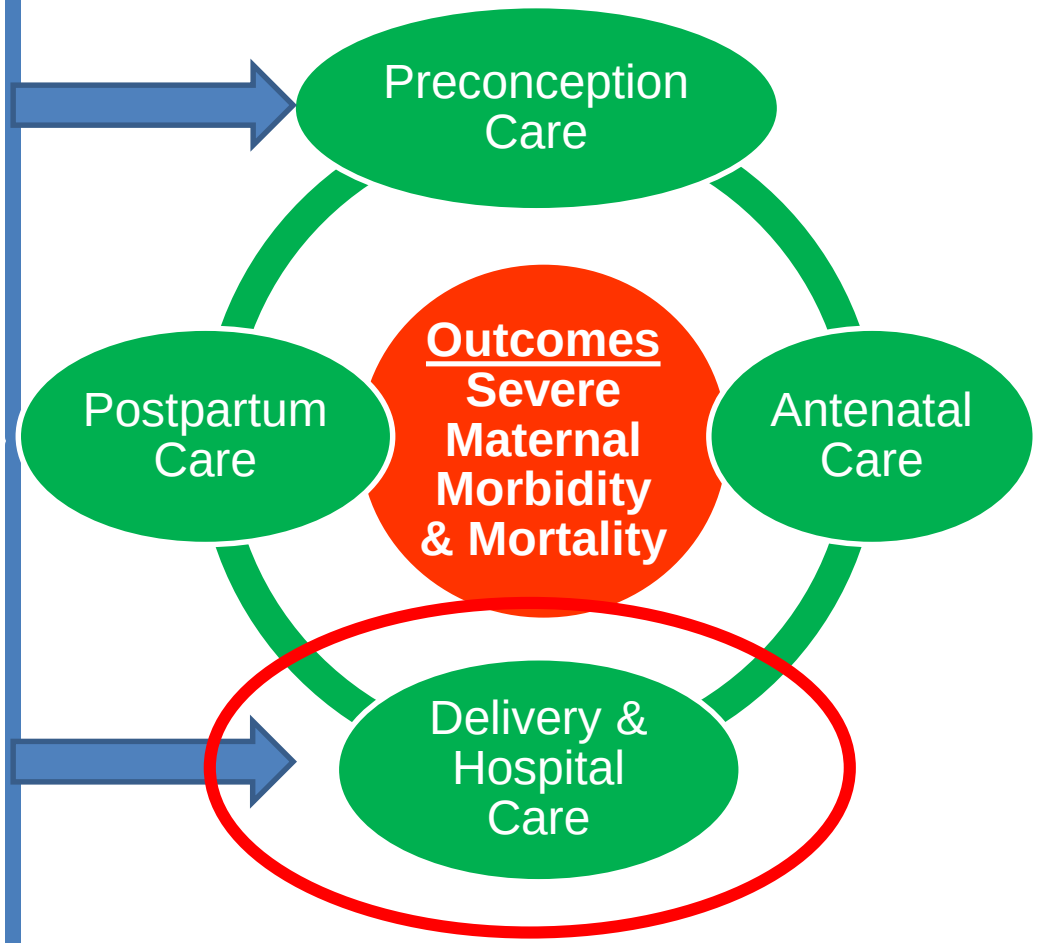
Community/ Neighborhood
- Community, social network
- Neighborhood: crime, poverty, built environment, housing

Clinician Factors
- Knowledge, experience, implicit bias, cultural competence, communi-cation

System Factors
- Access to high quality care, transportation, structural racism, policy

Health status: comorbidities (e.g. HTN, DM, obesity, depression); Pregnancy complications

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



Adapted from Howell EA. Clin Obstet Gynecol. 2018 Jun;61(2):387-399

Mixed Methods Study to Investigate Contribution of Hospital Quality to Racial and Ethnic Disparities in Severe Maternal Morbidity

- Phase 1: Quantitative analyses to examine hospital risk-adjusted SMM and racial/ethnic distribution of deliveries
- Phase 2: Qualitative interviews to examine safety culture, quality improvement, and other factors that may explain wide variation in hospital performance
- Phase 3: Focus groups to explore patient barriers to receipt of high quality care
- Phase 4: Dissemination efforts to increase uptake of best practices

*Funded by NIMDH #R01MD007651

Bradley Implementation Science 2009 May 8;4:25; Howell. Clin Obstet Gynecol. 2019. Sep;62(3):560-571

