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

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Please note: webinar is being recorded

Mount Sinai

Agenda:

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

Background

PROPUBLICA TOPICS ▾ SERIES ▾ ABOUT

LOST MOTHERS

How Hospitals Are Failing Black Mothers

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

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

Nothing Protects Black Women From Dying in Pregnancy and Childbirth

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

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

Erica Garner Andrew Burton/ Getty Images

Racism Linked to High Maternal and Infant Mortality for Native Women

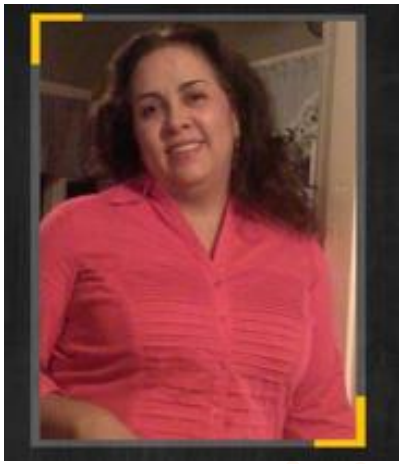
"We stopped keeping statistics on the number of Native moms and babies that are lost in our region; it was just too upsetting."

Avana Byrd | JUL 10. 2018 1:12PM EDT

MENU COLORLINES PUBLISHED BY race forward

HOT TOPICS ARTS & CULTURE CRIMINALIZATION TRUMP PRESIDENCY

Shalon MauRene Irving was a lieutenant commander org/ e uniformed ranks of the U.S. Public Health



Rosa Diaz; Courtesy of Diana Diaz

Background

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

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

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

SHARE

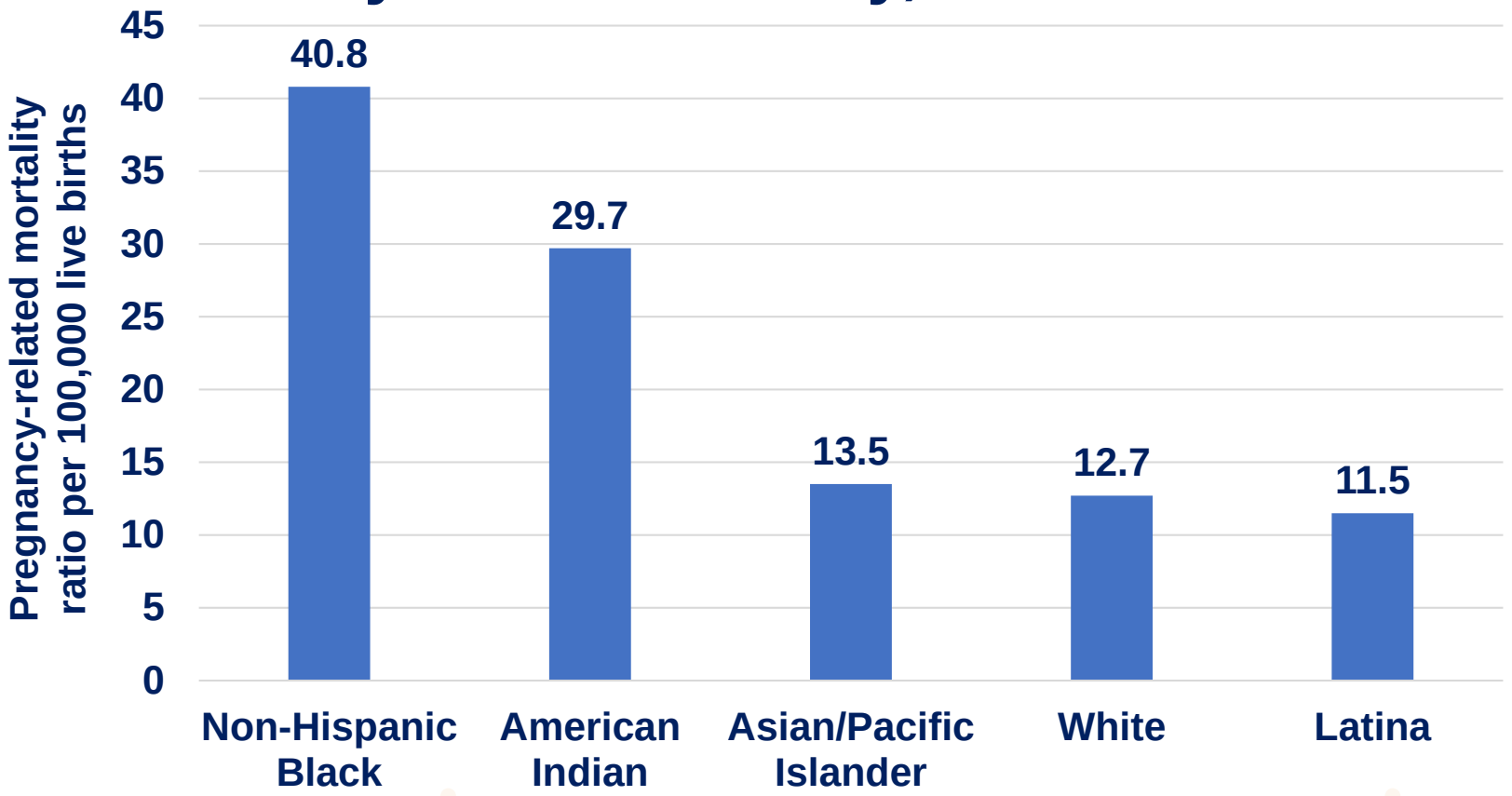
ProPublica and NPR story - Nothing Protects Black Women From Dying in Pregnancy and Childbirth

