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Addressing the National Crisis Facing Black and Latina Women, Birthing People, and Infants: The Maternal and Infant Health Equity Summit

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Abstract

To address the national crisis of maternal and infant health disparities, especially outcomes experienced by Black and Latina women and birthing people, The New York Academy of Medicine, the Icahn School of Medicine at Mount Sinai, the Blavatnik Family Women's Health Research Institute, and the University of Pennsylvania Health System and Perelman School of Medicine hosted the Maternal and Child Health Equity Virtual Summit. The primary purpose of the summit was to disseminate findings to a national audience on two NIH-funded mixed methods studies that investigated the contribution of hospital quality to disparities in maternal and infant Health in New York City (R01MD007651 and R01HD078565). In addition, the summit showcased factors in maternal and infant health inequity from leading diverse experts in both fields, identified outstanding challenges to reducing maternal and infant morbidity and mortality disparities, and strategies to address them. Summit presenters and participants identified five primary areas of focus in proposed clinical actions and approaches for maternal and neonatal healthcare based on discussions during the summit: (1) quality and standardization of care; (2) adjustment of care strategy based on patient-reported experience; (3) healthcare professional and institutional accountability to patients; (4) commitment to building trust; and (5) antiracism practices in education, training, and hiring. Recommendations from this conference should inform hospital care and public policy changes and frame a national agenda to address perinatal health disparities for Black, Indigenous, and other women and birthing people of color (BIPOC).

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A list of Summit presenters is available in Appendix 1 online at http://links.lww.com/xxx.

This article describes a national summit addressing Black maternal and infant morbidity and mortality. The five-hour national summit was held virtually on January 12, 2021 and had over 450 attendees.

Precis:

The Maternal and Infant Health Equity Summit framed the national crisis of maternal and infant health disparities and produced recommendations to inform hospital and policy changes.

Introduction

It is well established that there are significant and entrenched racial and ethnic disparities within pregnancy care for mothers and their infants. Over the past 60 years, the risk of maternal mortality among Black women has consistently remained 3–4 times higher than the equivalent risk for White women[1]. Currently, it remains the largest disparity among all conventional population perinatal health measures, regardless of geographic location[2]. Black infants are more than twice as likely to die as White infants in the first year of life[3]. Despite growing attention and funding to these intractable disparities, there has been no evidence that perinatal-related disparities have decreased. Thus, there is a dire need to integrate knowledge and perspectives from research experts, community-based organizations and public health, education and policy sectors to address this crisis.

On January 12, 2021, the New York Academy of Medicine, the Icahn School of Medicine at Mount Sinai, the Blavatnik Family Women's Health Research Institute, and Perelman School of Medicine held the Maternal and Child Health Equity Virtual Summit. Produced with funding from the National Institutes of Health, the Summit convened stakeholders from across the country. The purpose of the Maternal and Child Health Equity Virtual Summit was to (1) disseminate research findings on hospital quality and its contribution to racial/ethnic disparities in severe maternal morbidity and mortality and very preterm birth morbidity and mortality in NYC, (2) to learn from diverse leaders in the fields of maternal and infant health on the implications of this and other recent research, and (3) summarize recommendations on the modifiable factors that hospitals can implement to improve maternal and child outcomes for birthing individuals nationwide. Presenters at the summit represented a diverse array of leaders in the field of maternal and infant health, including program directors and chairs in obstetrics, gynecology, neonatology, pediatrics, nursing, doula care, research scientists in epidemiology and public health, and community-based organization leaders. One thousand and thirty-seven individuals registered for the summit, with ultimately over 450 attendees on the day of the event.

The five-hour long summit focused on three major themes: Maternal Health, Infant Health, and the Mom-Baby Dyad. Each section included a featured speaker followed by a panel of diverse participants led by an expert moderator. After the first and second panels, summit attendees proposed recommendations for reducing maternal mortality, severe maternal morbidity and infant mortality and morbidity. It is the intent of this article to disseminate the key findings and recommendations from the conference to a broader audience and stimulate action to implement change to address the current maternal and infant health disparity crisis.

The summit was opened with a statement that acknowledged that the discussion had implications for Black, Indigenous, and other birthing people of color (BIPOC) and that both terms – *women* and *birthing people* – would be used. In addition, while the majority of

research presented was on Black and Latina women and infants, findings from this summit may have implications for all BIPOC birthing people.

