No Disclosures
Objectives

At the end of this session participants will be able to:

- Name at least one upstream contributor or determinant of health
- Identify at least one potential midstream point of intervention
- List at least one equity-promoting strategy we can implement

“It’s common to blame women for their own deaths. Many scientific publications have cited that women are coming to pregnancy older (called advanced maternal age, or geriatric pregnancy), sicker (with hypertension, diabetes or other chronic illnesses) and fatter (that is, suffering from obesity).”

Health Disparities are the metrics we use to measure progress toward achieving health equity.

- Paula Braveman and Laura Gottlieb


Pregnancy-Related Deaths, 2007-2016

Pregnancy-Related Deaths


N.H. Severe Maternal Morbidity by Race & Hispanic Origin
2016-2018

IOM's Six Dimensions of Quality

Health Care Should Be:
- Safe
- Effective
- Patient Centered
- Timely
- Efficient
- Equitable

IOM, Crossing the Quality Chasm: A New Health System for the 21st Century (2001)

There can be no quality without equity!
Health equity means that everyone has a fair and just opportunity to be as healthy as possible.


Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

To achieve this, we must remove obstacles to health — such as poverty, discrimination, and deep power imbalances — and their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Human Impact Partners’ HealthEquityGuide.org https://healthequityguide.org/about/defining-health-equity/

What Is Health Equity?

The following should be added when the definition is used to guide measurement; without measurement there is no accountability:

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

Equity = No Significant Difference Between Groups

Without measurement there is no accountability

Capacity to disaggregate data to identify disparities depends on our collection of those demographic/SES/SDOH identifiers!

...by age
...by geography
...by insurance status
...by sexual orientation
...by gender identity
...by race/ethnicity
...by language
...by veteran status

...by disability status
...by migrant status
...by access to housing
...by income
...by employment status
...by education level
...by incarceration history
...by distance to service

And those identifiers need to be collected correctly and consistently!
Health Equity [Data] Organizational Assessment

HRET 2018

1) Data collection: self-reporting methodology
2) Data collection training
3) Data validation
4) Data stratification
5) Communicate findings: equity dashboard
6) Address and resolve gaps in care: implement interventions
7) Organizational infrastructure and culture: cultural and linguistic competence, leadership, policies


Potential Quality Metrics: Sample Dashboards

Clinical

Figure 2. Dashboard displaying race and ethnicity associated with 30-day readmissions

<table>
<thead>
<tr>
<th>30-day Readmissions</th>
<th>White</th>
<th>Hispanic</th>
<th>African-American</th>
<th>American Indian</th>
<th>Asian</th>
<th>Unknown/Other</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart failure rate</td>
<td></td>
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<tr>
<td>Heart failure volume</td>
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<tr>
<td>AMI rate</td>
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<tr>
<td>AMI volume</td>
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<tr>
<td>Pneumonia rate</td>
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<tr>
<td>Pneumonia volume</td>
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<tr>
<td>COPD rate</td>
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<tr>
<td>COPD volume</td>
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</tbody>
</table>

Patient Satisfaction

Figure 4. Template dashboard displaying race and ethnicity by HCAHPS score

HCAMPS (Hospital)

<table>
<thead>
<tr>
<th>Overall rating</th>
<th>Non-Hispanic White N</th>
<th>Hispanic N</th>
<th>Back/ African-American</th>
<th>Asian N</th>
<th>American Indian N</th>
<th>Pacific Islander N</th>
<th>Multiple Races N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall hospital recommendations</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Nurse communication</td>
<td></td>
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<tr>
<td>Doctor communication</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Quiet at night</td>
<td></td>
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<tr>
<td>Room cleanliness</td>
<td></td>
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<tr>
<td>Pain control</td>
<td></td>
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<tr>
<td>Medication information</td>
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<td>Discharge information</td>
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<td>Staff responsiveness</td>
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</tbody>
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### Potential Respectful Maternity Care Indicators for Quality Improvement

**Dignified care**
1. Women treated with respect (subject to women’s/local interpretation)
2. Providers introduce themselves to women
3. Women treated in a friendly manner (subject to women’s/local interpretation)
4. Women called by name

**Privacy and confidentiality**
5. Physical privacy ensured (e.g., examined behind screens or curtains and other physical visual barriers)
6. Auditory privacy ensured (Private patient health information not heard by others)
7. Patient records and medical files are kept confidential (not accessible to people not involved in care provision)

**No abuse**
8. No verbal abuse (insults, intimidation, shouting, scolding, threatening)
9. No physical abuse (slapping, hitting, pushing, pinching, restraining, or otherwise beating the patient)
10. No episiotomy given or sutured without anesthesia

**Autonomy**
11. Providers explain to women what to expect and any medications administered, or procedures performed
12. Women give informed consent prior to procedures and examinations
13. Women and family involved in care (e.g., decision making on treatment and procedures)
14. Women allowed to assume position of choice during labor and delivery

**Communication**
15. Women encouraged to and able to ask questions
16. Providers speaks to women in a language and at a language-level that they understand

