BLACK MATERNAL HEALTH STAKEHOLDER GROUP MEETING #1

March 19, 2021

PROJECT BACKGROUND

The United States is in the midst of a maternal health crisis, with Black women being three- to four-times more likely to die from pregnancy-related complications within a year of childbirth than their white counterparts. In response to this crisis, the March of Dimes and the U.S. Department of Health and Human Services (HHS), with funding from United Healthcare Community & State, created a public-private partnership to address the Black-white gap in severe maternal morbidity (SMM) rates.

This HHS-March of Dimes Public-Private Partnership pilot will focus on sustained quality improvement in the hospital setting and will build on a shared vision that every Black woman will have a safe and respectful birth experience with access to high-quality care before, during and after pregnancy. The ultimate goals of the project are to close the Black-white disparity gap in Nulliparous, Term, Singleton, Vertex (NTSV), or low-risk cesarean birth rates, and SMM.

Essential to this work is the stewardship of leaders in Black maternal health. March of Dimes, National Birth Equity Collaborative (NBEC), and HHS convened individual expert consultants to obtain their input on specific steps to reduce disparities in maternal health outcomes. Invited participants shared their perspectives through a pre-meeting survey, and through robust facilitated conversations.

MEETING STRUCTURE

In preparation for the meeting, participants were asked to complete a survey to gauge what each person believed to be the most important course of action that hospital staff can take to reduce the Black-white disparity gap in maternal morbidity (Figure 1). Responses to the survey were used to populate a driver diagram (Figure 2) that outlined project aims, and the primary and secondary drivers contributing to the Black-white disparity in NTSV cesarean birth rates and SMM.

During the meeting, participants received detailed information on the history of the HHS-March of Dimes Public-Private Partnership from the partnership's clinical leads. Following the plenary session, the participants were divided into three breakout rooms to discuss the driver diagram. In breakout groups, the participants were first asked to review and revise the driver diagram, then share if they agreed or disagreed with what were listed as primary and secondary drivers. Next, participants were asked to imagine that two years had passed and the project had successfully achieved its aims, and to consider which specific steps had made the effort so successful.

Responses from the pre-meeting survey were used to populate the driver diagram as primary and secondary drivers. Change ideas from the pre-meeting survey included continuous and required education in hospitals, medical schools, and nursing schools focused on dismantling racism and ensuring high-quality equitable care; patient-education that facilitates truly informed consent and shared-decision making based on a life

course perspective, approaching the work from a racial justice and human rights perspective, specialized levels of care to ensure risk-appropriate care; and acknowledging the critical role of structural racism in the inequities that prevail and leading with this acknowledgement in the QI activities and other care-delivery efforts designed to improve maternal health.

KEY THEMES

Racism

Racism, not race, was listed as the root cause of all Black maternal care issues and outcomes, determining the rest of the primary drivers. Participants suggested listing racism explicitly as a pre-driver or in the aim statement(s) rather than as a primary driver. They noted that racism exists in every facet of the traditional healthcare system – individually, institutionally, and structurally – so it is not realistic to expect to solve it in two years, but a plan can be put in place so that work can begin and progress can be made.

Participants mentioned that training and education should specifically call out racism against Black birthing people. This “anti-Black-racism” training should be comprehensive, culturally relevant, and developed by people of color. Anti-Black-racism education must be ongoing and not just a one- or two-hour course. Per participant feedback, this training should be embedded within educational curricula, and be a core part of the accreditation process and criteria for hospitals and institutions.

Currently, there is no gold standard for measurement of racism and equitable care in the clinical setting, so participants suggested that new national standards and metrics centered on the patient experience be developed. Ideally, all healthcare facilities should have access to the same resources and information necessary to provide high quality, respectful, equitable care, and those that fall short of these standards should be required to develop and implement corrective action plans. In a similar vein, participants suggested a designation or certification program that would publicly recognize institutions who meet strict equitable care quality standards.

