Transforming Maternity Care Blueprint for Action
Disparities in Access and Outcomes of Maternity Care

This document presents the content of the Transforming Maternity Care Blueprint for Action that addresses one of eleven critical focus areas. The complete Blueprint for Action can be accessed at http://transform.childbirthconnection.org/blueprint

Problems
Disparities in maternal and newborn outcomes
In the United States, women from racial and ethnic minority communities and low-income women and their newborns are more likely to report worse overall health and poorer performance on standard indicators of maternal and newborn health. For example, the midcourse Healthy People 2010 review found that disparities for black non-Hispanic women were increasing for numerous indicators, including neonatal deaths, very low birthweight infants, mental retardation, and cerebral palsy.

Disparities in health system access and provider-level barriers
Non-Hispanic black, Hispanic, and American Indian-Alaskan Natives were more than twice as likely as non-Hispanic white women to receive late or no prenatal care in 2006; as of 2008, nearly 40% of low-income women ages 18 to 44 were uninsured. Access to high-quality maternity care is impacted by insurance transitions in pregnancy, daunting documentation processes, language and cultural barriers, limited health literacy, out-of-pocket costs, and financial disincentives for providers to accept underserved women and provide high-quality, comprehensive services. Women in remote rural areas face particular challenges, and immigrants and refugees also face disparities. Even in urban areas, provider maldistribution and transportation barriers may impact access to timely maternity care. Care available to underserved women is often more fragmented. Unequal treatment, including provider prejudice and stereotyping, and a limited ability to understand perspectives of patients with diverse backgrounds, contributes to health disparities. Communication that fails to convey respect, collaboration, and transparency reinforces mistrust.

Limitations of current “safety net” government care programs Caregivers who participate in Medicaid and other public insurance programs may not be fairly compensated for care of vulnerable populations with complex health challenges and may not have access to participating specialists for needed referral. Women with public insurance may have difficulty finding participating providers. For many women, Medicaid eligibility begins only when the pregnancy is medically determined and ends 60 days postpartum, resulting in problems accessing family planning, preconception care, and long-term postpartum services. Although Medicaid is the primary payor for about 42% of births in the country, a large proportion of which are to women of color, at the federal level CMS has not provided national leadership in developing strategies to address maternity disparities through the program.
Poor understanding of disparities and inadequate ability to measure and address them
Although this is a growing field of study, more research is needed to clarify the complex factors leading to disparities in the outcomes of care for childbearing women and newborns. While the NQF identified disparities-sensitive criteria and recommended that they be used when submitting and reviewing all candidate measures, this has been done for just 5 of the NQF-endorsed maternity care measures (all relating to prenatal care). No NQF-endorsed maternity care measures have been stratified by priority considerations of race/ethnicity, socioeconomic status, primary language, and health insurance status. Without measuring disparities, safety net providers may be penalized, and little attention may be paid to closing gaps. (See the Blueprint section on Performance Measurement and Leveraging of Results.)

The maternity care system is ill-equipped to address many perinatal disparities that arise from social factors (e.g., intergenerational poverty, social isolation, low education, and racism); these contribute through nutritional, inflammatory, infectious, and vascular pathways to preterm birth, fetal growth restriction, and other pregnancy-related morbidity, and take a toll on women, newborns, and society.

Reimbursement and funding misalignment contributes to disparities in maternity care outcomes
Payment is misaligned with goals of care. Payors often fail to reimburse for preventive services that might especially benefit low-income and minority women and ameliorate disparities, but pay readily for various overused maternity services. There is no financial reward for good outcomes, and separate, lucrative NICU payment further lessens incentives for optimal outcomes. Pay for performance (P4P) without case-mix adjustment to account for disparities in baseline population risks has the potential for unintended consequences, including diverting resources from safety net providers if the lack of adjustment makes it appear that their performance is poor compared to care of lower-risk populations. Furthermore, these settings may be less prepared for P4P because, for example, they have fewer resources to invest in health IT.

Health IT infrastructure, including electronic medical records, is inadequate, particularly among safety net providers
Inadequate health IT is a major obstacle to data collection for measuring and understanding disparities in care processes and outcomes in the settings where vulnerable populations receive care. Safety net providers may also have fewer available resources for transitioning to health IT for solutions to care coordination and decision support that can improve quality and reduce disparities. This poses a particular problem for small practices and community clinics, especially those located in medically underserved areas, and those who serve a disproportionate share of the uninsured. (See the Blueprint section on Development and Use of Health Information Technology.)

