RACIAL DISPARITIES PROVIDER PRESENTATION





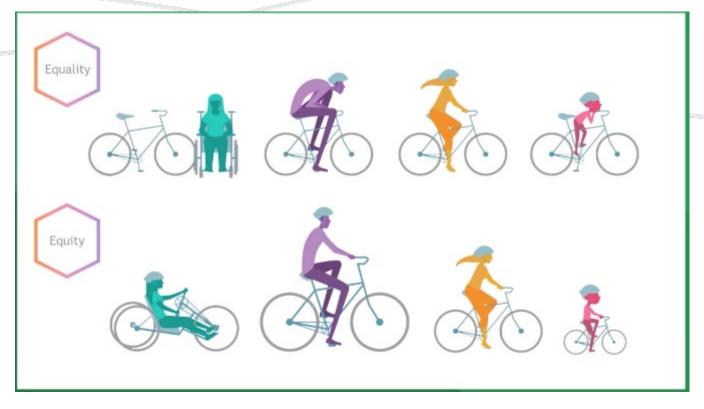
"There is no quality improvement without equity."

Joia Adele Crear-Perry, MD, FACOG Founder & President of the National Birth Equity Collaborative



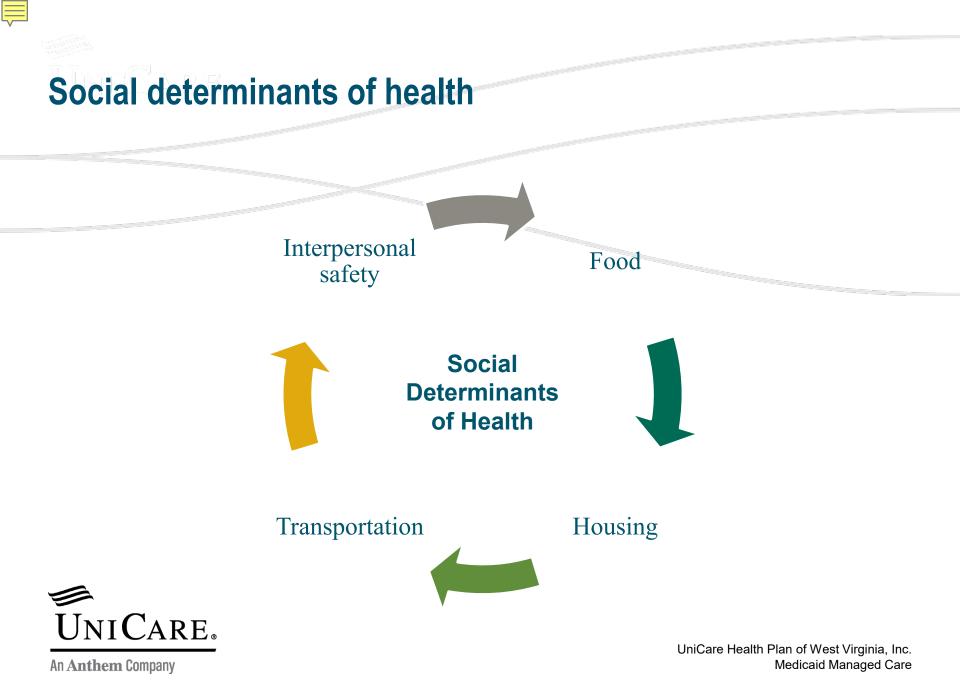
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Equality vs. equity





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Reducing disparities in severe maternal morbidity and mortality

	 Patient Factors Socio-demographics: age, education, poverty, insurance, marital status, employment, language, literacy Knowledge, beliefs, health behaviore 	obesity, depression); s	Figure 1: Pathways to Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality Preconception Care
Kace/ Eth	 behaviors Psychosocial: self-efficacy, social support Community/ Neighborhood Community, social network Neighborhood: crime, poverty, built environment, housing Provider Factors Knowledge, experience, implicit bias, cultural competence, communication System Factors Access to high quality care; transportation, structural racism, policy 	.g. HTN, DM, complication	Postpartum Care Delivery & Hospital Care



Implicit bias, explicit bias and racism

- Implicit bias
 - The attitudes or stereotypes that affect our understanding, actions and decisions in a subconscious manner.
- Explicit bias
 - The attitudes and beliefs we have about an individual or group on a conscious level; much of the time these biases and their expression arise as the direct result of a perceived threat.
- Racism
 - Prejudice, discrimination or antagonism directed against someone of a different race based on the belief that one's own race is superior.

https://implicit.harvard.edu/implicit/takeatest.html





Make sure pregnant women receive quality care during pregnancy and after.