While participants were generally in agreement that racism should be listed as a primary driver and labeled as a contributing factor to poor outcomes, many expressed that intersectional racism should also be examined. Birthing peoples’ age and identity should be taken into consideration, along with the agency or lack of agency that they have during the birthing experience.

Accountability

The concept of accountability, including taking responsibility for and being held liable for words and/or actions, was an important component of every discussion, and participants thought it should be listed as a primary driver. Participants talked about accountability in many forms, from individual to institutional levels.

Several participants shared that institutions and providers should be held accountable by third-party entities without ties to the hospitals or providers they are monitoring. This third-party involvement is important for impartial observations and accountability that is not subject to bias or power dynamics from hospital-employed entities. Such a body could be a community accountability board made up of Black birth justice workers or care providers, community-based organizations (CBOs), or other unbiased, neutral community members. Participants discussed the merits of placing unbiased, independent birth observers to monitor who would observe births, similar to election poll watchers.

Financial accountability could come from incentives or sanctions. Poor performers – either at the facility or provider level – should not be paid for poor outcomes, though "poor outcomes" was not well-defined and could unintentional consequences for higher acuity facilities. Payers could also hold institutions and providers accountable through payments linked to quality metrics.

The discussion of financial accountability also included the consideration of incentives, rather than introducing new punitive measures to increase provider concerns of punishment. Participants agreed that providers should not be paid for poor outcomes, but considered the idea of paying for positive outcomes more than punishing for poor ones.

When discussing accountability, participants also noted that providers should not only be accountable to hospitals and institutions, but also to birthing people. Transparency of data and actions could hold institutions and providers accountable by publicizing information so that birthing people can make informed decisions about where and from whom they receive their care. The presence of an accessible Patient Bill of Rights could help to empower patients, and that hospitals should bear the responsibility of holding conversations with patients on birthing options.

Data Transparency

Data is an essential component of any quality improvement initiative, and was included in the original driver diagram as a primary driver for this project. However, discussions with meeting participants uncovered a more specific recommendation of transparency in data. Participants felt that quality data, such as those provided by CMS, the Joint Commission, Leapfrog Group, that are accessible to consumers could help drive actionable changes in outcomes.

Across all breakout rooms, meeting participants were in agreement that data should not only be available for providers, but for the public as a means to allow birthing people to make informed decisions on where to seek care, and to promote accountability for outcomes. The mechanism recommended was a public platform for outcomes data, sanctioned and supported by HHS or others.

One participating clinician discussed the effectiveness of the 2016 Consumer Reports social media campaign featuring a photo of a person holding a sign with a hospital's NTSV cesarean birth rate in front of the hospital in driving action within the hospital to address high cesarean birth utilization rates. The behavior that was changed was not the consumer's per this participant, but rather that of hospital administrators and providers after the media got involved.

Beyond making data publicly available, participants also stated the need for quality data that enables analysis and insight into what is happening during hospital experiences that contributes to poor outcomes. Quality data that leads to actionable items needs to be stratified by race and ethnicity, and participants also shared that data should be disaggregated by race and gender identity to provide a better understanding of how intersections appear in the birthing experience.

Participants also reflected on the importance of collecting data that captures the patient experience. Existing data collection tools don't capture the patient encounters during labor and delivery, but there are many stories from mothers who had poor experiences with providers and poor health outcomes from their birthing experiences. The use of patient satisfaction surveys and other means of collecting experiences alongside birth outcomes would support hospital understanding of exactly how racism and other factors play a role in those outcomes.

The discussion around data also led to the idea that there is a need for new measures of capturing and measuring racism. As the maternal health crisis unfolds and awareness of racism as a driver rises, there are different means for measuring or demonstrating its effects across different settings. Establishing a standard for how racism is measured will help guide future discussions and interventions.

Financial Incentives

Participants raised the importance of aligning financial incentives with desired outcomes, citing the success in states that instituted a non-reimbursement policy for early elective cesarean births. Discussion centered around understanding whether the misalignment in financial outcomes is a function of risk mitigation and fear of litigation, or because they would be paid more. Some clinicians offered the perceived fear of litigation as the predominant driver.