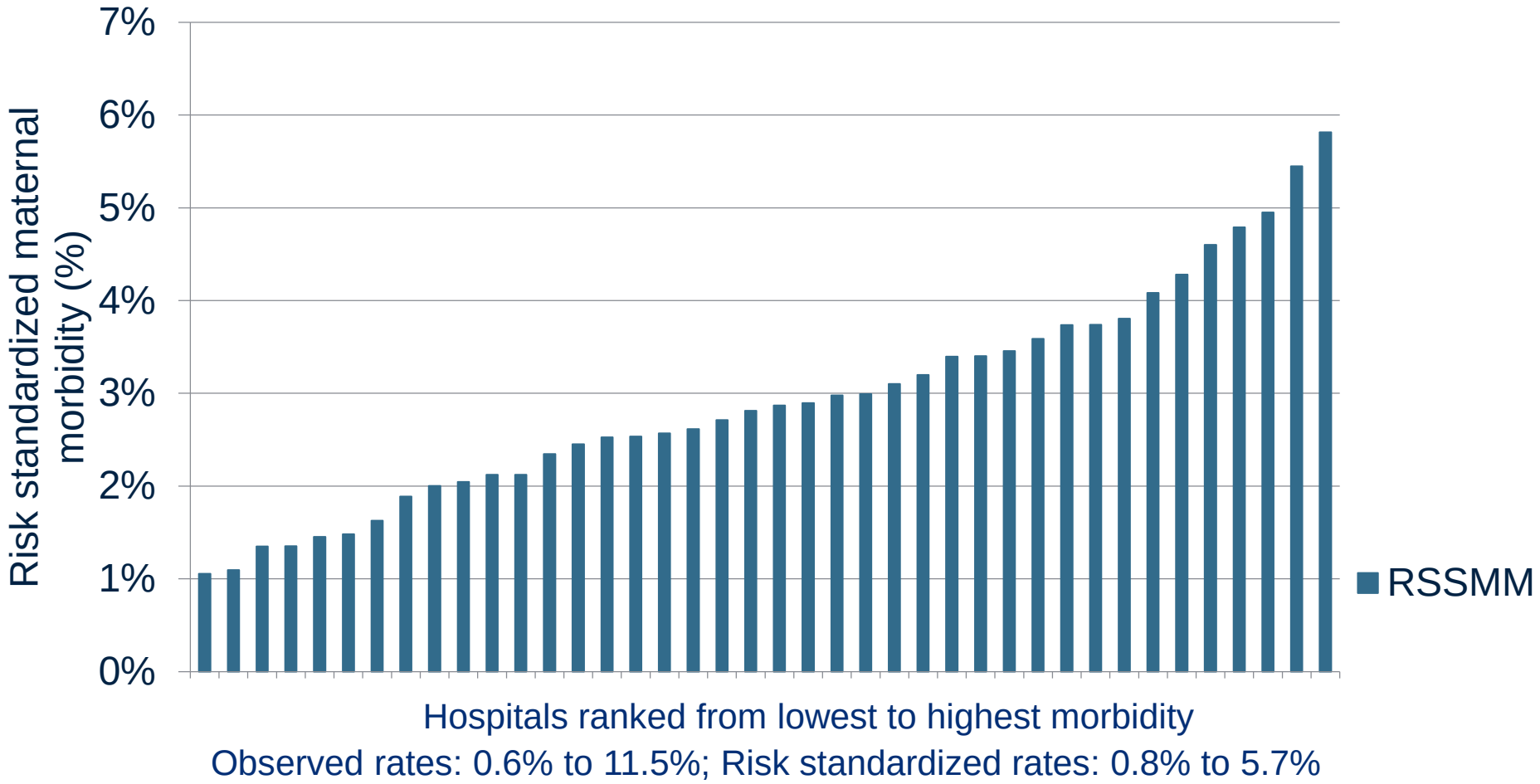
Phase 1 Methods

- Vital Statistics linked with SPARCS for all New York City deliveries (2011-2014)
- CDC algorithm to identify severe morbidity
- Mixed-effects logistic regression to calculate risk-standardized severe maternal morbidity rates (SSMMR) for each hospital
- Ranked hospitals based on SSMMR
- Assessed black-white differences and Latina-white differences in delivery location

Risk-Adjustment Models

- Sociodemographic characteristics (self-identified race/ethnicity, age, education, nativity, insurance, parity)
- Clinical and obstetric factors (multiple pregnancy, mode of delivery, body mass index, prenatal care)
- Maternal comorbidities (e.g. diabetes, hypertension, heart disease)