PROPOSED CLINICAL ACTIONS AND APPROACHES IN MATERNAL AND NEONATAL HEALTHCARE

The Summit presenters identified five primary areas of focus:

1. Quality and standardization of care
2. Adjustment of care strategy based on patient-reported experience
3. Healthcare professional and institutional accountability to patients
4. Commitment to building trust
5. Antiracism practices in education, training, and hiring

Area 1: Quality and standardization of care

Research findings were disseminated from two NIH-funded mixed methods studies which investigated the contribution of hospital quality to racial and ethnic disparities in maternal and very preterm infant severe morbidity and mortality. Using mixed-effective logistic regression to calculate risk-standardized severe rates, hospitals in NYC were ranked based on their performance in severe maternal morbidity and very preterm birth morbidity and mortality.[1,4,5] There was wide variation in hospital performance and researchers estimated that hospital of delivery explained up to 48% of the Black-White disparity and 37% of the Latinx-White disparity in severe maternal morbidity and up to 40% of the Black-White disparity and 30% of the Latinx-White disparity in very preterm birth morbidity-mortality.[1,4, 5] Within-hospital disparities also existed, as Black and Latina women compared with White women had significantly higher risk for severe maternal morbidity in the same hospital even after accounting for insurance type and comorbidities ($p<.001$).[6]

Hospitals were then divided into tertiles based on their risk-standardized rates and qualitative interviews were conducted in high-performing hospitals (low morbidity tertile) and low-performing hospitals (high morbidity tertile) for severe maternal morbidity and very preterm birth morbidity and mortality.[7] Overall themes distinguishing high versus low performing hospitals included stronger nurse physician communication/teamwork, sharing of performance data with nurses and other front line clinicians, more focus on supervision, senior leadership was more involved in day-to-day quality activities, and more awareness that disparities and racism may be present in hospital and could lead to differential treatment. [7] In addition, in high-performing maternal morbidity hospitals there was a stronger focus on standardized care.

Summit panelists agreed that medical teams across all hospitals, especially those that are low-performing, should better integrate into their healthcare systems the following: (1) tools to identify mothers at risk for delivery and postpartum complications, (2) efforts to increase awareness of maternal health disparities amongst delivery teams, (3) use of standardized

safety bundles that have been shown to improve outcomes in obstetrics care and (4) enhance communication strategies and sharing of performance data between leadership and frontline clinicians. Continually updating health technology and programs, especially given the lessons learned from the COVID-19 pandemic, were noted as particularly important in enhancing connections between patients and healthcare professionals and potentially improving outcomes.

An important axis that cannot be excluded from quality of care is the experience of the mother-infant dyad. The results of the two NIH-funded mixed methods studies on this domain were described to support the need for research in this intersection. The mother-infant dyad emphasizes the physiologic and psychosocial interaction between the mother and infant. Quantitative analysis of live very preterm infants within the cohort found that severe maternal morbidity is an independent risk factor for very preterm mortality.[3] This association is more common among non-Hispanic Black very preterm babies. This means that management of severe maternal morbidity is a potential lever for improving very preterm birth outcomes. Researching potential unique needs that may arise when both the mother and infant experience delivery complications is an important aspect of quality of care.

Specific recommendations from summit participants included:

- Prioritize evidence-based practices throughout care by providing labor and delivery units with standardized safety bundles, and consistently evaluate the effectiveness of these bundles, especially among Black and Latina patients. Encourage checklists and competency lists for assessing and evaluating health concerns while on service.
- Standardize care by improving communication between patient and healthcare professional, such as increased access to multilingual services for patients. This also includes health literacy services, as pregnancy has been identified as an opportune time to improve health literacy among women[8]
- Bolster technology services for prenatal and maternal care; improve telehealth care to potentially reduce loss to follow up; leverage social media and apps to connect healthcare healthcare professionals, pregnant persons, public health agencies and the community to improve health outcomes and amplify the collective voice of underrepresented people.
- Integrate a maternal-infant dyad lens to improve quality of care for maternal and infant health.

Area 2: Adjustment of Care Strategy Based on Patient-Reported Experience

Black and Latina patient perspectives must be integrated into hospital practices and care. One example of this is the “SACRED birth” collaboration, a Black woman-led team of Black women scholars in partnership with academic institutions, community-based organizations, midwifery, doula support, and more. Programs like this advocate for higher quality participatory birth care that can be used “to shift power to generate and disseminate knowledge of the quality improvement space to Black mothers, birthing people, community

members and scholars".[9] Likewise, hospitals and clinics need to establish clear and effective feedback systems for Black, Latina, and other birthing people of color to voice their experiences during pregnancy and birth to better identify areas in need of improvement.