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."

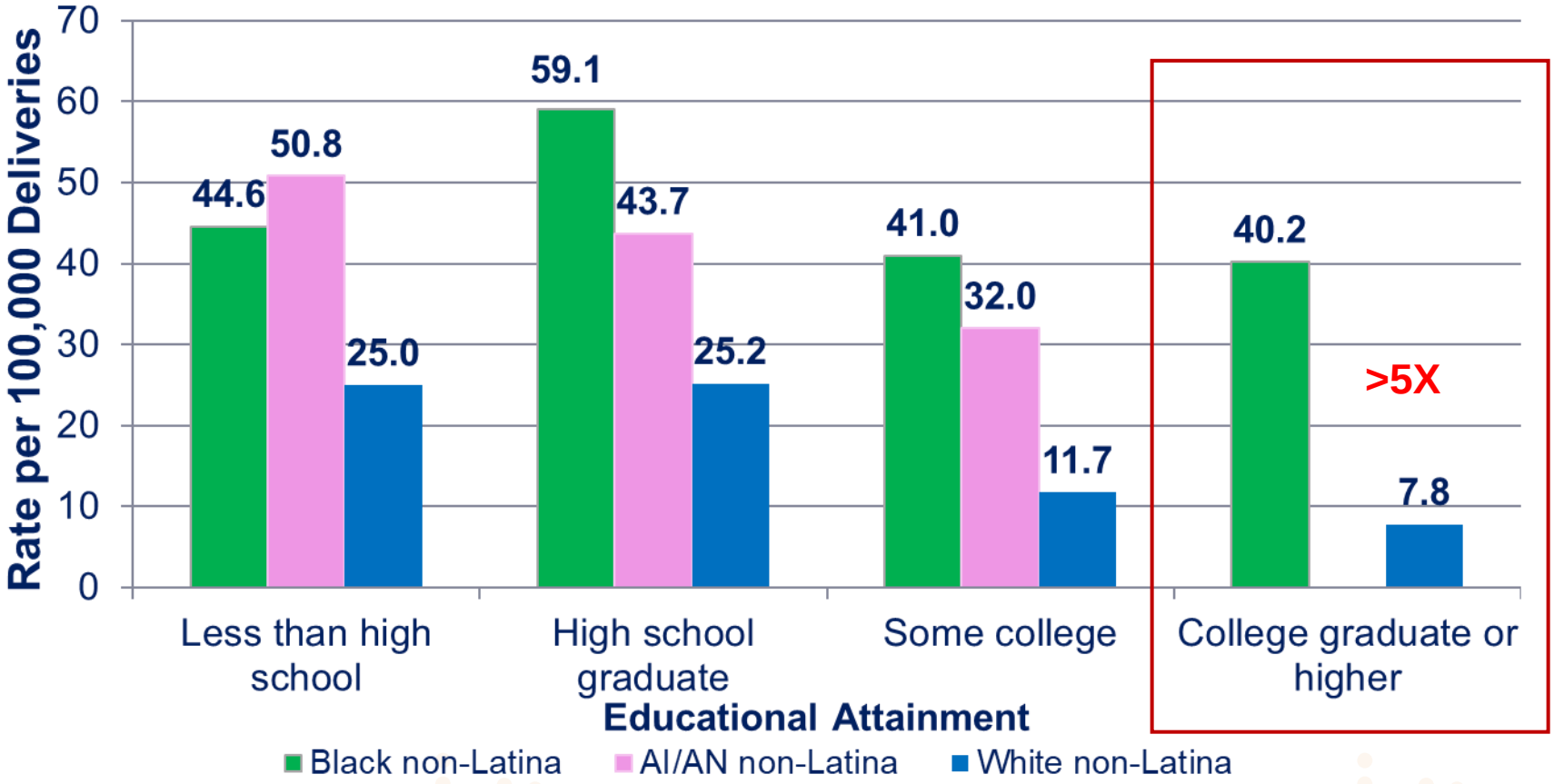
https://www.vox.com/identities/2018/1/11/16879984/serena-williams-childbirth-scare-black-women