Hospital Rankings for Severe Maternal Morbidity



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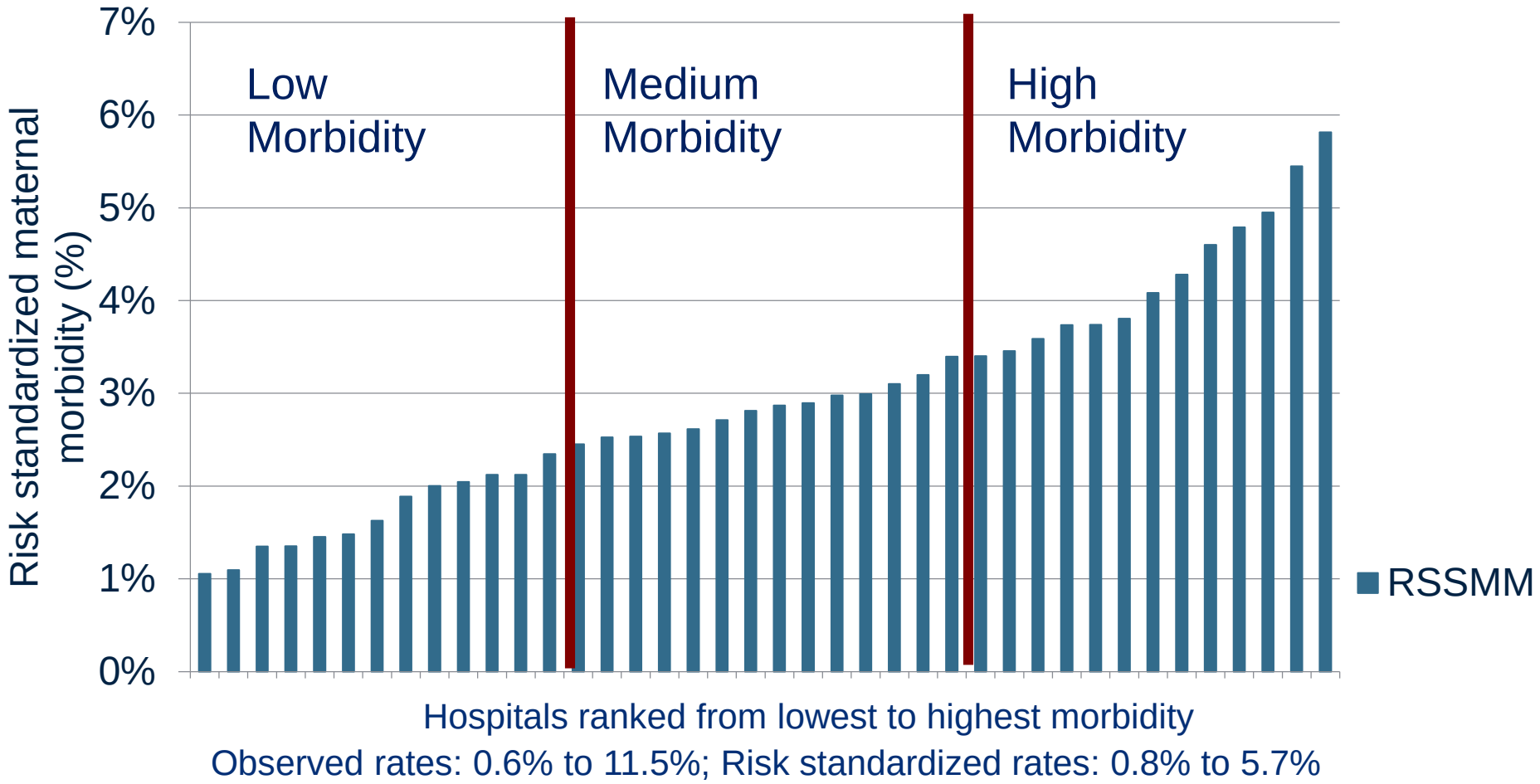
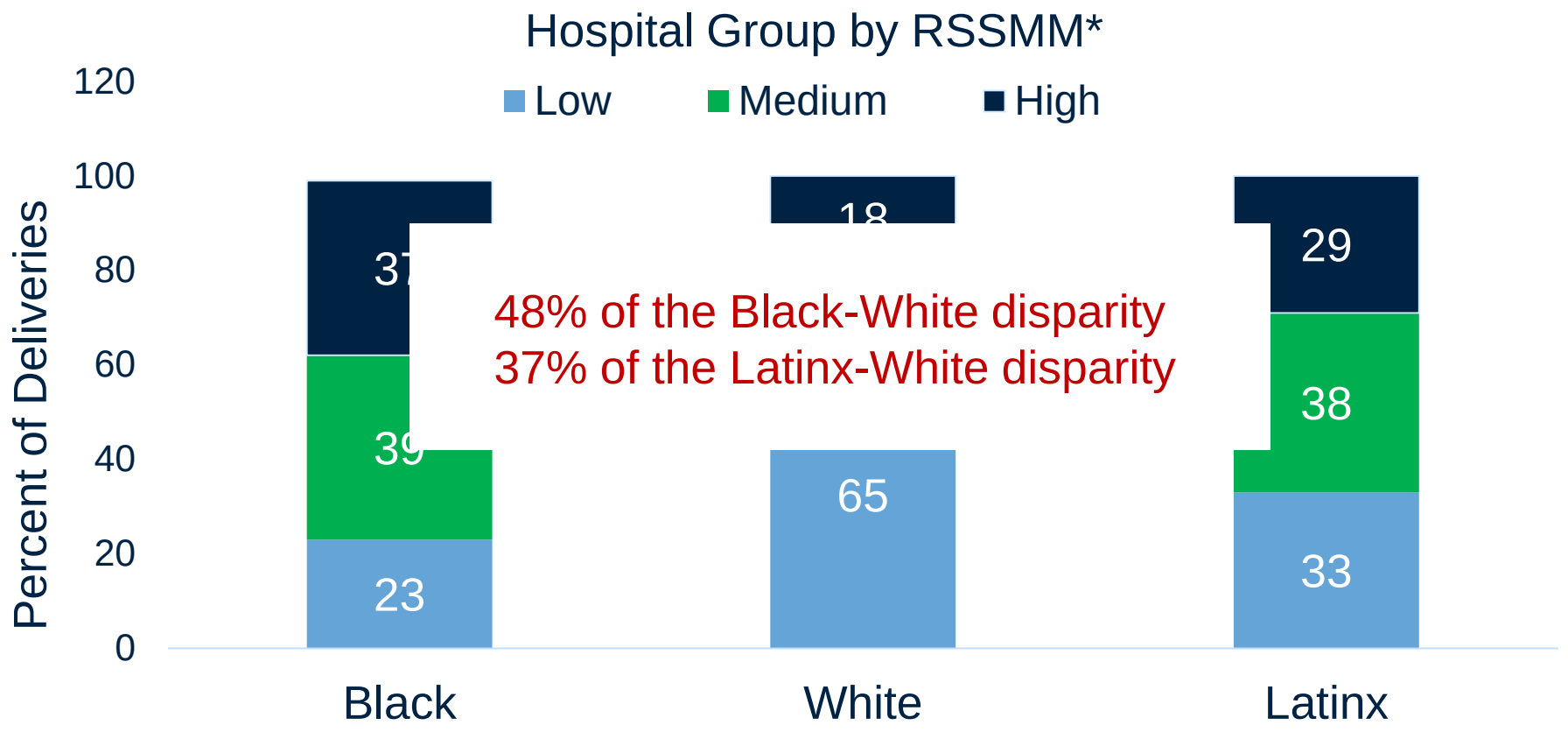
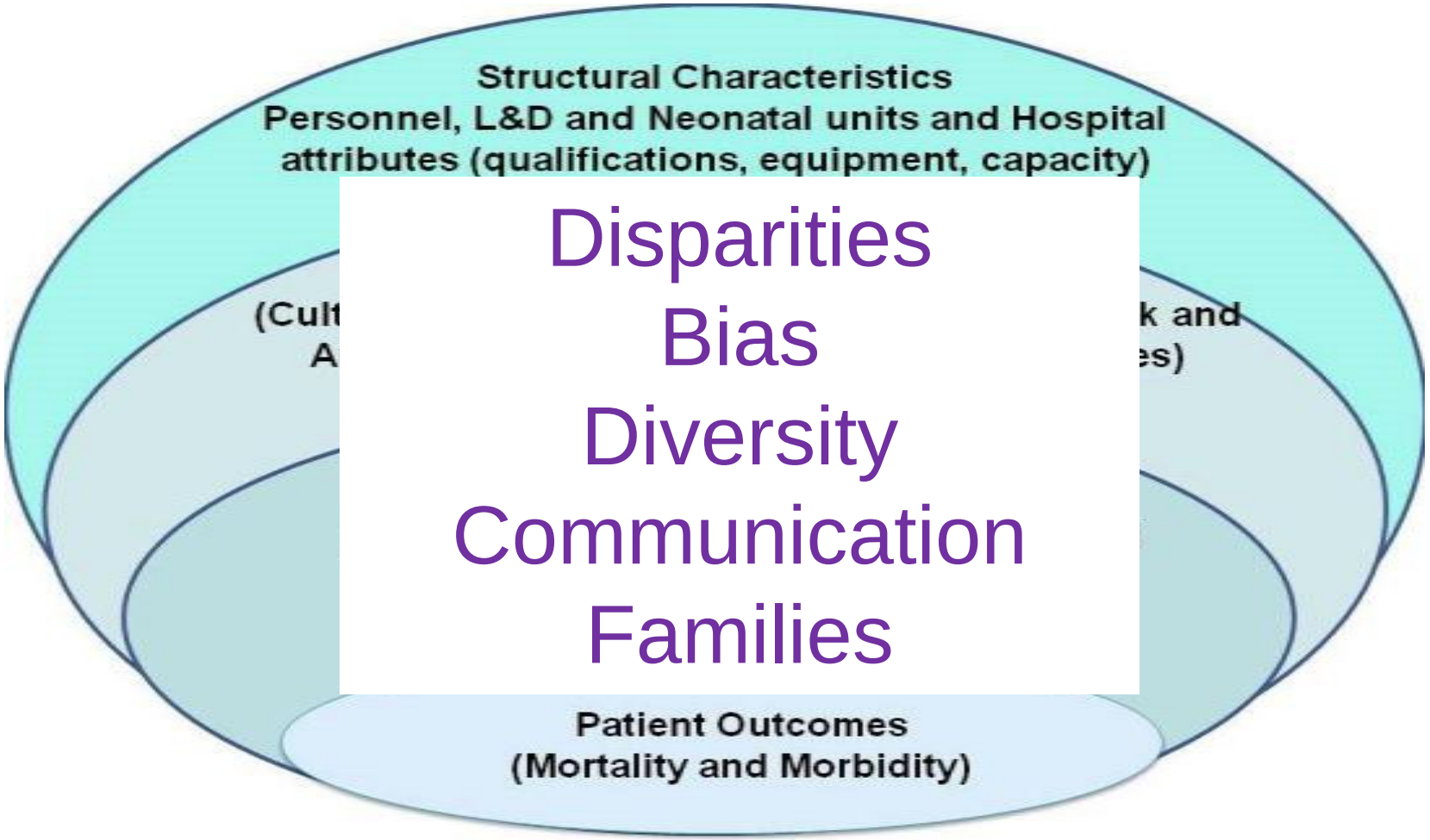


