Addressing Racial Inequity in Healthcare Outcomes with a Focus on Cherished Futures for Black Moms and Babies

March 17, 2022
Moderators

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Housekeeping Items

• All lines will be muted. Raise your hand if you wish to be unmuted.

• The presentation slides and recording will be available within 1-3 business days.

• 1 CE unit will be provided to CHPSO/HQI/CHA Members:
  — Complete the survey by March 25, 2022
  — CE certs will be emailed within two weeks after survey is closed.
How to join in the discussion
Speakers

Esther Priscilla Ebuehi, MS
Birth Equity Impact Analyst
Cherished Futures for Black Moms & Babies with the Alliance

Asaiah Harville, IBCLC
Birth Equity Coordinator
Cherished Futures for Black Moms & Babies with the Alliance
Addressing Racial Inequity in Healthcare Outcomes with a Focus on *Cherished Futures for Black Moms and Babies*

March 17, 2022
Disclosure Statements

Presenters have no relevant financial relationship(s) or nonfinancial relationship(s) to disclose.
Session Objectives

At the close of this session, participants should be able to:

✓ Describe factors that contribute to racial inequity in healthcare
✓ Analyze data to assess disaggregated outcomes for their local birthing units
✓ Understand the importance of patient experience as an outcome metric in clinical care
What Legacy Will We Leave?

Every generation leaves behind a legacy. What that legacy will be is determined by the people of that generation. What legacy do you want to leave behind?

— John Lewis, Across That Bridge: A Vision for Change and the Future of America
ABOUT CHERISHED FUTURES
Meet the Cherished Futures Team

Dana Sherrod, MPH
Birth Equity & Racial Justice Manager, Alliance

Asaiah Harville, BA, IBCLC
Birth Equity Coordinator, Alliance

Esther Priscilla Ebuehi, MS
Birth Equity Impact Analyst, Alliance

Karen Ochoa
Director of Health Equity Programs and Operations, CLC

Claudia Pacheco, MPH
Health Equity Coordinator, CLC

Alimat Adebiyi, MPH, DrPH(c)
Quality Improvement Specialist, Alliance

Tracy Delaney, Ph.D., RD
Founding Executive Director, Alliance

Julia Slininger, RN, BS, CPHQ
Quality Improvement Consultant

Susan Harrington, MS, RD
President, CLC
The Public Health Alliance of Southern California is a coalition of executive leadership from 10 local health departments across Southern California.

Our members have statutory responsibility for nearly 60% of California’s population.

City of Long Beach
City of Pasadena
Los Angeles County
Riverside County
Orange County
San Diego County
San Bernardino County
Imperial County
Santa Barbara County
Ventura County
Los Angeles County

- Approx. 10 million residents
- If it were a state, it would be the 11th largest in the U.S.
- Approximately 114,000 births on average each year
- 46 delivery hospitals
Cherished Futures is a multi-sector collaborative effort to reduce Black infant and maternal inequities and improve patient experiences for Black birthing people in Los Angeles County.

CREATING LASTING SYSTEMS CHANGE

Clinical  Institutional  Community
Cherished Futures: A 2-Year Cohort Experience

Year 1: Capacity Building “getting grounded”
- Getting Grounded Approach through series of workshops and technical assistance
- Build the knowledge and understanding of birth inequity among Black babies, moms, birthing people
- By year end, all teams developed implementation plan

Year 2: Implementation
- Implement hospital plans
- Continued coaching and technical assistance
- Convene collaborative at least 3 times
- Evaluation

Source: Reid, A. et al. Getting Grounded: Building a Foundation for Health Equity and Racial Justice Work in Health Care Teams. NEJM Catalyst Innovations in Care Delivery 2022; 01
DOI:https://doi.org/10.1056/CAT.21.0320

#citeBlackwomen
**Goal:** To reduce Black maternal and infant health inequities and improve the Black patient experience in Los Angeles County.

**Objectives:**
- Activate a multi-sector collaborative of hospitals, public health, insurance payers, and Black women community advisors
- Develop and implement systems-level strategies to address Black maternal and infant health inequities
- Support the development of a "regional oasis" for Black families by building a cadre of institutional leaders that are actively addressing these systemic injustices

**Outcomes**

**By the end of 2022, hospital teams will:**
- complete the Organizational Birth Equity Assessment
- developed actionable, Black women and data-informed, implementation plans
  identifying clinical, institutional, and community strategies from the Menu of Interventions
- deepen the knowledge about anti-Black racism, clinical and community data, systems-change strategies and regional collaboration opportunities

**By the end of 2023, hospital teams will:**
- implement systems-change strategies at the clinical, institutional, and community levels to advance birth equity.
- identify opportunities to strengthen collaboration and partnership with Black patients and community
DEVELOPING SHARED LANGUAGE
Racism

A system of power that structures opportunity and assigns value based on the social interpretation of how one looks (which is what we call “race”).