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.

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



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Rural Disparities

EXHIBIT 2

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

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

Source: Kozhimannil KB. Health Affairs. 2019 Dec; Vol.38, No.12.

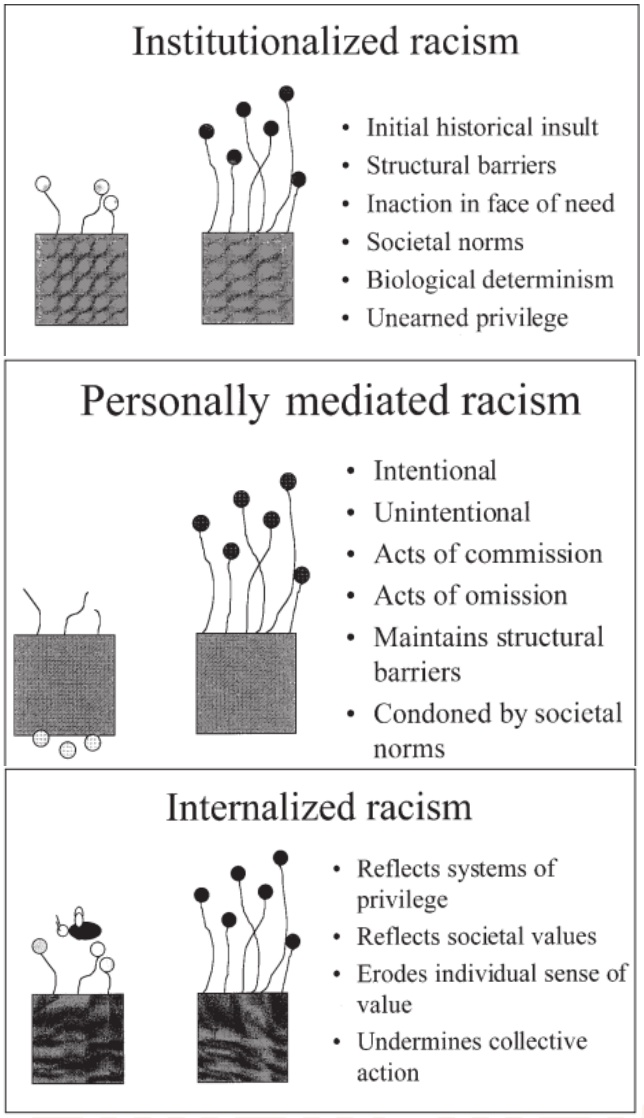
How Did We Get Here?

Framework

Levels of Racism: A Theoretic Framework and a Gardener's Tale

Camara Jones, MD, PhD, MPH

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



Jones CP. Am J Public Health. 2000; 90(8): 1212–1215.; Jones CP. Ethn Dis. 2008 Autumn;18(4):496-504.; Jones CP. Med Care. 2014 Oct;52(10 Suppl 3):S71-5.