As part of the discussion, participants also raised payment reconfiguration and how to better reimburse for value over volume. One solution discussed was finding a way for Medicaid and commercial insurers to institute a non-payment policy if specific maternal health quality outcomes are not achieved.

Team-Based Approach

Midwives were frequently discussed as an invaluable asset for improving maternal health outcomes, and it was noted that some of the areas with the highest maternal mortality rates also have some of the lowest midwifery rates. Participants expressed a desire for truly effective peer teamwork across care teams, with physicians, midwives, doulas, nurses, and patients working as a team as the standardized model of care.

Noting that the midwifery model of care centers on relationships, many participants felt that patients desire a partner who can be present to support them throughout the entire process. Participants noted that patients are currently being passed along from one provider to another with no one serving as a consistent touch-point, and this model is failing birthing families.

Within their groups, participants also identified a difference in mindsets between midwives and physicians when it comes to labor support. Midwives are inclined to let a birth proceed naturally, while physicians are trained to be prepared for a problem, leading to medical intervention that is not absolutely necessary. Participants all agreed that midwives should be a fully autonomous partners in the birthing process, with midwives and physicians working side-by-side on the labor floor.

Another component vital to care teams are doulas, and participants agreed that they should be included in the team-based approach to care. During the COVID-19 outbreak, doulas have been restricted from supporting hospital births, but they should be considered essential.

After reviewing the driver diagram, participants felt that the community piece was missing, and several participants highlighted the value of community-based organizations and community health workers, who they feel are instrumental in preparing patients to play a role in a shared decision-making process during labor. Many participants noted that if there are no interventions or support offered before a mother reaches the hospital, it may already be too late to prevent poor outcomes. Additionally, participants highlighted the importance of building relationships between community birth centers and hospitals.

Person-Centered Care

The importance of patient-centered care was noted as a missing primary driver, as currently the birthing person is typically centered. Participants felt that the drafted diagram omitted how patients may feel about what is happening to them. There are many factors that influence patient wellbeing, including mental health, police violence, housing or food insecurity, economic injustice, and wage gaps.

Participants recommended that health literacy be taken into consideration in addressing care, and giving patients the knowledge and confidence to navigate the system rather than being victims of what happens to them. Additionally, the value of having a perinatal navigator or ambassador to support patient care

throughout the entire perinatal period was noted by multiple participants, provided that navigators are employed by a third party and can operate with their patients' wellbeing as their primary concern without complicating relational dynamics.

While centering patients and working collaboratively, it was also recognized that different cultural experiences will factor into interactions, but that respect and understanding are essential. Participants stressed the importance of recognizing differences between the current standard of care and patient-centered, preference-sensitive care.

Along with cultural differences and perspectives, patients will have varying pre-gestational experiences, pre-existing conditions, and social determinants of health that are not always taken into consideration. Knowledge and understanding of these factors are important so that these can be taken into consideration by hospital staff and providers when making medical decisions.

Leadership

Participants lifted up perinatal leadership as a missing primary driver. Beyond the discussion of the importance of individual champions within the hospital was a collective call for diversification of the workforce, retention and promotion of people of color, and inclusion on hospital and health system boards of directors.

Systems Issues

Many participants challenged the idea that project aims could be achieved in the traditional hospital setting without collaboration and integration of community-based organizations (CBOs) and providers. The question of a hospital quality improvement focus instead of one on integrated models of care that include birth centers and access to midwives and doulas was raised.

Much discussion centered on how to build an ideal system that is intentionally equitable, including medical and midwifery education that is collaborative and integrative. A system that is safe for Black birthing people, per many participants, would be one that allows for 1) choice of providers and birth setting outside of the existing system, and 2) equitable reimbursement of all antenatal and perinatal providers, and birth settings.

PROPOSED IN-SCOPE SOLUTIONS

Participants shared a broad range of perspectives and gave multiple strategies to address the maternal health crisis in the United States. The HHS-March of Dimes Public-Private Partnership's quality improvement pilot will focus specifically on reducing disparities and improving care during the birth hospitalization, and is currently slated to take place over a two-year period. Therefore, and some of the solutions, while viable options for improving birth outcomes, are not feasible to implement during this pilot initiative.