Distribution of Deliveries by Race / Ethnicity and Hospital Ranking



Howell Am J Obstet Gynecol. 2016 Aug;215(2):143-52; Howell. Obstet Gynecol. 2017 Feb;129(2):285-294

Phase 2: Hospital Factors, Quality, and Disparities



Howell. Semin Perinatol. 2017 Aug;41(5):266-272

Hospital Selection

- Ranked hospitals by risk-standardized rates into three groups: low, medium, and high SSMMR
- Selected 4 hospitals from the high morbidity group and 4 from the low morbidity group for both studies
- Additional criteria: criteria: volume of deliveries, % Black/AA, %Latina, % Medicaid and feasibility

Qualitative Interviews

- Sample
  - 8 New York City Hospitals
  - 50 Interviews
  - September 2017-October 2018
- Semi-structured interview
- Respondents consented, interviews audiotaped and transcribed
- Qualitative research staff blinded to hospital ranking

Hospital Qualitative Interviews

Position		**Total**
Chair of OB/GYN at 8 sites		8
Physician Director of L&D		7
Physician/Nurse Quality & Safety Lead		6
Nurse Manager of L&D		8
Front Line L&D Nurse		7
Chief Medical Officer		7
Other (e.g. Chief Quality Officer)		8
	Total	50

Themes in High and Low Performing Hospitals

- Almost everyone believes they provide equally good care to all patients
- Everyone believes staff communication is a critical factor in quality and safety
  - Hospitals vary in what they have done/do to improve communication
- Re rise in maternal morbidity/mortality rates, respondents point ONLY to factors OUTSIDE the hospital
- Nurse staffing issues – shortages, variation in experience
- Wide variation in quality measurement and improvement
- Individual adverse events more likely to lead to quality improvement than monitoring trends
- ***No one analyzes data to compare performance across race, ethnicity or insurance source***