Surveys of birthing peoples' experience in the hospital should be ongoing and consistent, throughout pregnancy and postpartum care. Current literature has demonstrated that real-time data collection of microaggressions during pregnancy, rather than an aggregate review at the conclusion of the healthcare experience, can provide a more complete picture of the obstetrical experience.[10] Summit presenters reinforced the importance of consistent collection of patient outcomes stratified by race and ethnicity, and the integration of these data and feedback into the healthcare system to yield continuous improvement. Understanding and identifying social needs reported from patients (i.e. food insecurity, housing conditions, intimate partner violence) or patterns of racism, micro-aggressions, or inequity can be compiled to develop partnered quality improvement intervention programs.

Specific recommendations from summit participants included:

- Promote patients' agency and sense of self-efficacy by encouraging healthcare professionals to actively collaborate with patients and their families to make decisions in accordance with their priorities, outside of emergency decisions.
- Implement institutional and hospital mechanisms that allow for meaningful feedback from patients and their families, including disrespectful care and discrimination; develop regular and consistent feedback system tools utilized at multiple time points to ensure and enhance optimal birth experiences, outcomes, and cultural sensitivity.
- Expand the repertoire of quality metrics to include measures of patient-reported experience of mistreatment and discrimination during delivery hospitalizations in an effort to hold hospitals accountable for their performance.

Area 3: HealthCare Professional and Institutional Accountability to Patients

Hospitals and healthcare professionals should be held accountable to patient feedback and outcomes, and for any gaps in quality of care using known quality improvement metrics. The California Perinatal Quality Improvement Collaborative (CPQCC), which comprises a statewide network of about 90% of NICUs in California, has developed a Health Equity Dashboard to collect and share data on NICU health outcomes with stratified racial and ethnic data.[11] The use of quality data, through these types of "disparities dashboards", was emphasized as the responsibility of all health care systems marked by sharing of data of health outcomes stratified by race and ethnicity and shared openly with patients/clients. Workshop participants recommended a composite maternal child dashboard which could be used to exemplify the necessary link of maternal health to fetal and infant health. This tracking of joint maternal-infant disparities is important for developing effective quality interventions and measuring the full burden of quality gaps on disparities. The public availability of these data is necessary in hospital quality improvement. Consistent data collection of risk-adjusted outcomes by race should be established as a norm at hospitals,

with disparities in outcomes noted and publicly available, similarly to cardiac outcome data.[12]

Specific recommendations from summit participants included:

- Establish disparity dashboards to assess equity and health disparities in outcome by race and ethnicity to guide hospital policy, improve quality of care, and address upstream allocation for needed resources especially in overburdened, disadvantaged communities of color.
- Standardize annual reporting of all hospitals severe maternal morbidity and maternal mortality rates; these measures can be linked to healthcare professional and institutional outcomes and to payment systems. However, these efforts must not use these metrics to further divest from systems of care in disadvantaged communities. Tracking growing health disparities will be key.

Area 4: Commitment to Building Trust within the Community

Healthcare professionals should improve communication, transparency and trust with their patients throughout the lifespan stages of care. Despite the well-documented research that outlines how social determinants of health and structural racism influence patient outcomes,[13] 40% of Black patients have stated that they almost never feel that their healthcare team considered their life outside of the hospital during their counseling, or decision-making.[14] The Vermont Oxford Network emphasized the importance of “Follow Through” and the responsibility of healthcare professional teams to practice social, not just technical medicine. This practice includes measures such as screening all families for protective factors, social risks and social support using standardized tools, assessing eligibility for public programs such as WIC, and connecting families with appropriate community-based organizations and services. Follow through was also echoed in the concept of the mother-baby dyad, in efforts to integrate and strengthen quality improvement throughout the health system and especially in both obstetrical and neonatal care at hospitals where Black and Latina women deliver.

Community-based organization leaders outlined how community healthcare workers can act as sustainable and effective bridges between healthcare professionals to community services such as WIC, food pantries, healthy start/home visitation programs, and mental health programs.[15] These partnerships are possible only when hospital leadership acknowledges the needs of their patient population and the strengths and abilities of community-based organizations in the area. Panelists from community-based organizations such as Ancient Song Doula Services described how partnerships can exist on a spectrum including consultancy, committee board positions, and more. Community-based organizations that partner and collaborate with hospitals not only increase workforce capacity but also improve the trust that a patient has for their care team and its cultural awareness. Other panelists emphasized having lawyers or paralegals as working members of the team to address immigration status, housing, and employment.

Specific recommendations from summit participants included:

- Incorporate a life course perspective into care to emphasize the effects of social determinants of health and integrate an understanding of psychosocial and behavioral risk factors, as well as protective factors, into the fabric of standardized care.
- Commit to continuity of care and the follow-through of birthing people and their newborns. Pregnancy, postpartum and newborn care are not separate but should be treated together for a full patient profile. Co-locate services that may be needed post-birth and retain a healthcare healthcare professional (physician, nurse midwife, nurse, doula etc.) that can be a continued source of contact.
- Implement a diverse healthcare team in high intensity spaces like the NICU, including midwives, doulas, legal aids, or mental healthcare professionals, as a way to build trust with a family dealing with the trauma and stress of negative birth outcomes.
- Collaborate and develop partnerships between local community-based organizations and hospitals to assess community needs and preferences, develop strategies for problem solving and novel approaches to quality improvement.