Racism & Discrimination

Patient Factors
- Socio-demographics: age, education, poverty, insurance, marital status, employment, language, literacy, food insecurity, disability, gender, sexual orientation, body weight
- Knowledge, beliefs, health behaviors
- Psychosocial: stress, self-efficacy, social support

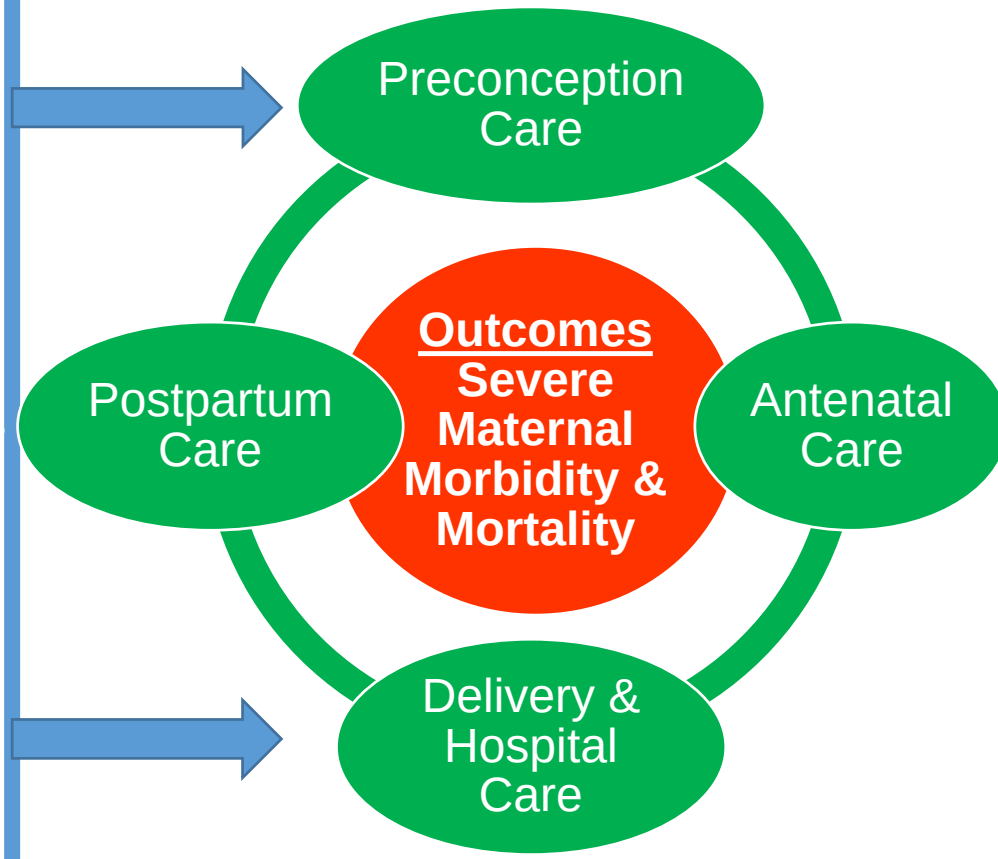
Community/ Neighborhood
- Community, social network
- Neighborhood: crime, poverty, built environment, housing, environmental exposure, interpersonal violence

Provider Factors
- Knowledge, experience, implicit bias, cultural competence, communication

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

Discrimination in Maternal Healthcare

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

Attanasio L. Med Care. 2015 Oct;53(10);863-871; Hausmann LR. Med Care. 2008;46(9):905–914. Hausmann LRM. Med Care. 2011;49(7):626–633; Weech-Maldonado R. Med Care. 2013;50(9 Supplement 2):S62–S68. Blanchard J. J Fam Pract. 2004;53(9):721–731.

Impact of Discrimination on Perinatal Outcomes

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

Grobman W. Am J Perinatol. 2016 Dec;33(14):1426-1432.; Slaughter-Acey JC. Womens Health Issues. 2013 Nov-Dec;23(6):e381-7.; Borders AE. J Perinatol. 2015 Aug;35(8):580-4.; Mendez DD. Ethn Health. 2014;19(5):479-99.