Phase 3: Focus Groups

- Three focus groups stratified by race/ethnicity (N=20)
- Experienced severe morbidity (e.g. hemorrhage, ICU stay, hysterectomy)
- Explored how women experienced care

Wang Womens Health Issues. 2021 Jan-Feb;31(1):75-81

Focus Groups: Mothers Who Experienced Severe Maternal Morbidity

- Traumatic Experience
  - “Traumatized,” “Scary,” “Never want to have a child again”
  - Complemented with gratitude
- Poor Communication
  - “They just rushed me to the OR, and that was it. I was just lying there. I'm cold. I'm shaking. I know I'm not feeling good, but nobody is telling me anything.”
- Not Feeling Heard
  - …I essentially diagnosed my own pulmonary embolism, because nobody was listening to me. It's very scary to me how much I really had to advocate [for myself].”
- Subtle Discrimination
  - Access limited by insurance
  - Less time spent on education

Wang. Womens Health Issues. 2021 Jan-Feb;31(1):75-81

Within-Hospital Disparities

Original Research

Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities

Elizabeth A. Howell, MD, MPP, Natalia N. Egorova, PhD, MPH, Teresa Janevic, PhD, MPH, Michael Brodman, MD, Amy Balbierz, MPH, Jennifer Zeitlin, DSc, MA, and Paul L. Hebert, PhD

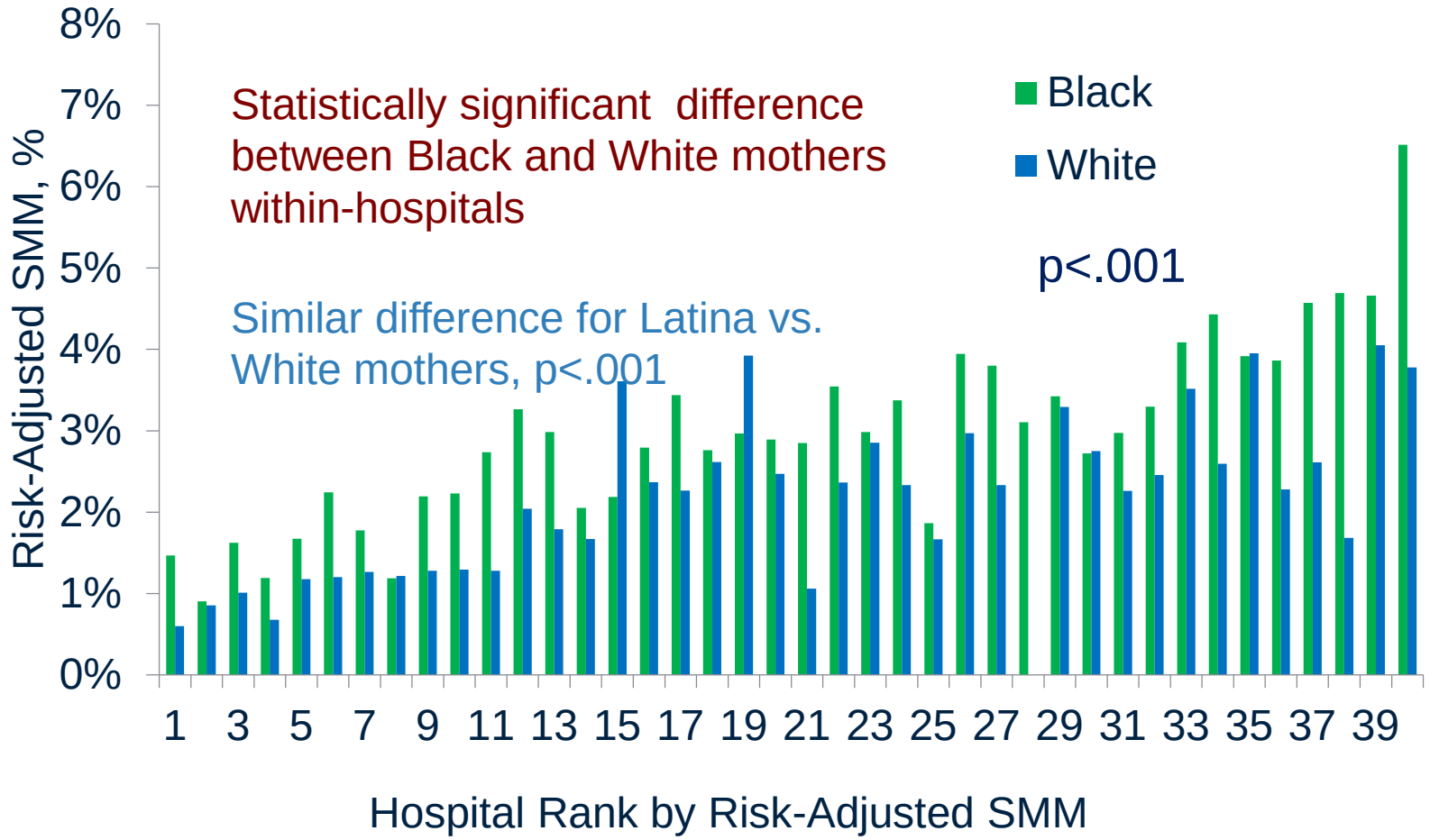
OBJECTIVE: To examine within-hospital racial and ethnic disparities in severe maternal morbidity rates and determine whether they are associated with differences in types of medical insurance.

hospital adjusted rates using paired *t*-tests and conditional logit models.