System Goals
- All women and newborns have access to and receive comprehensive high-quality, high-value reproductive health and maternity care.
- Comprehensive health care reform strategies address maternity care disparities.
- As a recognized national priority, fundamental responsibility for eliminating maternity care disparities is shared by federal agencies with broad engagement from multiple stakeholders.
Major Recommendations and Action Steps

1. Expand access to services that have been shown to improve the quality and outcomes of maternity care for vulnerable populations.
   - Through national health care reform legislation and its implementation, ensure that access to comprehensive, high-quality reproductive health and maternity care services are essential benefits for all women, without qualification, with careful attention to the adequacy of safety net programs, providers, and institutions.
   - In the short term, encourage states to exercise Medicaid’s presumptive eligibility option for pregnant women and children under Medicaid and CHIP to help ensure immediate access to maternity and pediatric care.
   - Expand public support for maternity care programs, providers, and institutions serving vulnerable populations, including undocumented women and underserved areas. Provide quality improvement funding to Federally Qualified Community Health Centers and other safety net providers, including support for health IT, training in quality improvement, and team-based care. Increase federal Title V-Maternal and Child Health block grant funding for areas where many disadvantaged women seek care.
   - Develop a standard, comprehensive set of evidence-based services for maternity care focused on health promotion and prevention of complications that addresses the entire maternity spectrum, from preconception through prenatal care, labor and birth, postpartum care and the period between pregnancies (Chatterjee, Kotelchuck, & Sambamoorthi, 2008; Wise, 2008). Include effective, high-value services that have not traditionally been maternity benefits, which can be paid for through value-based purchasing and elimination of waste. (See the Blueprint section on Scope of Covered Services for Maternity Care.)
   - Restructure payment with risk-adjusted bundling of the full episode of maternal and newborn care. Incentives for providing appropriate care through high-value clinicians and settings and achieving optimal outcomes could especially benefit minority and low-income women at increased risk for adverse outcomes and newborn intensive care unit admissions. (See the Blueprint section on Payment Reform to Align Incentives with Quality.)
   - Encourage state Medicaid programs to implement payment reform pilots. These demonstrations should target participating facilities, providers, and health centers, with guidance from CMS and MACPAC. Such payment reform pilot projects should have improvement in care processes and outcomes and reductions in disparities as primary goals. (See the Blueprint section on Payment Reform to Align Incentives with Quality.)

2. Conduct research into the determinants and the distribution of disparities in maternity care risks and outcomes of care, and improve the capacity of the performance measurement infrastructure to measure such disparities.
   - Rectify current underfunding of research addressing maternal and child health disparities, and make this a national research priority with targeted funding from the National Institutes of Health (NIH) and other federal agencies. Carry out research to determine the causes of health disparities and how to eliminate disparities created by health system processes.
   - Support the development of innovative methods for measuring the social constructs of race and ethnicity and the social determinants of disease. Encourage research collaboration with investigators in biomedicine, the social sciences, psycho-neuro-immunology, ethnography, and medical anthropology.
• Utilize the database of race, ethnicity, primary language, and gender that will be developed in response to the recommendation of the Health IT Policy Committee as directed in the recently approved federal stimulus package to track and monitor maternity care delivered and outcomes of care for all women and for relevant subgroups of women. These data need to be collected in state and national public databases.

• Integrate electronic birth certificate data with electronic medical record information to better identify risk factors and risk demographics for adverse maternal and infant outcomes. (See the Blueprint section on Performance Measurement and Leveraging of Results.)

• Develop, field test, and submit specific disparities-sensitive performance measures for NQF endorsement.

• Applying disparities-sensitive criteria from National Voluntary Consensus Standards for Ambulatory Care: Part 2 (NQF, 2009), identify a starter subset of NQF-endorsed maternity care measures for stratification by race/ethnicity, socioeconomic status, primary language, and insurance status, and specify the number of cases needed for reporting stratified results. Begin with the measures that are especially relevant to populations experiencing disparities because of high prevalence of the targeted condition or evidence of disparities in delivery of the care. Over time, add and stratify new maternity care quality measures, particularly those relevant to disparities. (For a list of suggested priority measures for risk stratification and reporting, see the full report from the Stakeholder Workgroup of Measurement and Quality Research Experts)

• Report NQF-endorsed maternity care measures stratified by key populations experiencing disparities. Call on organizations and programs that report measures to correlate measurement outcomes with maternal variables associated with disparity, such as race, ethnicity, and socio-economic status.

• Use NQF-endorsed measures to pilot risk-adjusted P4P through Medicaid demonstration projects supported by Medicaid programs, National Association of Public Hospitals and Health Systems, and National Association of Community Health Centers, focusing initially on process measures that are less affected by case mix. Use outcome data from pilots to refine case-mix adjustment.

• Use risk-adjusted data to mitigate unintended P4P consequences and worsening disparities. Without use of measures that consider differences in case-mix, for example, complexity of patient problems and needs, P4P could worsen disparities by siphoning funding away from resource-constrained providers.

3. Compare effectiveness of interventions to reduce disparities in maternity services and outcomes, and implement and assess effective interventions.
   • Ensure that the national comparative effectiveness research program, including the NIH and other sources of research funding, allocate resources to compare the effectiveness of interventions to reduce disparities in the quality and outcomes of maternity care before conception, during pregnancy, around the time of birth, and in the postpartum period.
   • Identify comparative effectiveness research priorities, including 1) assessing effectiveness in populations experiencing disparities of interventions that have been found to be beneficial in randomized controlled trials, such as progesterone for prevention of preterm birth in high-risk pregnancies, 2) further assessment of interventions that have been found to be effective in populations experiencing disparities, such as infection treatment for prevention of preterm birth in African American women, 3) further research on promising perinatal programs that focus...
on health literacy and education to improve perinatal outcomes, such as CenteringPregnancy and Baby Basics, and 4) a rigorous overview of best practices for reducing disparities in maternity care and outcomes.