Unfairly disadvantages some individuals and communities while unfairly advantaging others.

Source: Dr. Camara Jones, “Levels of Racism: A Theoretic Framework and a Gardener’s Tale.”
Racism NOT Race

Research supports that racism is the root cause of maternal and infant health inequities in the U.S.

The overexposure to racism and discrimination throughout Black women’s lives contributes to the physical weathering of Black bodies. This is phenomenon is seen Black women across lines of class, education, maternal attitudes and behaviors.

Equality, Equity, Justice

**Equality** is the condition under which all individuals receive uniform treatment, resources, and opportunities.

**Equity** is acknowledging that we do not all start from the same place, and therefore, we need different resources and opportunities to thrive.

**Justice** is fixing systems in a way that leads to sustained equitable access for all. People don’t need additional support because the cause of the inequity is addressed— the system is changed.

Source: Milken Institute School of Public Health, George Washington University
Birth Equity

birth equity (noun):
The assurance of the conditions of optimal births for all people with a willingness to address racial and social inequities in a sustained effort.

Joia Crear-Perry, MD
National Birth Equity Collaborative

#citeBlackwomen
FACTORS CONTRIBUTING TO BIRTH INEQUITIES
Getting to the Roots

Disparity in the Distribution of Disease, Illness, and Wellbeing
Adapted from R. Hofrichter, Tackling Health Inequities Through Public Health Practice.
The Impact of Structural Racism

• The afterlife of slavery
  • “The suboptimal care that some Black women receive may result in part from the legacy of racist treatment during the antebellum period and in the afterlife of slavery” – Dr. Dana-Ain Davis

• Reproductive coercion and medical racism
  • Slaveholders and physicians wielded control over the reproductive health of enslaved Black women
  • Black women have been systematically denied agency over their own health and reproductive decisions


#citeBlackwomen
Weathering & Allostatic Load

Key Findings

- Black women bear a larger burden of allostatic load than men and women of all other ethnicities.

- Black women find that they must spend significant time, thought, and emotional energy watching every step they take, managing an array of feelings, and altering their behavior to cope with it all.

- Many of the women in their study found that to fit in, keep the peace, and move forward, they had to censor their conversations and funnel their ideas.

“‘The weathering effects of living in a race conscious society may be greatest among those Blacks most likely to engage in high-effort coping’.”

The rates of pregnancy-related death for Black and American Indian/Alaska Native women over the age of thirty are 4 to 5 times higher than their White peers.

Black women are 27 percent more likely to experience severe pregnancy complications than White women.

A Black woman with a college degree is nearly 2 times more likely to experience pregnancy complications compared to a white woman that has not completed high school.

Sources:
Differential Experiences in Health Care

Issues such as disrespect, abuse, and discrimination within the health care system play a significant role in how women of color access and experience care during pregnancy, birth, and postpartum, which contributes to adverse outcomes for mother and baby.

“There is a lack of safety felt by Black women in the healthcare system. Black women’s stress is exacerbated by having to navigate a system that is unfamiliar, and at times hostile to them.”


Sources: Attanasio and Kozhimannil, 2015; McLemore et al., 2018; Ruiz et al., 2014; Salm Ward et al., 2013

#citeBlackwomen
DISAGGREGATING BIRTH DATA BY RACE & ETHNICITY
The Importance of Disaggregated Birth Data

• Disaggregating data: breaking data down to identify underlying trends and patterns, including social determinants of health

• Disaggregated data allows us to see which populations are experiencing disproportionate rates of certain clinical outcomes

• This allows us to develop and implement initiatives that are grounded in data and are tailored to the communities most in need

• When we address the needs of communities most impacted by disparities, EVERYONE BENEFITS!
Hospitals from both Cherished Futures Cohorts 1 and 2 represent approximately 45% of Black deliveries in LA County

Cohort 1 (2020 – 2021)

[Logos of hospitals]

Cohort 2 (2022 – 2023)
# LAMB Follow-Up Snapshot: Maternal Characteristics and Health Indicators by Race/Ethnicity, Los Angeles County 2018