RESULTS: Severe maternal morbidity was higher among black and Latina women than white women (4.2% and

Howell EA. Obstet Gynecol 2020;135:285–93

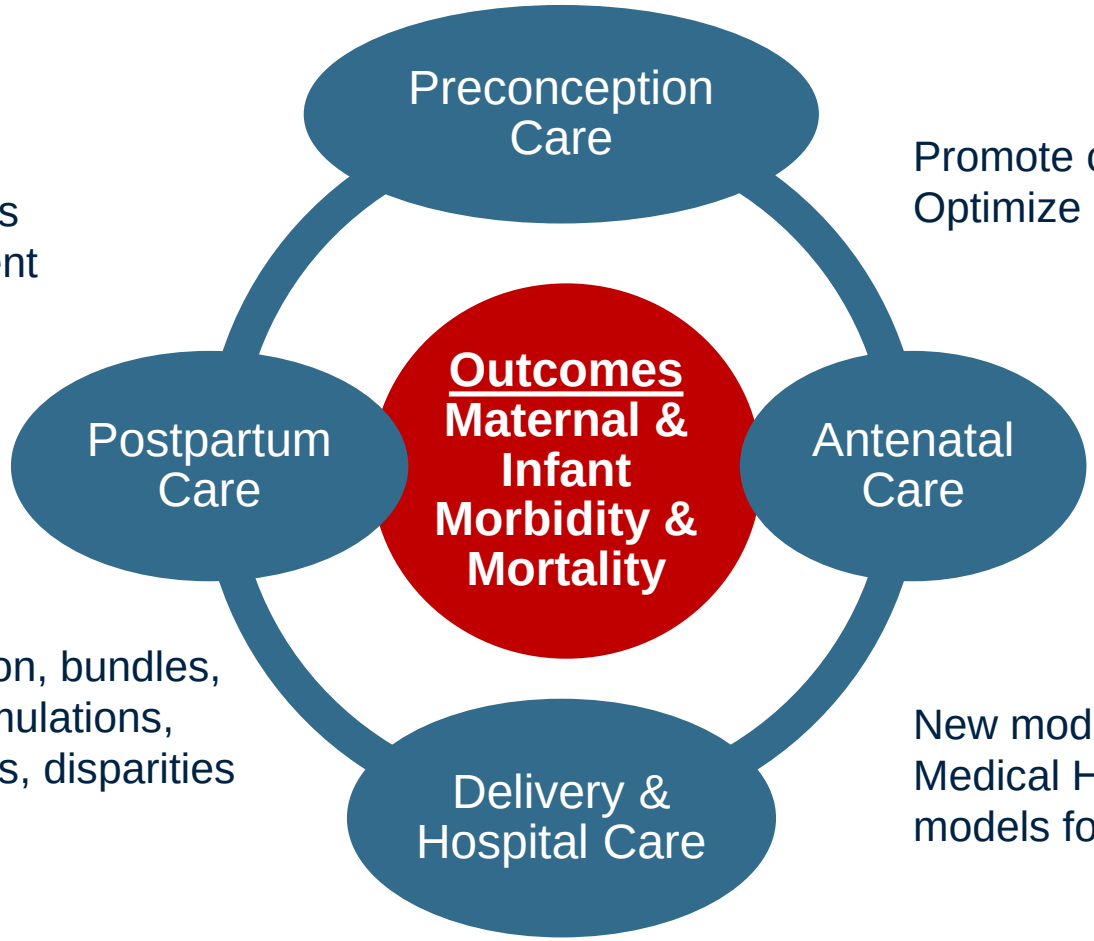
Within-Hospital Comparison of Risk-Adjusted SMM for Black versus White Women



Howell EA. Obstet Gynecol 2020;135:285–93

Levers to Reduce Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality

Lifecourse



New models –
Patient navigators
Case management

Promote contraception
Optimize preconception health

QI, standardization, bundles, team training, simulations, reviews, protocols, disparities dashboard

New models – Centering, Medical Homes, enhanced models for high risk women

What Serena William's scary childbirth story says about medical treatment of black women

https://www.vox.com/identities/2018/1/11/16879984/serena-williams-childbirth-scare-black-women

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

"In the more than 200 stories of African-American mothers that ProPublica and NPR have collected over the past year, the feeling of being devalued and disrespected by medical providers was a constant theme….

Over and over, black women told of medical providers who equated being African American with being poor, uneducated, noncompliant and unworthy. "Sometimes you just know in your bones when someone feels contempt for you based on your race," said one Brooklyn woman who took to bringing her white husband or in-laws to every prenatal visit."