Area 5: Antiracism Practices in Education, Training, and Hiring

The diversity of healthcare workers on labor and delivery floors should mirror the diversity of their patient populations in order to better service Black and Latinx maternal and neonatal care.[16] Especially in hospitals in which patient populations are over-represented by Black, Latinx, and indigenous birthing people, having more BIPOC healthcare staff (across physicians, nurse midwives, nurses, clinical staff) was outlined as one of the first steps in developing antiracism medical models of care. Improvements in medical and clinical education that attend to the nuanced and complex historical perspectives of diverse patient populations must be integrated into the curricula and can be augmented through qualitative narrative and quantitative data.

Hospitals can increase the variety of care options for women and birthing people, specifically providing full spectrum midwifery care. Having more licensed social workers, midwives and doulas on the in-patient units can help build rapport with people of color to help restore trust in the health care system. Integration of midwifery care into the local medical care delivery system can lead to better health for mothers and babies across a wide range of outcomes, such as lower cesarean rates, lower preterm birth rates, and fewer low birth weight infants'.[17] There was consensus, that promoting and funding midwifery and also doulas, especially those organizations that are Black-led, not only helps Black birthing people in their quest to find sustainable care options, but also increases the overall workforce and resources on labor and delivery floors.

Summit panelists maintained the importance of implicit and explicit bias training as an important avenue for training healthcare professionals and sustaining a culture of antiracism. While panelists appreciated current efforts to increase bias trainings, they also emphasized evaluation of these interventions and their outcomes as well as a commitment to antiracism by hospital leadership expanding past these efforts.

Specific recommendations from summit participants:

- Provide education on implicit bias, anti-racism, cultural awareness, trauma-informed care, social equity theory, social determinants of health, all specifically focused on the needs of BIPOC individuals to all members of the clinical team.
- Research the effects and efficacy of implicit bias training on perinatal health outcomes.
- Develop medical school curricula that reflect the specific needs of BIPOC populations.
- Diversify the workforce by promoting policies (scholarships, loan repayment, etc.) to increase admissions of BIPOC individuals to and attendance at medical schools and other clinical training programs.
- Integrate midwives, doulas and community health workers into healthcare, especially Black women led birthing support options, more seamlessly into care to protect and support Black women as the obstetrical institution changes its culture around implicit, anti-Black bias.
- Dedicate hospital resources to implement staff training in areas of implicit bias and anti-racism. Speakers suggested that these trainings could be standardized at the state and national level. Evaluate efficacy by tracking perinatal outcomes pre- and post- implicit bias training with expectations that facilities should improve disparities. Address non-adherence to staff training in areas of implicit bias and anti-racism.

Future Policy Approaches to Maternal and Infant Care

Several cross-cutting policy approaches, essential to the proposed clinical actions to prevent maternal and neonatal morbidity and mortality, were identified among the Summit presenters and validated by public input:

- There is a dire need for Paid Family Leave (PFL) as there is emerging evidence that it will improve infant and maternal outcomes by reducing hospitalizations postpartum.[18] Implementation and evaluation of PFL legislation should consider race and ethnicity to determine trends and disparities in usage of the program.
- Access to Medicaid, especially for those that may not be eligible due to legal status. National initiatives to remove the five-year waiting period that even legal residents have to wait to be eligible for Medicaid should be advocated for.
- Increased federal funding for research in racial and ethnic disparities in maternal and neonatal mortality and morbidity.
- Standardize state-wide maternal mortality review committees and require all to review deaths that occur up to one year postpartum, determine if pregnancy-related deaths were preventable, review cases and track trends of maternal morbidity, and consider racial disparities and equity in conducting reviews.

Next Steps

Racial and ethnic disparities in maternal and infant health outcomes persist. This highly complex issue must be addressed in a multidisciplinary and multipronged approach. Equity-focused improvements in hospital care policies and practices, from the implementation of patient safety bundles and mechanisms for reporting bias to race-stratified data collection and antiracism hiring practices, are just a few of the approaches that, when coupled with federal and state policy programs that address upstream, structural access issues, can address both social and medical risk factors across the pregnancy care continuum. This summit was a productive call-to-action that outlined key frameworks to combat structural racism and help solve the national crisis affecting BIPOC mothers, birthing people, and infants.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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