**Supportive care**
17. Women allowed to have choice of companion during labor and delivery
18. Not denying women care (e.g., refusing care for any reason)
19. Not abandoning women during labor and delivery (e.g., not responding to woman’s Call for help)
20. Providers ask about emotional feelings and concerns of women
21. Women trust staff (subject to women’s interpretation)

---

**Focus on better understanding underlying contributors, including:**

- Lack of data
- Not educating pts about signs and sx’s -- and not believing them when they speak up
- Errors made by health care providers
- Poor communication among different health care teams

**Interventions effective in improving maternal health outcomes, such as:**

- Midwifery
- Group prenatal care
- Social and doula support

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[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7108935/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7108935/)

[To Prevent Women from Dying in Childbirth, First Stop Blaming Them](https://www.scientificamerican.com/article/to-prevent-women-from-dying-in-childbirth-first-stop-blaming-them/)
Quality Improvement Approach to Eliminate Disparities in Perinatal Morbidity and Mortality

Debra Bingham, DPH, RN, MS,†, David K. Jones, MD, Elizabeth A. Howell, MD, MPH

KEYWORDS
- Quality improvement
- Perinatal
- Disparities
- Maternal mortality
- Maternal morbidity
- Implementation
- Equity
- Population health

KEY POINTS
- Women and infants of color are disproportionately affected by health care disparities.
- The Socio-Ecological Perinatal Disparities Ishikawa Diagram outlines numerous modifiable factors that can be addressed to reduce societal, community, relationship, and individual factors that contribute to perinatal disparities.
- Quality and safety principles can be used to guide national, state, and hospital-based efforts to eliminate disparities and ensure equity for all women and newborns.

Fig. 1. Socio-Ecological Model.

Fig. 2. Socio-Ecological Perinatal Disparities Ishikawa Diagram. (Courtesy of Copyright owned by the Institute for Perinatal Quality Improvement, www.perinatalqi.org, 2018. All rights reserved. Reprinted with permission.)
Operationalizing SDOH Screening

Where can we intervene?

**PRAPARE Pre-Screener**
- Pre-screener developed
- Partnership with community-based organization

---

Health starts long before illness in our homes, schools, and jobs. The more we know about you, the better health care we can provide. We want to support your health and wellness.

Please check the areas you would like assistance with. We cannot guarantee assistance in all areas, but we will do our best to respond to your priorities.

I am having a hard time getting access to and/or paying for:

<table>
<thead>
<tr>
<th>HOUSING</th>
<th>UTILITIES (electricity, phone, heat, etc.)</th>
<th>FOOD</th>
<th>PHYSICAL SAFETY</th>
<th>MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSPORTATION</th>
<th>HEALTH INSURANCE</th>
<th>LEGAL ASSISTANCE</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYMENT</th>
<th>MATERIAL GOODS [clothing, furniture, household]</th>
<th>HEALTH SUPPLIES [prescriptions, medicine, etc.]</th>
<th>EDUCATION</th>
<th>CHILD CARE</th>
<th>SOCIAL SUPPORT</th>
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Would you like to be contacted by a member of our health care team about this survey?

### What questions are in PRAPARE?

#### Core

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Choose not to answer this question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you worried about being housed?</td>
<td></td>
<td></td>
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<tr>
<td>Which races are you?</td>
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<tr>
<td>What is the highest level of the school you have attended?</td>
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<tr>
<td>What languages are your most comfortable speaking?</td>
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<tr>
<td>How many family members, including yourself, do you currently work with?</td>
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<tr>
<td>What is your housing situation today?</td>
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<td></td>
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<tr>
<td>How often do you discuss housing issues with others?</td>
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<tr>
<td>Are you worried about being housed?</td>
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</tbody>
</table>

#### Optional

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Choose not to answer this question</th>
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</thead>
<tbody>
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<tr>
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</tr>
<tr>
<td>Are you worried about being housed?</td>
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</tbody>
</table>

#### Optional Granular

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Choose not to answer this question</th>
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<tbody>
<tr>
<td>Are you worried about being housed?</td>
<td></td>
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<tr>
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<tr>
<td>What is the highest level of the school you have attended?</td>
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<tr>
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<tr>
<td>What is your housing situation today?</td>
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<tr>
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<tr>
<td>Are you worried about being housed?</td>
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</tr>
</tbody>
</table>

*UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

**Find the tool at www.nachc.org/prapare**

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**PRAPARE Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences**

Paper Version of PRAPARE® for Implementation as of September 4, 2016

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**PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences**

Paper Version of PRAPARE® for Implementation as of September 4, 2016

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Take Action!

Black Maternal Health Week
April 11 - 17, 2021
BLACK MAMAS MATTER:
CLAIMING OUR POWER, RESILIENCE & LIBERATION

Join us April 11-17 for a week of activism and community building for Black Mamas! In solidarity with National Minority Health Month and the International Day for Maternal Health and Rights, Black Mamas Matter Alliance founded BMHW to raise awareness, inspire activism, and strengthen organizing for Black maternal health. Join the conversation: #BMHW21 and #BlackMaternalHealthWeek

www.blackmamassmatter.org/bmhw

Thank you!
Trinidad Tellez, MD
[Health] Equity Strategies
trinidad.l.tellez@dartmouth.edu
drttellez@gmail.com