<table>
<thead>
<tr>
<th>Maternal Demographics</th>
<th>Los Angeles County, 2018</th>
<th>White</th>
<th>Latina</th>
<th>Black</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (95% CI)</td>
<td>N</td>
<td>% (95% CI)</td>
<td>N</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>120,332</td>
<td>18.6 (16.9-20.4)</td>
<td>22,428</td>
<td>55.5 (52.9-58.1)</td>
</tr>
</tbody>
</table>

### Maternal Demographics

#### Education at time of follow up

<table>
<thead>
<tr>
<th>Age at time of delivery</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;12 years</td>
<td>12.7 (10.8-14.6)</td>
<td>15,135</td>
<td>0.7 (0.2-1.2)</td>
<td>149</td>
<td>20.5 (17.2-23.8)</td>
<td>13,498</td>
<td>11.2 (7.3-15)</td>
<td>870</td>
<td>2.3 (0.2-4.4)</td>
<td>439</td>
</tr>
<tr>
<td>12 years</td>
<td>15.6 (13.4-17.8)</td>
<td>18,604</td>
<td>4.5 (3.6-1)</td>
<td>1,013</td>
<td>23.0 (19.4-26.6)</td>
<td>15,146</td>
<td>14.3 (9.6-19)</td>
<td>1,112</td>
<td>5.0 (1-9)</td>
<td>963</td>
</tr>
<tr>
<td>&gt;12 years</td>
<td>71.6 (69.7-74.3)</td>
<td>85,263</td>
<td>94.8 (93.2-96.4)</td>
<td>21,118</td>
<td>56.5 (52.3-60.6)</td>
<td>37,174</td>
<td>74.6 (69.8-80.1)</td>
<td>5,815</td>
<td>92.7 (88.3-97.1)</td>
<td>17,880</td>
</tr>
</tbody>
</table>

#### Age at time of delivery

<table>
<thead>
<tr>
<th>Age at time of delivery</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 years old</td>
<td>4.2 (3.5-4.8)</td>
<td>5,021</td>
<td>0.5 (0.1-0.9)</td>
<td>107</td>
<td>6.6 (5.5-7.7)</td>
<td>4,425</td>
<td>5.0 (2-8)</td>
<td>400</td>
<td>0.1 (0-0.3)</td>
<td>27</td>
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<tr>
<td>20-24 years old</td>
<td>15.9 (13.4-18.4)</td>
<td>19,118</td>
<td>5.7 (2.9-4)</td>
<td>1,271</td>
<td>23.0 (19.1-26.9)</td>
<td>15,355</td>
<td>20.5 (14.3-26.7)</td>
<td>1,630</td>
<td>3.4 (0-6.9)</td>
<td>655</td>
</tr>
<tr>
<td>25-34 years old</td>
<td>55.7 (53.5-58.6)</td>
<td>67,078</td>
<td>59.9 (55.2-64.6)</td>
<td>13,432</td>
<td>52.1 (48-56.2)</td>
<td>34,804</td>
<td>55.6 (49.4-61.7)</td>
<td>4,411</td>
<td>62.9 (56.5-69.2)</td>
<td>12,161</td>
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<tr>
<td>35+ years old</td>
<td>24.2 (22.26-26.4)</td>
<td>29,114</td>
<td>34.0 (29.7-38.2)</td>
<td>7,618</td>
<td>18.3 (15.1-21.4)</td>
<td>12,219</td>
<td>18.9 (14.9-22.8)</td>
<td>1,497</td>
<td>33.5 (27.6-39.6)</td>
<td>6,496</td>
</tr>
</tbody>
</table>

#### Married at time of follow up

<table>
<thead>
<tr>
<th>Married at time of follow up</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>62.5 (59.8-65.3)</td>
<td>73,971</td>
<td>86.7 (83.9-89.5)</td>
<td>19,268</td>
<td>49.7 (45.5-53.9)</td>
<td>32,442</td>
<td>35.0 (29.3-40.7)</td>
<td>2,697</td>
<td>87.2 (82.3-92.1)</td>
<td>16,808</td>
<td></td>
</tr>
</tbody>
</table>

### Maternal Health & Well-being at Follow-Up

#### Access to Health Care

<table>
<thead>
<tr>
<th>Access to Health Care</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>90.2 (88.4-91.9)</td>
<td>108,241</td>
<td>98.3 (97.2-99.3)</td>
<td>22,038</td>
<td>84.7 (81.7-87.6)</td>
<td>56,336</td>
<td>96.3 (94.1-98.4)</td>
<td>7,634</td>
<td>96.9 (94.7-99)</td>
<td>18,706</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>42.1 (39.2-45)</td>
<td>45,276</td>
<td>16.7 (12.3-21)</td>
<td>3,665</td>
<td>60.8 (56.3-65.2)</td>
<td>33,914</td>
<td>60.7 (54.9-66.5)</td>
<td>4,580</td>
<td>13.0 (8.8-17.2)</td>
<td>2,437</td>
</tr>
</tbody>
</table>