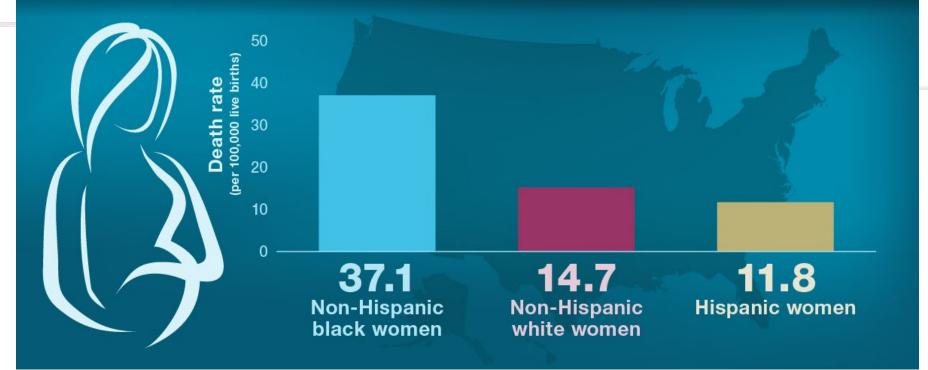


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Maternal mortality rates



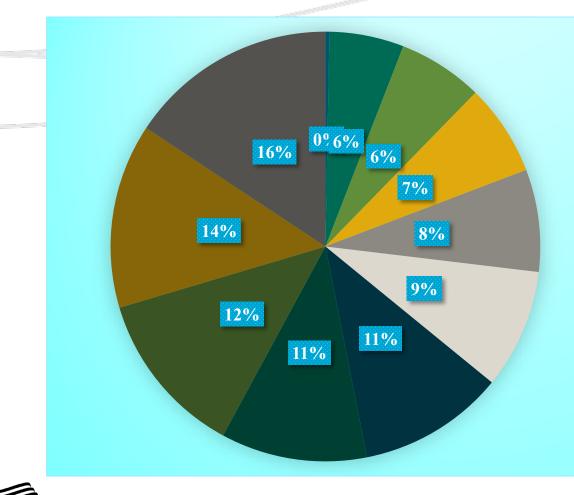
2018 MATERNAL MORTALITY STATISTICS HIGHLIGHT WIDE RACIAL AND ETHNIC GAPS





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Pregnancy-related deaths in the United States



- Anesthesia Complications
- Amniotic Fluid Embolism
- Unkown
- Hypertensive disorder 6.9%
- Cerebrovascular accidents
- Thrombotic pulmonary or other embolism
- Cardiomyopathy
- Hemorrhage
- Infection or sepsis
- Other non-cardiovascular medical conditions
- Other cardiovascular conditions

Pregnancy-related deaths in the United States during 2011 to 2016

Leading causes of death differ throughout pregnancy and after.

Heart disease and stroke cause most deaths overall. Obstetric emergencies such as severe bleeding and amniotic fluid embolism cause most deaths at delivery.

In the week after delivery, severe bleeding, high blood pressure and infection are most common.

