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

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Please note: webinar is being recorded
Agenda:

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

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.”

Erica Garner Andrew Burton/ Getty Images

Rosa Diaz; Courtesy of Diana Diaz
"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."
Pregnancy-Related Mortality Ratios by Race-Ethnicity, 2007-2016

- Non-Hispanic Black: 40.8
- American Indian: 29.7
- Asian/Pacific Islander: 13.5
- White: 12.7
- Latina: 11.5

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

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>Rate per 100,000 Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>44.6</td>
</tr>
<tr>
<td></td>
<td>50.8</td>
</tr>
<tr>
<td></td>
<td>25.0</td>
</tr>
<tr>
<td>High school graduate</td>
<td>59.1</td>
</tr>
<tr>
<td></td>
<td>43.7</td>
</tr>
<tr>
<td></td>
<td>25.2</td>
</tr>
<tr>
<td>Some college</td>
<td>41.0</td>
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<tr>
<td></td>
<td>32.0</td>
</tr>
<tr>
<td></td>
<td>11.7</td>
</tr>
<tr>
<td>College graduate or higher</td>
<td>40.2</td>
</tr>
<tr>
<td></td>
<td>&gt;5X</td>
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<tr>
<td></td>
<td>7.8</td>
</tr>
</tbody>
</table>

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

Source: Kozhimannil KB. Health Affairs. 2019 Dec; Vol.38, No.12.
How Did We Get Here?
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

Framework

Institutionalized racism
- Initial historical insult
- Structural barriers
- Inaction in face of need
- Societal norms
- Biological determinism
- Unearned privilege

Personally mediated racism
- Intentional
- Unintentional
- Acts of commission
- Acts of omission
- Maintains structural barriers
- Condoned by societal norms

Internalized racism
- Reflects systems of privilege
- Reflects societal values
- Erodes individual sense of value
- Undermines collective action
Figure 1: Pathways to Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality

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

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.

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

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.)
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.
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.
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.

• 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.
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.

• 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.
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
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.**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Negative patient/provider/facility interaction <em>(stigmatizing language, dismissing concerns, case notes suggest provider/facility conflict)</em></td>
</tr>
<tr>
<td>2</td>
<td>Excessive gatekeeping <em>(inability to reach provider, leaving messages, etc.)</em></td>
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<tr>
<td>3</td>
<td>Indicated labs not ordered / delayed labs ordered</td>
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<td>4</td>
<td>Leaving against medical advice</td>
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<td>5</td>
<td>Repeated ED visits in short time frame <em>(for urgent care)</em></td>
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<tr>
<td>6</td>
<td>Cultural incompetence <em>(lack of translator, awareness of other culture)</em></td>
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<tr>
<td>7</td>
<td>Lack of access to health care before, during, and after pregnancy <em>(structural bias)</em></td>
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<tr>
<td>8</td>
<td>Treatment decisions and recommendations inconsistent with best practices</td>
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<td></td>
<td>8a. Over-treatment</td>
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<tr>
<td></td>
<td>8b. Under-treatment</td>
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<td></td>
<td>8c. Delay in treatment</td>
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<td></td>
<td>8d. Inadequate pain management</td>
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<td></td>
<td>8e. Assumptions about patient’s adherence to treatment</td>
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<td></td>
<td>8f. Other, <em>please specify</em></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>UNK</th>
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<tbody>
<tr>
<td></td>
<td>Racial/ethnic</td>
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<td></td>
<td>Age</td>
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<td>Income</td>
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<td></td>
<td>Immigration status/Citizenship</td>
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<td></td>
<td>Disability</td>
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<td>Other, <em>please specify:</em></td>
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<td>None</td>
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<td></td>
<td>Gender</td>
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<td>Weight</td>
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<td></td>
<td>Socioeconomic</td>
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<td></td>
<td>Language</td>
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</tbody>
</table>

*In development by the Texas Maternal Mortality Review Committee*
Recommendations

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

<table>
<thead>
<tr>
<th>WAS THIS DEATH PREVENTABLE?</th>
<th>□ YES</th>
<th>□ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANCE TO ALTER OUTCOME</td>
<td>□ GOOD CHANCE</td>
<td>□ SOME CHANCE</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>CONTRIBUTING FACTOR LEVEL</th>
<th>CONTRIBUTING FACTORS (choose as many as needed below)</th>
<th>DESCRIPTION OF ISSUE (enter a description for each contributing factor listed)</th>
<th>COMMITTEE RECOMMENDATIONS [WHO?/WHAT?] [WHEN?] [WHERE?] Map recommendations to contributing factors.</th>
<th>PREVENTION LEVEL (choose below)</th>
<th>IMPACT LEVEL (choose below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT/FAMILY</td>
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<tr>
<td>PROVIDER</td>
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<tr>
<td>FACILITY</td>
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<tr>
<td>SYSTEM</td>
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<tr>
<td>COMMUNITY</td>
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<td></td>
</tr>
</tbody>
</table>

### 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/trai
- Access/financia
- 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: 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.)