Impact of Structural Racism on Adverse Birth Outcomes

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

Mendez DD. Public Health Rep. 2011 Sep-Oct;126 Suppl 3:102-14.; Bower KM. Womens Health Issues. 2018 Nov - Dec;28(6):495-501.;Mendez DD. Ethn Health. 2014;19(5):479-99.

Charge

Identify Bias as a Contributing Factor in Maternal Death

CONTRIBUTING FACTOR KEY (DESCRIPTIONS ON PAGE 4)

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

CONTRIBUTING FACTOR DESCRIPTIONS

DELAY OR FAILURE TO SEEK CARE
The provider or patient was delayed in referring or accessing care, treatment, or follow-up care/action.

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).

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

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).

ENVIRONMENTAL FACTORS
Factors related to weather or social environment.

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

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

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

TOBACCO USE
The patient's use of tobacco directly compromised the patient's health status (e.g. long-term smoking led to underlying chronic lung disease).

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

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.

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.

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

SOCIAL SUPPORT/ISOLATION - LACK OF FAMILY/ FRIEND OR SUPPORT SYSTEM
Social support from family, partner, or friends was lacking, inadequate, and/or dysfunctional.

INADEQUATE OR UNAVAILABLE **EQUIPMENT/ TECHNOLOGY**
Equipment was missing, unavailable, or not functional, (e.g. absence of blood tubing connector).

LACK OF STANDARDIZED **POLICIES/PROCEDURES**
The facility lacked basic policies or infrastructure germane to the woman's needs (e.g. response to high blood pressure, or a lack of or outdated policy or protocol).

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.

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).

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

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

LACK OF **REFERRAL** OR CONSULTATION
Specialists were not consulted or did not provide care; referrals to specialists were not made.

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.

LEGAL
Legal considerations that impacted outcome.

OTHER
Contributing factor not otherwise mentioned. Please provide description.

- MMRC members have reported that bias and discrimination play significant roles as contributing factors leading up to maternal death
- Yet no distinct category for bias or discrimination in MMRIA

Goals

- Design a consistent approach for documenting bias as a contributing factor to pregnancy-related deaths
- Provide recommendations specific to how to prevent bias as a contributing factor to pregnancy-related deaths
- Promote MMRC member understanding of opportunities to eliminate disparities

Ultimate goal:

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

Language

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

Contributing Factors
(Page 2*)

REVIEW to ACTION

CONTRIBUTING FACTOR KEY (DESCRIPTIONS ON PAGE 4)

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- Social support/ isolation
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- Communication
- Continuity of care/ care coordination
- Clinical skill/ quality of care
- Outreach
- Law Enforcement
- Referral

Added three new contributing factors*:

- Structural Racism
- Interpersonal Racism
- Discrimination

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

New Contributing Factors (Page 4*)

CONTRIBUTING FACTOR DESCRIPTIONS

DELAY OR FAILURE TO SEEK CARE
The woman was delayed in seeking or did not access care, treatment, or follow-up care/actions (e.g. missed appointment and did not reschedule).

ADHERENCE TO MEDICAL RECOMMENDATIONS
The woman did not accept medical advice (e.g. refused treatment for religious or other reasons or left the hospital against medical advice).

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

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).

ENVIRONMENTAL FACTORS
Factors related to weather or terrain (e.g. the advent of a sudden storm leads to a motor vehicle accident).

VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)
Physical or emotional abuse other than that perpetrated by intimate partner (e.g. family member or stranger); IPV: Physical or emotional abuse perpetrated by the woman's current or former intimate partner.

MENTAL HEALTH CONDITIONS
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SUBSTANCE USE DISORDER – ALCOHOL, ILLICIT/ PRESCRIPTION DRUGS
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or friends.

SOCIAL SUPPORT/ISOLATION - LACK OF FAMILY/ FRIEND SUPPORT SYSTEM
Social support from family, partner, or friends was lacking, inadequate, and/or dysfunctional (e.g. domestic violence, no one to rely on to ensure appointments were kept).

INADEQUATE OR UNAVAILABLE **EQUIPMENT/ TECHNOLOGY**
Equipment was missing, unavailable, or not functional, (e.g. absence of blood tubing connector).