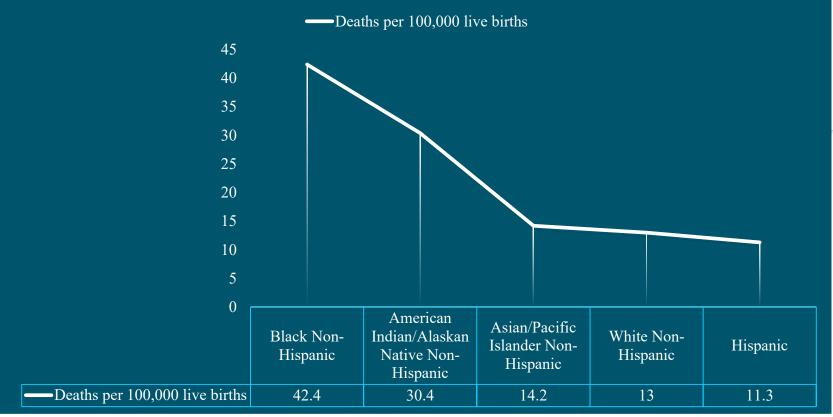
Cardiomyopathy (weakened heart muscle) is the leading cause of deaths one week to one year after delivery.



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Racial/ethnic disparities in pregnancy-related mortality

DEATHS PER 100,000 LIVE BIRTHS





Irving family's story

- The Story of the Irving Family
- https://youtu.be/YptST8FHAK4





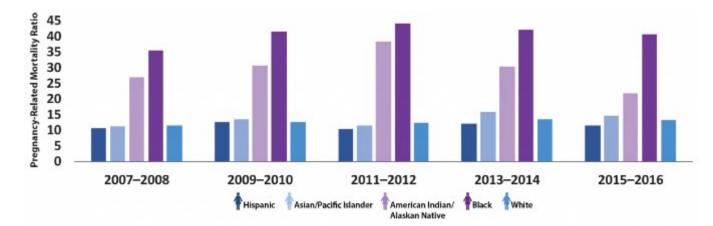
RAISING Soleil...



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H.R. 1318 Preventing Maternal Deaths Act of 2018

On December 21, 2018, the *Preventing Maternal Deaths Act (H.R. 1318)* was signed into law. This legislation sets up a federal infrastructure and allocates resources to collect and analyze data on every maternal death in every state in the nation.





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Maternal deaths in West Virginia from 2007 to 2017

	WV Maternal Deaths 2007-2017						
Year	Maternal Deaths	Resident Births	Pregnancy related Count	Pregnancy related Rate/100,000			
2007	13	22,017	2	9.1			
2008	10	21,493	2	9.3			
2009	6	21,275	1	4.7			
2010	11	20,471	4	19.5			
2011	12	20,705	1	4.8			
2012	11	20,813	1	4.8			
2013	14	20,829	3	14.4			
2014	11	20,303	3	14.8			
2015	12	19,778	3	15.2			
2016	19	19,070	2	10.5			
2017	16	18,675	4	21.4			
Total	135	225,429	26	11.5			



West Virginia maternal risk screening

Maternal risk screening is a comprehensive and uniform approach to screening conducted by maternity care providers to discover at-risk and high-risk pregnancies. The law provides for better and more measurable data regarding at-risk and high-risk pregnancies.

The law requires the West Virginia Department of Health and Human Resources (DHHR), the Bureau for Public Health (BPH) and the Office of Maternal, Child, and Family Health (OMCFH) to convene the maternal risk screening advisory committee annually and provide administrative and technical assistance to the Committee as needed.



Maternal risk screening

A prenatal risk screening instrument (PRSI) was created to be used by all maternity care providers in the State and is to be submitted to OMCFH at the first prenatal visit. Data is housed within OMCFH. (WV Code § 16-4E-1, et seq.)

http://dhhr.wv.gov/Documents/BPHResponse.pdf





- H.R.1318 Preventing Maternal Deaths Act of 2018
- 115th Congress (2017-2018)
- ACOG Partners with Black Mamas Matter Alliance
- <u>CDC Infant Mortality</u>
- <u>CDC Pregnancy-related Deaths</u>
- <u>http://dhhr.wv.gov/Documents/BPHResponse.pdf</u>
- <u>https://www.cdc.gov/reproductivehealth/maternal-</u> mortality/disparities-pregnancy-related-deaths/infographic.html



www.unicare.com

UniCare Health Plan of West Virginia, Inc. UWVPEC-1640-20 September 2020