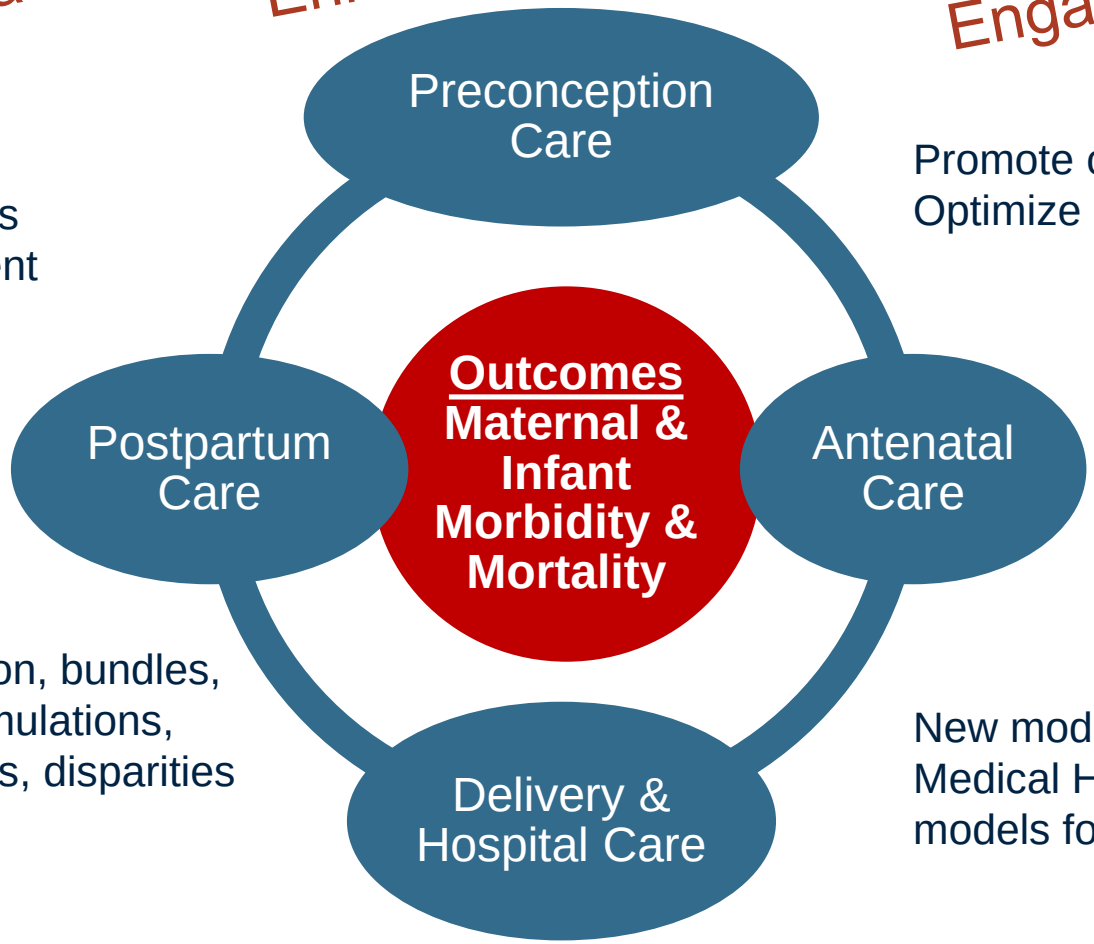
Levers to Reduce Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality

Eliminate Bias

Enhance Communication

Engage Community

New models –
Patient navigators
Case management



Promote contraception
Optimize preconception health

QI, standardization, bundles, team training, simulations, reviews, protocols, disparities dashboard

New models – Centering, Medical Homes, enhanced models for high risk women

Steps to Address Healthcare Crisis for Moms of Color

- Collect self-identified race/ethnicity /language data
- Implement disparities dashboard; utilize QI tools to address identified gaps in care
- Provide education on cultural humility, shared decision-making, implicit bias training
- Provide education on racial and ethnic disparities in maternal outcomes
- Include community members in quality committees
- Utilize enhanced severe maternal morbidity and mortality reviews
- Promote a culture of equity

CDC-MMRIA Bias Working Group

- Response to Maternal Mortality Review Committees reporting the role of bias in maternal death, but no distinct category for bias on MMRIA*
- Aim to design a consistent approach for documenting racism and discrimination as contributing factors to pregnancy-related deaths
- Provide recommendations on how to prevent pregnancy-related deaths when bias is a contributing factor

*Maternal Mortality Review Information Application (MMRIA) is a comprehensive database that provides for standardized documentation of committee decisions.

Hardeman. Findings from the CDC Maternal Mortality Review Information Application (MMRIA) Racism & Discrimination Working Group. *Under review*.

Contributing Factors

CONTRIBUTING FACTOR KEY (DESCRIPTIONS ON PAGE 4)

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

THANK YOU

Research Team

Jennifer Zeitlin DSc MA
Paul Hebert PhD
Teresa Janevic PhD MPH
Natalia Egorova PhD MPH
Amy Balbierz MPH
Shoshanna Sofaer DrPH

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National Institute on Minority Health and Health Disparities (R01MD007651)

@LizHowellMD

Mount Sinai *The Blavatnik Family Women's Health Research Institute*

Penn Medicine Obstetrics and Gynecology

New Contributing Factors

CONTRIBUTING FACTOR DESCRIPTIONS

LACK OF **ACCESS/FINANCIAL** RESOURCES
System issues, e.g. lack or loss of healthcare insurance or other financial duress, as opposed to woman's noncompliance, impacted woman's ability to care for herself (e.g. did not seek services because unable to miss work or afford postpartum visits after insurance expired). Other barriers to accessing care: insurance non-eligibility, provider shortage in woman's geographical area, and lack of public transportation.

ADHERENCE TO MEDICAL RECOMMENDATIONS
The provider or patient did not follow protocol or failed to comply with standard procedures (i.e. non adherence to prescribed medications).

FAILURE TO SCREEN/INADEQUATE **ASSESSMENT** OF RISK
Factors placing the woman at risk for a poor clinical outcome recognized, and the woman was not transferred/transported to a provider able to give a higher level of care.

CHILDHOOD SEXUAL ABUSE/TRAUMA
The patient experienced rape, molestation, or one or more of the following: sexual exploitation during childhood plus persuasion, inducement, or coercion of a child to engage in sexually explicit conduct; physical or emotional abuse or violence other than that related to sexual abuse during childhood.