LACK OF STANDARDIZED **POLICIES/PROCEDURES**
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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.

LEGAL
Legal considerations that impacted outcome.

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

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

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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.

Social support from family, partner, or friends was lacking, inadequate, and/or dysfunctional (e.g. domestic violence, no one to rely on to ensure appointments were kept).

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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.

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

SOCIAL SUPPORT/ISOLATION - LACK OF FAMILY/ FRIEND SUPPORT SYSTEM
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Challenges:

- Difficult to identify racism from a medical record
- Lack of context for the abstractor
- Incomplete medical and non-medical/social records
- Lack of understanding and acceptance that racism is present in medical care among MMRC members

Trigger Tool: One Example*

- Example of one MMRC's approach to identifying racism as a contributing factor in pregnancy-related deaths
- Developed by Texas Maternal Mortality Review Committee to help identify racism as a contributing factor from the social worker's notes and the medical record
- Texas is currently piloting the tool and will be training abstractors and committee members to identify racism
- Does not prove racism, but increases awareness to the possibility that racism and discrimination were contributing factors to a maternal mortality

*In development by the Texas Maternal Mortality Review Committee

Trigger Tool: One Example*

Please note any of the following disparities observed in any of the materials reviewed as part of the case record.

	1	Negative patient/provider/facility interaction *(stigmatizing language, dismissing concerns, case notes suggest provider/facility conflict)*
	2	Excessive gatekeeping *(inability to reach provider, leaving messages, etc.)*
	3	Indicated labs not ordered / delayed labs ordered
	4	Leaving against medical advice
	5	Repeated ED visits in short time frame (for urgent care)
	6	Cultural incompetence *(lack of translator, awareness of other culture)*
	7	Lack of access to health care before, during, and after pregnancy *(structural bias)*
	8	Treatment decisions and recommendations inconsistent with best practices

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

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

YES	NO	UNK	
			Racial/ethnic
			Age
			Income
			Immigration status/ Citizenship
			Disability
			Other, *please specify:*
			None

YES	NO	UNK	
			Gender
			Weight
			Socioeconomic
			Language

*In development by the Texas Maternal Mortality Review Committee

Recommendations

- Developed collaboratively with your whole committee
- Align with identified issues and contributing factors

Standardized Committee Decisions Form (Page 2)

MMRIA | MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v18 | 2

COMMITTEE DETERMINATION OF PREVENTABILITY

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

WAS THIS DEATH **PREVENTABLE**? ☐ YES ☐ NO

CHANCE TO ALTER OUTCOME? ☐ GOOD CHANCE ☐ SOME CHANCE ☐ NO CHANCE ☐ UNABLE TO DETERMINE

CONTRIBUTING FACTORS AND RECOMMENDATIONS FOR ACTION (Entries may continue to grid on page 5.)

CONTRIBUTING FACTORS WORKSHEET

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

RECOMMENDATIONS OF THE COMMITTEE

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

CONTRIBUTING FACTOR LEVEL	CONTRIBUTING FACTORS (choose as many as needed below)	DESCRIPTION OF ISSUE (enter a description for EACH contributing factor listed)	COMMITTEE RECOMMENDATIONS [Who?] should [do what?] [when?] Map recommendations to contributing factors.	PREVENTION LEVEL (choose below)	IMPACT LEVEL (choose below)
PATIENT/FAMILY					
PROVIDER					
FACILITY					
SYSTEM					
COMMUNITY					

CONTRIBUTING FACTOR KEY (DESCRIPTIONS ON PAGE 4)