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MMRIA committee decisions form ([https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form](https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form))
## Standardized Committee Decisions Form (Page 2)

### 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.

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

#### CONTRIBUTING FACTOR KEY (DESCRIPTIONS ON PAGE 4)
- Delay
- Adherence
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- Equipment/technology
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- Communication
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- Clinical skill/quality of care
- Outreach
- Law Enforcement
- Referral
- Assessment
- Legal

- Structural Racism
- Interpersonal Racism
- Discrimination

MMRIA committee decisions form ([https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form](https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form))
### Standardized Committee Decisions Form (Page 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.

<table>
<thead>
<tr>
<th>WAS THIS DEATH PREVENTABLE?</th>
<th>□ YES</th>
<th>□ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANCE TO ALTER OUTCOME?</td>
<td>□ GOOD CHANCE</td>
<td>□ SOME CHANCE</td>
</tr>
</tbody>
</table>

#### Contributing Factors and Recommendations for Action

**Contributing Factors Worksheet**

What were the factors that contributed to this death?

Multiple contributing factors may be present at each level.

<table>
<thead>
<tr>
<th>CONTRIBUTING FACTOR LEVEL</th>
<th>CONTRIBUTING FACTORS (choose as many as needed below)</th>
<th>DESCRIPTION OF ISSUE (enter a description for each contributing factor listed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Family</td>
<td></td>
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</tr>
<tr>
<td>Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
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<tr>
<td>System</td>
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<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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?

<table>
<thead>
<tr>
<th>COMMITTEE RECOMMENDATIONS [WHO?] [WHAT?] [WHEN?] [WHERE?] [WHY?] [HOW?]</th>
<th>COMMITTEE RESPONSIBILITY [WHAT? WHEN?] [WHO?] [WHERE?] [WHY?] [HOW?]</th>
<th>PREVENTION LEVEL (choose below)</th>
<th>IMPACT LEVEL (choose below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PRIMARY: Prevent the contributing factor before it ever occurs</td>
<td>□ PRIMARY: Prevents the contributing factor before it ever occurs</td>
<td>□ PRIMARY: Prevents the contributing factor before it ever occurs</td>
<td>□ PRIMARY: Prevents the contributing factor before it ever occurs</td>
</tr>
<tr>
<td>□ SECONDARY: Reduces the impact of the contributing factor once it has occurred (i.e., treatment)</td>
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</tr>
<tr>
<td>□ TERTIARY: Reduces the impact or progression of what has become an ongoing contributing factor (i.e., management of complications)</td>
<td>□ TERTIARY: Reduces the impact or progression of what has become an ongoing contributing factor (i.e., management of complications)</td>
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MMRIA committee decisions form ([https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form](https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form))
Specific and Actionable Recommendations from State MMRCs

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

______ should _________ ________.
(who?) (do what?) (when?)
Achieving Health Equity Requires:

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

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Who?
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.
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.
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Achieving Health Equity Requires:

- Valuing all individuals and populations equally
- Recognizing and rectifying historical injustices
- Providing resources according to need
## Contributing Factors and Recommendations for Action

### Contributing Factors Worksheet

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

<table>
<thead>
<tr>
<th>Contributing Factor Level</th>
<th>Contributing Factors (choose as many as needed below)</th>
<th>Description of Issue (enter a description for EACH contributing factor listed)</th>
<th>Committee Recommendations [Who?] should [do what?] [when?]</th>
<th>How it helps to achieve health equity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient/Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>Interpersonal Racism; Discrimination</td>
<td>Communication failures, stereotyping by providers, concerns not addressed, ignored and improperly treated symptoms, lack of appropriate referral or consultation</td>
<td>OB clinicians should screen patients for social determinants of health (SDOH) at prenatal and L&amp;D visits, including late entry into healthcare system, and work with social workers to address specific needs and care coordination relevant to the SDOH.</td>
<td>Providing resources according to need</td>
</tr>
<tr>
<td><strong>Facility</strong></td>
<td>Structural Racism; Discrimination</td>
<td>Stereotyping by providers, racist policies and practices, failure to mandate anti-racism training, lack of quality care for racial minorities</td>
<td>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.</td>
<td>Valuing all individuals and populations equally</td>
</tr>
<tr>
<td><strong>System</strong></td>
<td>Structural Racism; Discrimination</td>
<td>Lack of resources, inadequate staffing in hospitals serving minority communities, lack of providers accepting patients insured by Medicaid</td>
<td>State governments should expand access to Medicaid to include coverage for specialists for high-risk patients during prenatal, delivery, and postpartum care.</td>
<td>Providing resources according to need</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>Structural Racism</td>
<td>Disconnect between community and hospital leaders and clinicians, lack of patient and community engagement</td>
<td>State MMRCs should include community members to ensure the patient perspective and lived experience is incorporated into the entire process.</td>
<td>Valuing all individuals and populations equally</td>
</tr>
</tbody>
</table>
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

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