CHRONIC DISEASE
Occurrence of one or more significant pre-existing medical conditions (e.g. obesity, cardiovascular disease, or diabetes).

CLINICAL SKILL/QUALITY OF CARE (PROVIDER OR FACILITY PERSPECTIVE)
Personnel were not appropriately skilled for the situation or did not exercise clinical judgment consistent with current standard of care (e.g. error in the preparation or administration of medication or unavailability of translation services).

POOR **COMMUNICATION**/LACK OF CASE COORDINATION OR MANAGEMENT/ LACK OF CONTINUITY OF CARE (SYSTEM PERSPECTIVE)
Care was fragmented (i.e. uncoordinated or not comprehensive) among or between healthcare facilities or units, (e.g. records not available between inpatient and outpatient or among units within the hospital, such as Emergency Department and Labor and Delivery).

LACK OF **CONTINUITY OF CARE** (PROVIDER OR FACILITY PERSPECTIVE)
Care providers did not have access to woman's complete records or did not communicate woman's status sufficiently. Lack of continuity can be between prenatal, labor and delivery, and postpartum providers.

CULTURAL/RELIGIOUS, OR LANGUAGE FACTORS Demonstration that any of these factors was either a barrier to care due to lack of understanding or led to refusal of therapy due to beliefs (or belief systems).

DELAY

INADEQUATE **LAW ENFORCEMENT** RESPONSE
Law enforcement response was not in a timely manner or was not appropriate or thorough in scope.

LEGAL
Legal considerations that impacted outcome.

MENTAL HEALTH CONDITIONS
The patient carried a diagnosis of a psychiatric disorder. This includes postpartum depression.

INADEQUATE COMMUNITY **OUTREACH**/RESOURCES
Lack of coordination between healthcare system and other outside agencies/organizations in the geographic/cultural area that work with maternal health issues.

LACK OF STANDARDIZED **POLICIES/PROCEDURES**

UNSTABLE HOUSING
Woman lived "on the street," in a homeless shelter, or in transitional or temporary circumstances with family or friends.

VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)
Physical or emotional abuse perpetrated by current or former intimate partner, family member, or stranger.

OTHER
Contributing factor not otherwise mentioned. Please provide description.

Structural Racism: the systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.

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

New Contributing Factors

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services because unable to miss work or afford postpartum
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insurance non-eligibility, provider shortage in woman's
geographical area, and lack of public transportation.

ADHERENCE TO MEDICAL RECOMMENDATIONS
The provider or patient did not follow protocol or failed to
comply with standard procedures (i.e. non adherence to
prescribed medications).

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The patient experienced rape, molestation, or one or more
the following: sexual exploitation during childhood plus
persuasion, inducement, or coercion of a child to engage in
sexually explicit conduct; physical or emotional abuse or
violence other than that related to sexual abuse during
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Physical or emotional abuse perpetrated by current or former
intimate partner, family member, or stranger.

OTHER
Contributing factor not otherwise mentioned. Please provide
description.

Interpersonal Racism: discriminatory interactions between individuals resulting in differential assumptions about the abilities, motives, and intentions of others and differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization.

Adapted from Jones CP. Am J Public Health. 2000; 90(8): 1212–1215.

New Contributing Factors

CONTRIBUTING FACTOR DESCRIPTIONS

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CLINICAL SKILL/QUALITY OF CARE (PROVIDER OR FACILITY PERSPECTIVE)
Personnel were not appropriately skilled for the situation or did not exercise clinical judgment consistent with current standards of care (e.g. error in the preparation or administration of medication or unavailability of translation services).

POOR **COMMUNICATION**/LACK OF CASE COORDINATION OR MANAGEMENT/ LACK OF CONTINUITY OF CARE (SYSTEM PERSPECTIVE)
Care was fragmented (i.e. uncoordinated or not comprehensive) among or between healthcare facilities or units, (e.g. records not available between inpatient and outpatient or among units within the hospital, such as Emergency Department and Labor and Delivery).

LACK OF **CONTINUITY OF CARE** (PROVIDER OR FACILITY PERSPECTIVE)
Care providers did not have access to woman's complete records or did not communicate woman's status sufficiently. Lack of continuity can be between prenatal, labor and delivery, and postpartum providers.

CULTURAL/RELIGIOUS, OR LANGUAGE FACTORS Demonstration that any of these factors was either a barrier to care due to lack of understanding or led to refusal of therapy due to beliefs (or belief systems).

DELAY

needed to keep appointment for psychiatric referral after an ED visit for exacerbation of depression).

INADEQUATE **LAW ENFORCEMENT** RESPONSE
Law enforcement response was not in a timely manner or was not appropriate or thorough in scope.

LEGAL
Legal considerations that impacted outcome.

MENTAL HEALTH CONDITIONS
The patient carried a diagnosis of a psychiatric disorder. This includes postpartum depression.

INADEQUATE COMMUNITY **OUTREACH**/RESOURCES
Lack of coordination between healthcare system and other outside agencies/organizations in the geographic/cultural area that work with maternal health issues.

LACK OF STANDARDIZED **POLICIES/PROCEDURES**

patient's health status (e.g. long-term smoking led to underlying chronic lung disease).

UNSTABLE HOUSING
Woman lived "on the street," in a homeless shelter, or in transitional or temporary circumstances with family or friends.

VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)
Physical or emotional abuse perpetrated by current or former intimate partner, family member, or stranger.

OTHER
Contributing factor not otherwise mentioned. Please provide description.

Discrimination: treating someone more or less favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making.

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