Many solutions that focus on community and out-of-hospital interventions were raised during the meeting, and although community solutions are not directly addressed in a hospital-based initiative, the transition from birth hospitalization to the community should be considered. Additionally, there will likely be ample opportunities to address behaviors driven by systemic and structural racism that contribute directly to poor clinical outcomes.

When asked to envision the project as successful, participants did note that it was unrealistic to expect the project to achieve major changes in two years, and even that it could be traumatizing to enter into this work with that unrealistic expectation. Partners recognize that the need for interventions to improve outcomes will expand beyond two years, and that there would be potential to broaden project scope. During the project's two-year duration, participants noted the opportunity to build a solid foundation for achieving its aims at scale over time.

1. Change relationship dynamics

At the core of recommendations made by many participants on improving outcomes for Black birthing people during the birth hospitalization was a call for a **shift in relational dynamics and communication**. The previously mentioned themes of normalizing person-centered care and implementing a team-based approach are aligned with the concept of respectful maternity care, which looks beyond physical safety and the prevention of morbidity or mortality to "encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care."

Participants noted that the lack of a consistent touch-point during the perinatal period and insufficient **continuity of care** resulted in poor outcomes and unnecessary stress for birthing people. One physician shared that she gives her cell number to patients largely to allay their fears of having to deal with a stranger during a vulnerable time, but acknowledged that this was not a scalable solution to the problem.

Part and parcel of the call for a respectful patient-provider relationship is a strong recommendation that **interpersonal and inter-professional respect** for all members of the birthing person's team, including

partners, doulas, perinatal support workers, nurses, midwives and physicians, would lend itself to non-dismissive, receptive communication during hand-offs, readmission and shift changes.

Fundamental to ensuring that respectful care and improved communication are applied specifically to Black birthing people would require **training and education on anti-Black-racism.** Participants recommended that the training be comprehensive, culturally-relevant, and developed by people of color, then embedded throughout educational curricula and included in hospital accreditation processes.

Participants translated the change concept of **data transparency** into several different change ideas. Several ideas were discussed that can be incorporated into a quality improvement project focused on changing clinician behaviors, as opposed to interventions that place the onus on pregnant people to educate themselves or choose a different hospital.

A patient satisfaction survey to collect experiences alongside birth outcomes could be designed to **inform providers and administrators on their patients' perceptions of racism and discrimination**. A standardized mechanism to interpret and share this information with providers to drive change would need to be developed and implemented. Providing guidelines and support for establishing and engaging with a **community-based accountability board** at each hospital is one actionable mechanism for incorporating accountability.

2. Apply external levers

There are several recommendations from participants that the public-private partnership can consider as high-impact efforts to complement the quality improvement pilot.

The change ideas proposed to motivate providers and hospital leadership— rather than patients— to modify behavior included publicizing outcomes data, incentivizing value-based care, setting outcomes-based benchmarks for reimbursement, and public recognition of meeting standards, such as a hospital designation or banner program.

3. Generate accurate hospital-derived data on race and ethnicity

Accurate availability and stratification of outcomes data by race and ethnicity to provide near real-time feedback to clinicians and administrators on disparities was recommended by participants. A mechanism would need to be implemented to share and interpret these data internally at each facility, then utilize targeted data to benchmark and measure progress.