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

PREVENTION LEVEL

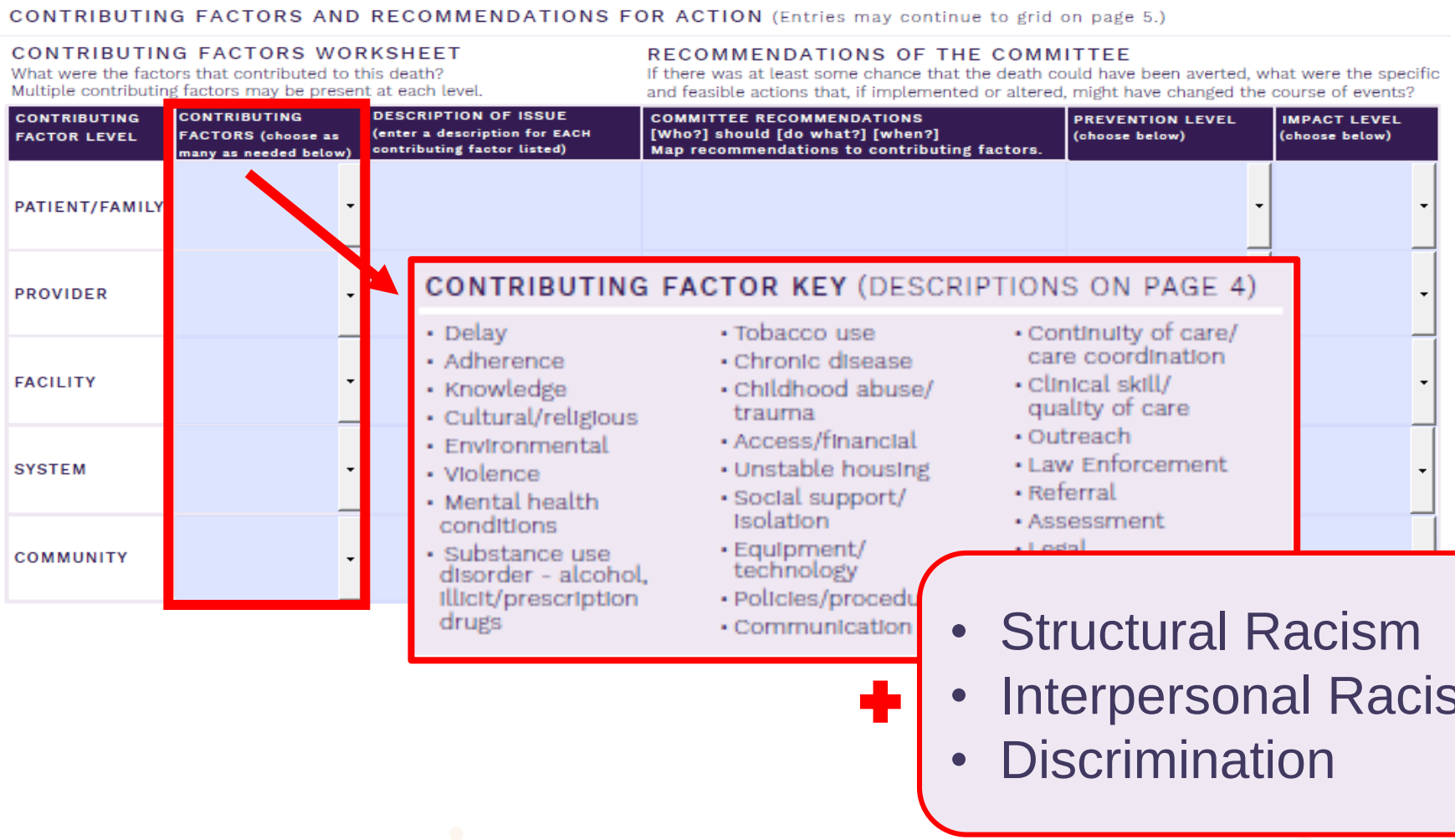
- **PRIMARY:** Prevents the contributing factor before it ever occurs
- **SECONDARY:** Reduces the impact of the contributing factor once it has occurred (i.e. treatment)
- **TERTIARY:** Reduces the impact or progression of what has become an ongoing contributing factor (i.e. management of complications)

EXPECTED IMPACT LEVEL

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

MMRIA committee decisions form (https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form)

Standardized Committee Decisions Form (Page 2)



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MMRIA | MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v18 | 2

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MMRIA committee decisions form (https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form)

Specific and Actionable Recommendations from State MMRCs

_____ should _____ _____.

(who?) (do what?) (when?)

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

WHAT is the intervention and **WHERE** is the intervention point?*

- Patient/Family
- Provider
- Facility
- System
- Community

WHEN is the proposed intervention point?