- Form quality collaboratives and community-based partnerships to evaluate and implement programs to close disparities in maternity care and outcomes. Scale up and fund interventions of demonstrated effectiveness, focusing especially on implementation within safety net infrastructure. Assess and report ongoing effectiveness.
- Evaluate in populations experiencing disparities the impact on outcomes and costs of effective preventive interventions that have not reliably been covered by insurance, including:
  - Language translation. With limited exception (i.e., large, urban teaching institutions), language translation is virtually nonexistent, because payors do not reimburse for it despite much research indicating that communication is fundamental to the delivery of quality care.
  - Care coordination. High-risk women especially may be expected to benefit from care coordination.
  - Nurse home visitation. High-quality evidence has found that nurse home visitation, beginning during pregnancy, improves long-term maternal and child outcomes.
  - Comprehensive breastfeeding promotion. There is consistent, growing evidence that breastfeeding improves child and maternal health, and that various interventions enhance breastfeeding from pregnancy through the postpartum period.
  - Doulas. Continuous, supportive care during labor has been shown to increase satisfaction and reduce risk for operative birth.
- Evaluate the impact on disparities in maternity care outcomes and the cost effectiveness of flexible care options, including expanded hours such as evening and weekend clinic schedules, and flexible care delivery settings such as schools (for adolescents), mobile vans, churches, and in-home care visits.
- Evaluate the impact on disparities in maternity care outcomes and the cost effectiveness of care coordinators and community health workers.
- Expand access to midwives with nationally recognized credentials and accredited birth centers across the country. Encourage health plans to foster access to these forms of care.

4. Improve maternity care and outcomes in populations experiencing disparities by increasing the number of underrepresented minority care-givers and improving the cultural and linguistic competence of health professionals generally.

- To recruit and retain maternity providers from populations experiencing disparities:
  - Create a “tipping point” for cultural competency by increasing recruitment of underrepresented minorities into the maternity professions. Strengthen recruitment, education, retention, mentoring, and other types of support to increase the racial/ethnic, geographic, linguistic, and socioeconomic diversity of the maternity care workforce and its capacity to provide high-quality care to underserved populations. (See the Blueprint section on Action on Workforce Composition and Distribution.)
  - Maternity care professionals should engage in early outreach to students in elementary and secondary schools in disparity communities about maternity care careers. Professional groups can help to develop
informative and inspirational educational modules, and work with colleges and universities to develop or refine distance and other innovative educational programs that foster recruitment and retention of members of communities experiencing disparities.

- Create assistance programs in community colleges and other institutions of higher learning to support low-income students and students of color who wish to become maternity caregivers (midwives, nurses, nurse-practitioners, and physicians). Financial and social benefits that may foster access to health professions training include grants and scholarships, housing stipends, health insurance for students and their families, and child care services for student-parents.

- Expand the scope and eligibility for the National Health Service Corps program, to increase the capacity of maternity care providers who can provide culturally competent care, communicate in diverse languages, and practice in underserved communities.

- Establish community-based doula, childbirth educator, and peer breastfeeding counselor training programs for women in underserved communities.

To build the cultural competence of the maternity care workforce:

- Incorporate development of respectful, collaborative communication and interviewing skills and examination of biases and stereotypes into maternity professions curricula.

- Incorporate questions about cultural competency into all maternity health professional credentialing and licensure examinations. Health professional credentialing bodies should include cultural competence in Core Competencies. Include culturally competent content in national maternity professional educational meetings and publications.

To increase awareness of biases and cultural beliefs among maternity caregivers, provide routine cultural competency training in facility-based maternity care quality improvement programs and obtain feedback through client satisfaction surveys and report cards that identify race/ethnicity and language (Betancourt et al., 2009).

- Institute ready access to interpretation services and culturally appropriate maternity educational materials within health care delivery systems to foster communication and engage women and their families in maternity care. Enact legislation to provide access to these services to childbearing women with limited English skills, beginning with those targeting the most common minority populations.

- Encourage The Joint Commission to make all elements of Culturally and Linguistically Appropriate Services standards mandatory.

- Develop joint workgroups comprised of public and private payors at national, state and regional levels to share communication strategies and co-develop materials on what constitutes quality maternity care for diverse groups of women and other key audiences.

- Present data to policy makers—including evaluations, systematic reviews, and testimony—that document reduced disparities in health behaviors and outcomes through improved health literacy and education.

**Lead Responsibilities**

Leadership for a national effort to end disparities in maternity care access and outcomes should be provided by CMS, its MACPAC, and state Medicaid programs; AHRQ; Health
Resources and Services Administration and its Maternal and Child Health Bureau; Congress; state Maternal and Child Health (Title V) agencies; major health foundations; safety net providers, organizations, and institutions; quality collaboratives; national quality organizations; health professional organizations; and consumers and advocates.

References