PARTICIPANTS

Valon Alford, MSW, LCSW, LICSW, PMH-C

Linda Goler Blount, MPH

Carolyn Brooks, ScD, MA

Allison Bryant, MD, MPH

Charlene Collier, MD, MPH, MHS, FACOG

Joia Crear Perry, MD, FACOG

Christina Davidson, MD

Ana Delgado, CNM

Lakeisha M. Dennis, MTS, MSN, RN, LCCE, CLC

Jamille Fields Allsbrook, JD, MPH

Veronica Gillispie-Bell, MD, MAS, FACOG

Millicent Gorham, PhD (Hon), MBA, FAAN

Rachel R. Hardeman, PhD, MPH

Zsakeba Henderson, MD, FACOG

Rose L. Horton, MSM, RNC-OB, NEA-BC

Elizabeth Howell, MD

Wanda Irving, MPA

Jennifer Jacoby, JD

Jennie Joseph, LM, CPM

Tonya Lewis Lee

Rolanda Lister, MD

Ebony Marcelle, CNM, MS, FACNM

Kay Matthews, LCHW

Monica McLemore, RN, PhD, FAAN

Catherine Oakar (White House Domestic Policy Council)

Julia Chinyere Operah, PhD

Chanel L. Porchia Albert CD, CPD, CLC, CHHC

Jessica Roach, MPH

Carol Sakala, PhD, MSPH

Carissa Smith (White House Office of Public Engagement)

Stacey D. Stewart, MBA

Jamila K. Taylor, PhD

Shannon Welch, MPH

Tiffany Wiggins, MD, MPH, FACOG

Dorian Wingard, MPA

Akilah Witherspoon, CLC, CPFSW, CD

Special thanks to the team at the National Birth Equity Collaborative for their thought leadership, organizational skills and unwavering collaborative spirit in the fight for justice and safety.

Denys Symonette Mitchell, MSW (Project Lead at NBEC)

Dawn Godbolt, PhD (Moderator)

Susan Perez, PhD (Moderator)

Joia Crear Perry, MD, FACOG

APPENDIX

Figure 1: Pre-Meeting Survey

BMH Stakeholder Group Pre-Meeting Survey

1. Have you participated in a quality improvement project in a clinical setting? Y/N

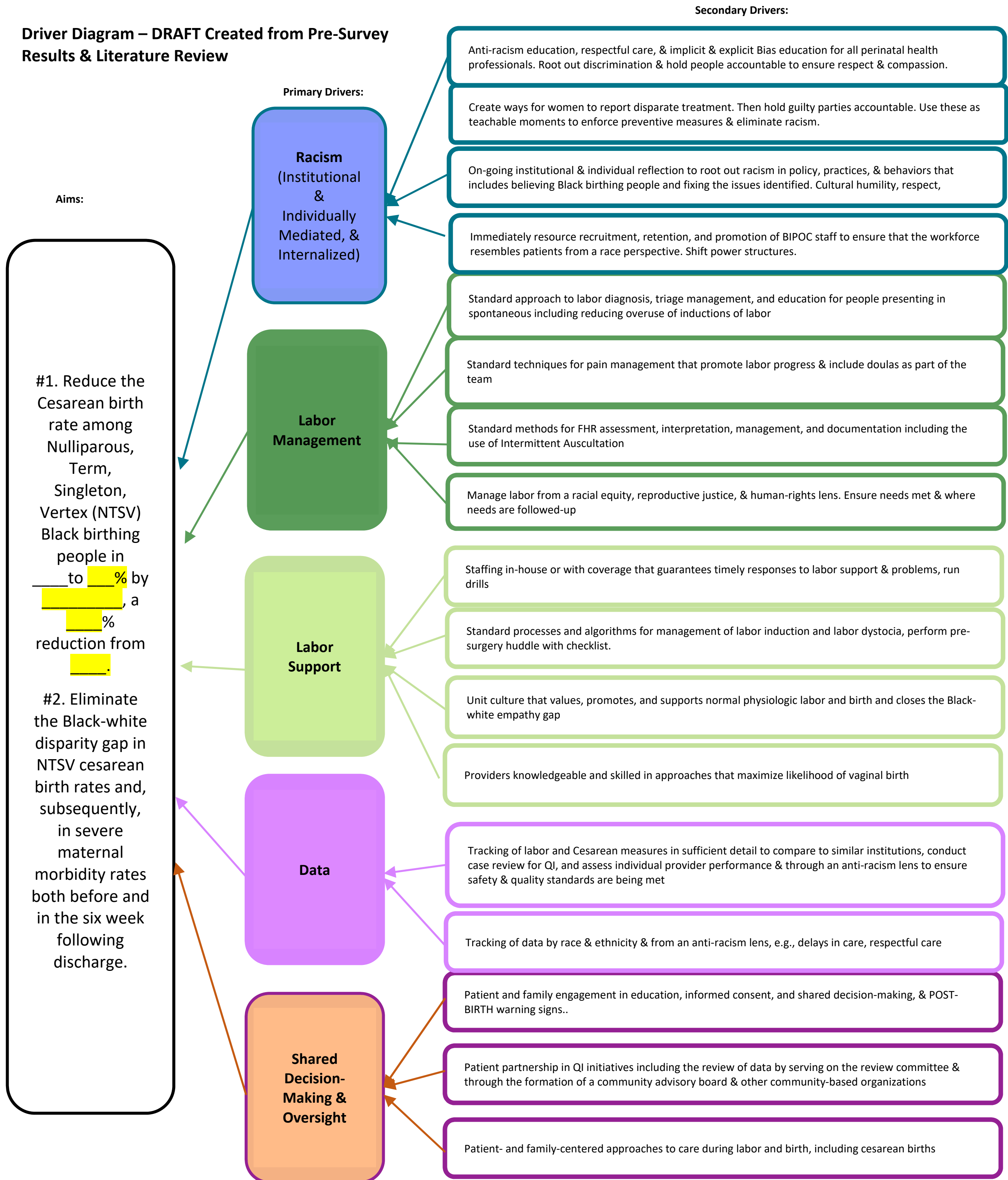
2.Which of the following best describes your role at the upcoming stakeholder meeting? (Select up to two)