- Among women of reproductive age ("preconception")
- In pregnancy and in the postpartum period
  - Labor & Delivery (L&D)
  - Prior to L&D hospitalization discharge
  - First 6 weeks postpartum
  - 42-365 days postpartum

Achieving Health Equity Requires:

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

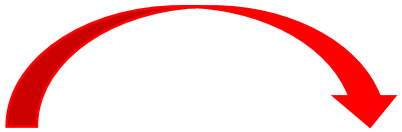
Jones CP. Med Care. 2014 Oct;52(10 Suppl 3):S71-5.

State MMRC Recommendations

Specific and Actionable Recommendations

Example 1:

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



Valuing all individuals and populations equally

Health Equity

State MMRC Recommendations

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State MMRC Recommendations

Specific and Actionable Recommendations

Example 2:

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

Recognizing and rectifying historical injustices

Health Equity

State MMRC Recommendations

Specific and Actionable Recommendations

Example 2:

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State MMRC Recommendations

Specific and Actionable Recommendations

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Specific and Actionable Recommendations

Example 3:

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

Providing resources according to need

Health Equity

State MMRC Recommendations

Specific and Actionable Recommendations

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PATIENT/FAMILY			OB clinicians should screen patients for social determinants of health (SDOH) at prenatal and L&D visits, including late entry into healthcare system, and work with social workers to address specific needs and care coordination relevant to the SDOH.	Providing resources according to need
PROVIDER	Interpersonal Racism; Discrimination	Communication failures, stereotyping by providers, concerns not addressed, ignored and improperly treated symptoms, lack of appropriate referral or consultation	Hospitals should mandate comprehensive communication training addressing implicit bias, explicit bias, racism, and shared-decision making training for all healthcare professionals on a continuous basis.	Valuing all individuals and populations equally
FACILITY	Structural Racism; Discrimination	Stereotyping by providers, racist policies and practices, failure to mandate anti-racism training, lack of quality care for racial minorities	State governments should expand access to Medicaid to include coverage for specialists for high-risk patients during prenatal, delivery, and postpartum care.	Providing resources according to need
SYSTEM	Structural Racism; Discrimination	Lack of resources, inadequate staffing in hospitals serving minority communities, lack of providers accepting patients insured by Medicaid	State MMRCs should include community members to ensure the patient perspective and lived experience is incorporated into the entire process.	Valuing all individuals and populations equally
COMMUNITY	Structural Racism	Disconnect between community and hospital leaders and clinicians, lack of patient and community engagement		

Members of the CDC-MMRIA Discrimination Working Group

- **Elizabeth Howell, MD, MPP**
- Breannon Babbel, PhD, MPH – Senior Public Health Program manager, National Indian Health Board
- Allison Bryant Mantha, MD, MPH – Vice Chair of Quality, Equity and Safety at Massachusetts General Hospital
- Andria Cornell, MPH – Associate Director of Women's & Infant Health at AMCHP
- Joia Crear Perry, MD, FACOG – President of the National Birth Equity Collaborative
- Rachel Hardeman, PhD, MPH – Assistant Professor of Health Policy & Management, Univ of Minn.
- Cornelia Graves, MD – Medical Director at Tennessee Maternal Fetal Medicine

- William Grobman, MD, MBA – Professor of OB/GYN, Northwestern (Maternal Fetal Medicine)
- Sascha James-Conterelli, DNP, CNM, FACNM – President of the NYS Association of Licensed Midwives
- Camara Jones, MD, MPH, PhD – Assoc. Professor of Community Health & Preventive Medicine, Morehouse
- Breana Lipscomb, MPH – US Maternal Health Campaign Manager, Center for Reproductive Rights
- Carla Ortique, MD – Chair of the Committee on Maternal & Perinatal Health, Texas Medical Association
- Alison Stuebe, MD, MSc – Associate Professor of Maternal and Child Health and OB/GYN, UNC
- Kaprice Welsh, CNM, MSN, MPH – Chair of the Georgia Perinatal Quality Collaborative Health Equity Committee

Questions and Comments

THANK YOU

MMRIA
MATERNAL MORTALITY REVIEW
INFORMATION APP

REVIEW to ACTION
WORKING TOGETHER TO PREVENT
MATERNAL MORTALITY

For questions contact
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Anna.Kheyfets@mountsinai.org

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