#### Maternal Medical Conditions

<table>
<thead>
<tr>
<th>Maternal Medical Conditions</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
<th>% (95% CI)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure*</td>
<td>5.6 (4.4-6.8)</td>
<td>6,701</td>
<td>4.4 (2.5-6.2)</td>
<td>981</td>
<td>6.3 (4.3-8.2)</td>
<td>4,177</td>
<td>11.9 (8.2-15.6)</td>
<td>946</td>
</tr>
</tbody>
</table>
ADVANCING PATIENT-CENTERED CARE
Patient-centered Care

- Clinical care models have historically *not* centered patients

- More researchers, clinicians, and public health experts are interested in **patient experience** as an outcome variable in assessing the quality of care
Cherished Futures Organizational Birth Equity Assessment (OBEA) & Menu of Interventions

II. PRACTICES TO IMPROVE THE BLACK PATIENT EXPERIENCE

- (0) Not Yet Started: We do not currently have specific equity-based practices in place to improve the Black patient experience.
- (1) Toes in the Water: We regularly review patient survey scores (i.e., Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Press Ganey) by race and ethnicity.
- (2) Fully Immersed: We regularly review patient survey scores and have implemented new practices to measure patient experience using evidence-based protocols and validated tools (i.e., nurse rounding, discharge phone calls, PREM-OB Scale, etc.).
- (3) Acclimated and Learning New Strokes: We measure and review data on the Black patient experience and have implemented small tests of change to address areas for improvement.

AIM: IMPROVE THE BLACK PATIENT AND FAMILY EXPERIENCE (RESOURCES)

<table>
<thead>
<tr>
<th>Toes in Water</th>
<th>Fully Immersed</th>
<th>Acclimated and Learning New Strokes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review patient experience data and/or patient survey scores (i.e., Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Press Ganey) by race and ethnicity.</td>
<td>Implement a process to capture and measure the Black patient experience using patient experience tools, apps (i.e.,irth App), nurse leader rounds, etc. to identify areas for improvement.</td>
<td>Pilot a Black perinatal cultural broker program to foster cultural responsiveness and collaboration among patients and providers within the department.</td>
</tr>
</tbody>
</table>

- The OBEA is designed to assist hospital teams in assessing their organization’s progress across four domains of systems-level change (data, clinical, institutional, and community).
- OBEA results can help teams identify opportunities for improvement and select the appropriate interventions from the Cherished Futures Menu of Interventions.
Elevating Black Voices, Experiences, and Thought Leadership

- **Community Advisors** elevate community perspective throughout hospital implementation plan development.

- **Black women-centered listening sister circle** for community to provide input on plans and other opportunities to improve care for and with Black women.

  “Medical professionals can work on not making assumptions about Black women (medical history, present circumstances, etc.) and see us for the individuals we are.”

  - Sister Circle Participant, Black Mother, 2021

#ListentoBlackWomen
What is one action you can commit to in advancing birth equity?
THANKS FOR YOUR TIME!
How to join in the discussion
## Upcoming Safe Table Forums
**Members Only**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 24</td>
<td>11:00 am – 12:00 pm Pacific</td>
<td>Multidisciplinary Optimizing Transitions of Care Committee can Lead to Optimizing Patient Safety Outcomes</td>
</tr>
<tr>
<td>April 21</td>
<td>10:00 am – 11:00 am Pacific</td>
<td>Wrong Events: An Assessment of Universal Protocol in a High Reliability Organization</td>
</tr>
<tr>
<td>April 28</td>
<td>10:00 am – 11:00 am Pacific</td>
<td>Pediatrics Depression/ Suicide Screening</td>
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# Upcoming HQI/CHPSO Webinars

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>March 18</td>
<td>11:00 a.m. – 12:00 p.m. Pacific</td>
<td><a href="#">Recent CDC Studies about COVID in California: An Epidemiological Review and Critique</a></td>
</tr>
</tbody>
</table>
Follow-up Email

• Feel free to share articles, tools, policies, or other resources for fellow members to info@chpso.org
  - We will de-identify your hospital and provider names

• Click here for the survey link
  - Please share potential topics for future meetings
Thank You!

Follow us on Twitter!
@CHPSO and @HQInstitute