Patient/Consumer
Doula
Community Health Worker
Physician
Midwife
Nurse
QI Professional
Researcher
Policy Analyst
Advocate

3.In your opinion, what is the most important course of action that hospital staff can take to reduce the Black-white disparity gap in maternal morbidity?

4.From your perspective, what is the greatest opportunity to achieving racial equity in maternal health? Via the hospital setting? Beyond?

Figure 2: Driver diagram pre-populated with survey responses



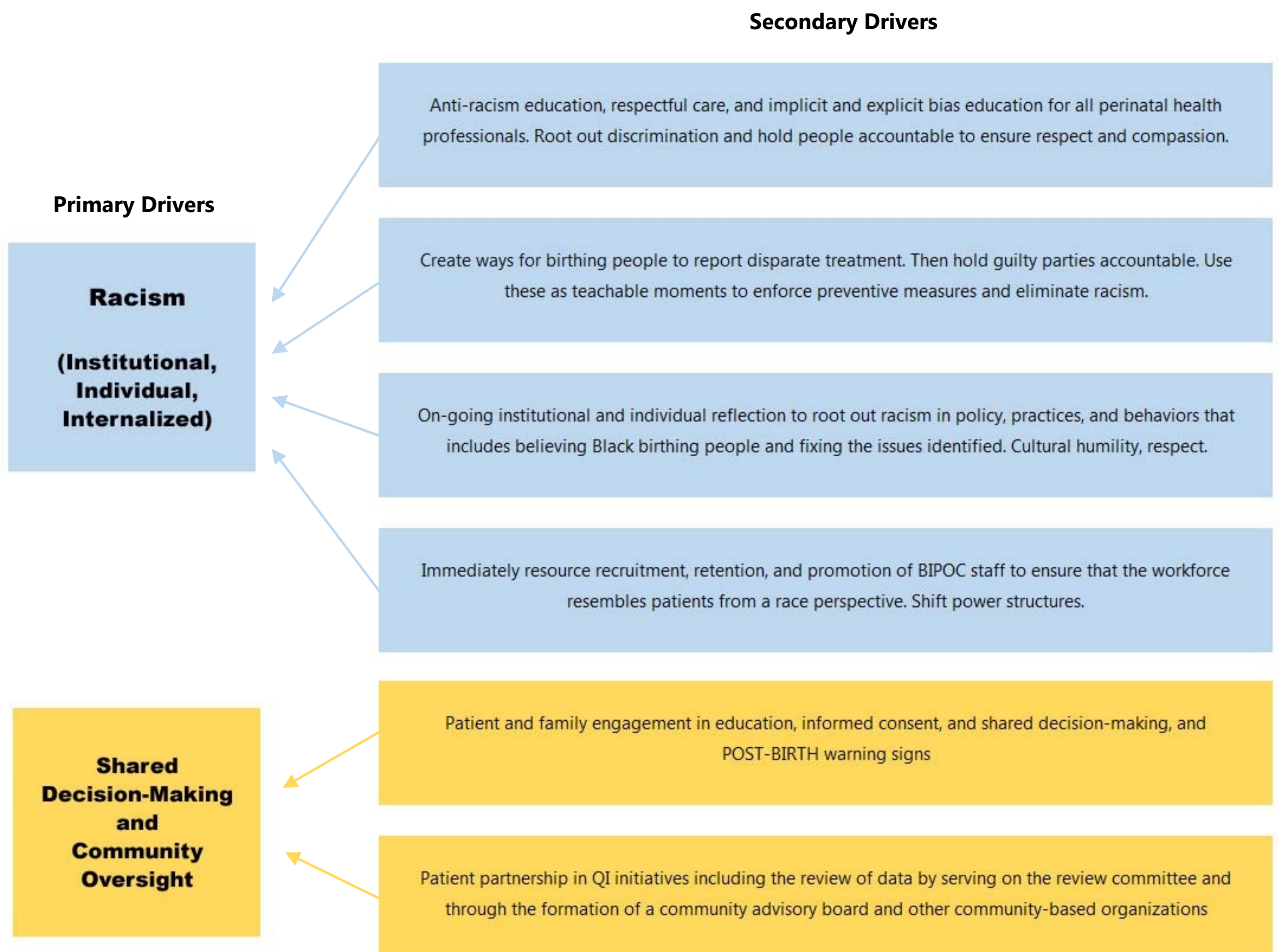
Driver Diagram v.2*

PROJECT AIMS

#1. Reduce the Cesarean birth rate among Nulliparous, Term, Singleton, Vertex (NTSV) Black birthing people by 2023. [Specific aims to be determined once hospital cohort selected]

#2. Eliminate the Black-white disparity gap in NTSV cesarean birth rates and, subsequently, in severe maternal morbidity rates both before and in the six week following discharge.

#3. Implement anti-racist structures and processes at each participating hospital.



*Created from pre-meeting survey results, literature review and meeting discussions

Secondary Drivers (cont.)

Primary Drivers (cont.)

Data for Accountability, Action and Financial Alignment

- Tracking of labor and cesarean measures in sufficient detail to compare to similar institutions, conduct case review for QI, and assess individual provider performance and through an anti-racism lens to ensure safety and quality standards are being met
- Tracking of data by race and ethnicity and from an anti-racism lens, e.g., delays in care, respectful care. Ensure payments and financial incentives match outcomes.

Leadership and Systems Issues

- Unit culture that values, promotes, and supports normal physiologic labor and birth and closes the Black-white empathy gap and expands the use of midwifery model of care, midwives, and doulas
- Formation of an anti-racism workgroup that develops and implements a hospital anti-racism statement and conducts a racial equity organizational assessment, implements anti-racist structures and process, and reviews all cesarean births and SMM by race/ethnicity

Labor Management + Labor Support using a Team-Based Approach

- Standard approach to labor diagnosis, triage management, and education for people presenting in spontaneous labor including reducing overuse of inductions of labor
- Person-centered care. Team Based approach to care. Standard techniques for pain management that promote labor progress and include doulas as part of the team
- Standard methods for FHR assessment, interpretation, management, and documentation including the use of intermittent auscultation (IA)
- Manage labor from a racial equity, reproductive justice, and human-rights lens. Ensure needs met and where needs are followed-up, run debriefs
- Staffing in-house or with coverage that guarantees timely responses to labor support and problems, run drills